

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G044	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2015
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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6381 LUTE RD PORTAGE, IN 46368
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W 000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey.</p> <p>Dates of Survey: February 23, 24, 25, 27 and March 2 and 3, 2015.</p> <p>Facility number: 000600 Provider number: 15G044 AIM number: 100233500</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/20/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review, the governing body failed to meet the Condition of Participation: Governing Body for 1 of 4 sampled clients and 1 additional client (clients #4 and #5). The</p>	W 102	On3/9/15 , the Chief Program Officer met with the Lead Nurse, Group Home Nurse and Director of Supervised Living to discuss proper documentation on client medical information and communication into the	04/02/2015

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>governing body neglected to exercise general policy and operating direction over the facility to develop and/or implement a policy and procedure on how the facility's nursing services were to document medical information and communication into the clients' records, failed to ensure the facility's nursing services developed risk plans/medical protocols and trained all staff who worked with the clients residing at the group home on risk plans/medical protocols, failed to ensure the facility's nursing services ensured clients' prescribed medications were available for administration at the group home, failed to ensure the facility's nursing services participated in Inter Disciplinary Team (IDT) meetings and failed to ensure the facility's nursing services developed a protocol and ensured staff were properly trained by a licensed medical professional for the daily use of client #4's prescribed dilation catheter.</p> <p>Findings include:</p> <p>1. Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (client #4) plus 1 additional client (client #5). The governing body neglected to ensure staff were trained on the use of a dilation</p>		<p>medical records;development of risk plans and medical protocols; and ensuring all staff are properly trained on high risk plans/medical protocols. During the facilitation of this meeting, it was also discussed that nursing will ensure all client's medications are available for administration. Lastly, it was discussed that the agency will ensure that nursing services and their recommendations are thoroughly documented in the IDT meeting notes, with the use of an additional supplemental notes pages. In the supplemental notes page, all conversation will be documented. The IDT meeting minutes and supplemental page process was begun at the 3/10/15 at Lute Road IDT. A Dilation Catheterization Protocol was written on 3/19/15 for individual #4 and on 3/27/15, the Group Home Nursere trained all staff on the protocol. On April 2, 2015, Policy number #5080 (Nurses Monthly Report/Nursing Notes) and #5075(Health Care Documentation) were revised to reflect the procedure for documentation of medical information. To ensure ongoing compliance, the following steps will be taken: The Director of Nursing, or designee, will conduct a check, once per month, of theTherap system, to ensure nursing is completing thorough and accurate documentation on each individual's health status.</p>		

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	<p>catheter for client #4. The governing body neglected to specifically address/develop a dilation catheter protocol/risk plan for client #4. The governing body failed to implement written policy and procedures to prevent neglect by not ensuring the facility's nursing services developed protocols and/or risk plans to give staff guidance on clients #4 and #5's medical needs. The facility's nursing services neglected to discuss medical/health concerns with clients #4 and #5's IDTs (Inter Disciplinary Teams). The facility neglected to ensure written documentation was entered into clients #4 and #5's medical regards in regard to change of health status.</p> <p>2. Please refer to W104. The governing body failed to exercise general policy and operating direction over the facility for 1 of 4 sampled clients (client #4), plus 1 additional client (client #5) to develop and/or implement written policy and procedure on how the facility's nursing services were to document medical information and communication into the clients' records, neglected to ensure the facility's nursing services developed risk plans/medical protocols and trained all staff who worked with the clients residing at the group home on risk plans/medical protocols, neglected to</p>		<p>Any time the IDT determines that a high risk protocol needs to be developed or updated (for reasons including, but not limited to: follow up from physician appointment, new diagnosis, emergency health condition, change of medical status), nursing will complete the request and then provide training to all group home staff. As medications are ordered/delivered from the pharmacy, member(s) of nursing will conduct a check-in of the medication to ensure proper delivery as well as the accuracy of the medications. They will then ensure the medication gets to the home for ongoing administration. The IDT notes will be completed by the Director of Supervised Living, or designee, and will be reviewed by the Chief Program Officer after each Interdisciplinary meeting, to ensure their completion and appropriate follow through for any necessary high risk protocol implementation and training.</p>	

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	<p>ensure the facility's nursing services participated in Inter Disciplinary Team (IDT) meetings and neglected to ensure the facility's nursing services developed a protocol and ensured staff were properly trained by a licensed medical professional for the daily use of client #4's dilation catheter.</p> <p>3. Please refer to W318. The governing body failed to exercise general policy and operating direction over the facility to meet the Condition of Participation, Health Care Services, as the governing body failed to provide adequate nursing services for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #7 and #8).</p> <p>9-3-1(a)</p>			

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W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (clients #1, #2, #4, #5, #7 and #8), the facility's governing body failed to exercise general policy and operating direction over the facility to develop and/or implement a policy and procedure on how the facility's nursing services were to document medical information and communication into the clients' records, failed to ensure the facility's nursing services developed risk plans/medical protocols and trained all staff who worked with the clients residing at the group home on risk plans/medical protocols, failed to ensure the facility's nursing services ensured clients' prescribed medications were available for administration at the group home, failed to ensure the facility's nursing services participated in Inter Disciplinary Team (IDT) meetings and failed to ensure the facility's nursing services developed a protocol and ensured staff were properly trained by a licensed medical professional for the daily use of client #4's dilation catheter.</p>	W 104	<p>On 3/9/15, the Chief Program Officer met with the Lead Nurse, Group Home Nurse and Director of Supervised Living to discuss proper documentation on client medical information and communication into the medical records; development of risk plans and medical protocols; and ensuring all staff are properly trained on high risk plans/medical protocols. During the facilitation of this meeting, it was also discussed that nursing will ensure all client's medications are available for administration. Lastly, it was discussed that the agency will ensure that nursing services and their recommendations are thoroughly documented in the IDT meeting notes, with the use of an additional supplemental notes pages. In the supplemental notes page, all conversation will be documented. The IDT meeting minutes and supplemental page process was begun at the 3/10/15 at Lute Road IDT. A Dilation Catheterization Protocol was written on 3/19/15 for individual #4 and on 3/27/15, the Group Home Nurse retrained all staff on the protocol. On April 2, 2015, Policy number #5080 (Nurses</p>	04/02/2015

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	<p>Findings include:</p> <p>Please refer to W149: The governing body neglected for 1 of 4 sampled clients and 1 additional client (clients #4 and #5), to develop and/or implement written policy and procedures to prevent neglect by not ensuring the facility's nursing services developed protocols and/or risk plans to give staff guidance on clients #4 and #5's medical needs. The facility's nursing services neglected to discuss medical/health concerns with clients #4 and #5's IDT (Inter Disciplinary Team). The governing body neglected to ensure written documentation was entered into clients #4 and #5's medical regards in regard to change of health status.</p> <p>Please refer to W331: The governing body neglected to ensure clients' prescribed medications (#1, #2, #4, #5, #7, #8) were available at the group home for administration to prevent medication errors. The facility's nursing services neglected to ensure facility staff were adequately trained and showed competency in regard to administering medications as ordered by the physician. The facility's nursing services neglected to ensure the pharmacist's recommendations were reported to the physician and Interdisciplinary Team (IDT). The facility's nursing services</p>		<p>Monthly Report/Nursing Notes) and #5075 (Health Care Documentation) were revised to reflect the procedure for documentation of medical information. To ensure ongoing compliance, the following steps will be taken: The Director of Nursing, or designee, will conduct a check, once per month, of theTherap system, to ensure nursing is completing thorough and accurate documentation on each individual's health status Any time the IDT determines that a high risk protocol needs to be developed or updated (for reasons including, but not limited to: follow up from physician appointment,new diagnosis, emergency health condition, change of medical status), nursing will complete the request and then provide training to all group home staff. As medications are ordered/delivered from the pharmacy, member(s) of nursing will conduct a check-in of the medication to ensure proper delivery as well as the accuracy of the medications. They will then ensure the medication gets to the home for ongoing administration. The IDT notes will be completed by the Director of Supervised Living, or designee, and will be reviewed by the Chief Program Officer after each Interdisciplinary meeting, to ensure their completion and appropriate follow through for any</p>		

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	<p>neglected to develop a medical protocol to specifically address client #4's physician ordered daily use of a dilation catheter and failed to ensure all staff who worked directly with client #4 were trained by a licensed medical professional on the use of a dilation catheter. The facility's nursing services neglected to maintain a reproducible written system on documentation of when the nursing services was notified of medical concerns for each client who resided at the group home, when the group home nurse assessed clients and when the group home nurse communicated with the clients' physicians in regard to medical conditions. The facility's nursing services neglected to discuss medical concerns at the clients' IDT meetings, when changes in clients' health status occurred.</p> <p>9-3-1(a)</p>		necessary high risk protocol implementation and training	

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W 122 Bldg. 00	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients and 1 additional client (clients #4 and #5). The facility neglected to implement its written policy and procedures to prevent neglect in regard to not ensuring clients' medications were available for administration at the group home. The facility neglected to ensure staff were trained on the use of a dilation catheter for client #4. The facility neglected to specifically address/develop a dilation catheter protocol/risk plan for client #4.</p> <p>Findings include:</p> <p>1. Please refer to W149: The facility neglected for 1 of 4 sampled clients and 1 additional client (clients #4 and #5), to implement written policy and procedures to prevent neglect by not ensuring the facility's nursing services developed</p>	W 122	<p>1. On 3/9/15, the Chief Program Officer met with the Lead Nurse, Group Home Nurse and Director of Supervised Living to discuss proper documentation on client medical information and communication into the medical records; development of risk plans and medical protocols; and ensuring all staff are properly trained on high risk plans/medical protocols. Lastly, it was discussed that the agency will ensure that nursing services and their recommendations are thoroughly documented in the IDT meeting notes, with the use of an additional supplemental notes page. In the supplemental notes page, all conversation will be documented. The IDT meeting minutes and supplemental page process was begun at the 3/10/15 at Lute Road IDT. A Dilation Catheterization Protocol was written on 3/19/15 for individual #4 and on 3/27/15, the Group Home Nurse retrained all staff on the protocol. Client #5 was</p>	04/02/2015

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	<p>protocols and/or risk plans to give staff guidance on clients #4 and #5's medical needs. The facility's nursing services neglected to discuss medical/health concerns with clients #4 and #5's IDTs (Inter Disciplinary Teams). The facility neglected to ensure written documentation was entered into clients #4 and #5's medical regards in regard to change of health status.</p> <p>2. Please refer to W331: The facility's nursing services failed to ensure clients' prescribed medications (#1, #2, #4, #5, #7, #8) were available at the group home for administration to prevent medication errors. The facility's nursing services failed to ensure facility staff were adequately trained and showed competency in regard to administering medications as ordered by the physician. The facility's nursing services failed to ensure the pharmacist's recommendations were reported to the physician and Interdisciplinary Team (IDT). The facility's nursing services failed to develop a medical protocol to specifically address client #4's physician ordered daily use of a dilation catheter and failed to ensure all staff who worked directly with client #4 were trained by a licensed medical professional on the use of a dilation catheter. The facility's nursing services failed to maintain a reproducible</p>		<p>hospitalized from 2/27/15 to 3/29/15, with the exception of an approximate 48 hour period and passed away on 3/29/15 in a Nursing Rehabilitation Facility from previously diagnosed cancer. On April 2, 2015, Policy number #5080 (Nurses Monthly Report/Nursing Notes) and #5075 (Health Care Documentation) were revised to reflect the procedure for documentation of medical information. To ensure ongoing compliance, the following steps will be taken: The Director of Nursing, or designee, will conduct a check, once per month, of the Therap system, to ensure nursing is completing thorough and accurate documentation on each individual's health status. Anytime the IDT determines that a high risk protocol needs to be developed or updated (for reasons including, but not limited to: follow up from physician appointment, new diagnosis, emergency health condition, change of medical status), nursing will complete the request and then provide training to all group home staff. The IDT notes will be completed by the Director of Supervised Living, or designee, and will be reviewed by the Chief Program Officer after each Interdisciplinary meeting, to ensure their completion and appropriate follow through for any necessary high risk protocol implementation and training.</p>	

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	written system on documentation of when the nursing services was notified of medical concerns for each client who resided at the group home, when the group home nurse assessed clients and when the group home nurse communicated with the clients' physicians in regard to medical conditions. 9-3-2(a)		1. On 3/9/15, the Chief Program Officer met with the Lead Nurse, Group Home Nurse and Director of Supervised Living to discuss how nursing will ensure all client's (#1,2,4,5,7,8) medications are available for administration. As medications are ordered/delivered from the pharmacy, member(s) of nursing will conduct a check-in of the medication to ensure proper delivery as well as the accuracy of the medications. They will then ensure the medication gets to the home for ongoing administration. All staff were retrained on medication administration on Jan. 15, 2015 to ensure they are competent in the administration of medications for all clients (including the 6 rites of medication administration). Staff will continue to receive annual retraining in medication administration (Med Review) at minimum or more frequently as needed. There were additional retraining's on 2/3/15 and 2/10/15 for individual staff who committed a further med errors. To ensure further compliance in this area, the QDDP will conduct random monthly home visits and will observe staff during med administration, nursing will monitor when completing random home visits, and the manager will monitor med passes by the certified med passer while on shift. Documentation will be maintained of these observations		

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W 149 Bldg. 00	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 record review and interview for 1 of 4 sampled clients and 1 additional client (clients #4 and #5), the facility neglected to implement written policy and procedures to prevent neglect by not	W 149	and competency will need to be demonstrated by certified med passers. If it is determined at any time, that staff fail to follow the policy for med administration, they will be required to retake Med Core A and B within 30 days taught by a certified nursing instructor. He/she will be suspended from med passes during this time. The certified Nurse trainer will ensure the appropriate measures have occurred. Nursing will continue to send the quarterly pharmacy reviews to the physician's for follow up. All recommendations will be sent to the appropriate physician with a letter of request for follow up. Further, the nurse will document the pharmacy recommendations on her monthly summary so the recommendations can be discussed by the interdisciplinary team. The QA coordinator will conduct random checks with the nursing office to ensure these pharmacy recommendations are being sent to the physicians. On 3/9/15 , the Chief Program Officer met with the Lead Nurse, Group Home Nurse and Director of Supervised Living to discuss proper documentation on client medical information	04/02/2015	

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	<p>ensuring the facility's nursing services developed protocols and/or risk plans to give staff guidance on clients #4 and #5's medical needs. The facility's nursing services neglected to discuss medical/health concerns with clients #4 and #5's IDT (Inter Disciplinary Team). The facility neglected to ensure written documentation was entered into clients #4 and #5's medical regards in regard to change of health status.</p> <p>Findings include:</p> <p>1. A review of client #4's record was conducted on 2/24/15 at 4:45 P.M.. Review of client #4's record indicated an Individual Support Plan (ISP) dated 11/1/14 which indicated: "Other chronic conditions: ...HX (History) of Urinary retention, Urethral Stricture (narrowing of the urethra caused by injury or disease such as urinary tract infection may cause decreased urine output)...4/12/13 [client #4] went to have a cystoscopy completed but unsuccessful due to urethral stricture. Dilation and cysto(scopy) to be completed at hospital. 4/23/13 [client #4] went to [Hospital name] and tip of urethra was dilated. Everything else looked good and procedure went well. 5/13/13 [client #4] saw [Physician name] for follow up from cystoscopy and urethral dilation. Ultrasound of bladder</p>		<p>and communication into the medical records; development of risk plans and medical protocols; and ensuring all staff are properly trained on high risk plans/medical protocols. Lastly, it was discussed that the agency will ensure that nursing services and their recommendations are thoroughly documented in the IDT meeting notes, with the use of an additional supplemental notes pages. In the supplemental notes page, all conversation will be documented. The IDT meeting minutes and supplemental page process was begun at the 3/10/15 at Lute Road IDT. A Dilation Catheterization Protocol was written on 3/19/15 for individual #4 and on 3/27/15, the Group Home Nurse retrained all staff on the protocol. Client #5 was hospitalized from 2/27/15 to 3/29/15, with the exception of an approximate 48 hour period and passed away on 3/29/15 in a Nursing Rehabilitation Facility from previously diagnosed cancer. On April 2, 2015, Policy number #5080 (Nurses Monthly Report/Nursing Notes) and #5075 (Health Care Documentation) were revised to reflect the procedure for documentation of medical information. To ensure ongoing compliance, the following steps will be taken: The Director of Nursing, or designee, will conduct a check, once per month, of the Therap system, to ensure nursing is completing</p>	

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	<p>shows bladder is not emptying completely. Urethra is starting to close. A catheter will need to be inserted daily to keep urethra opened. Will need to be done for at least 6 months-possibly for life. 6/17/13 [client #4] saw [Physician name] due to staff having difficulty inserting the catheter. [Physician name] notes that the urethra has closed again. Schedule for another dilation for 7/3/13. 7/3/13 [client #4] went to [Hospital name] for cystoscopy and urethra dilation. Needs to have catheter inserted and stay in for 10 days to ensure the opening does not close again. 7/12/13 [client #4] saw [Physician name] and catheter was removed. Insert the dilation catheter every night. Since dilation has been completed frequent urination and accidents have no longer continued."</p> <p>Review of client #4's record indicated a "Medical Appointment Form" dated 7/12/13 which indicated: "Start back up catheter inserting once daily." A review of a "Medical Appointment Form" dated 2/14/14 indicated: Reason for Appointment: Resistance of catheter...Collected urine sample. Dr. (Doctor) took an ultrasound of his bladder. Inserted catheter wants us to insert catheter all the way until we see urine. He said [client #4] was tight when he inserted the catheter. He wants to see</p>		<p>thorough and accurate documentation on each individual's health status. Any time the IDT determines that a high risk protocol needs to be developed or updated (for reasons including, but not limited to: follow up from physician appointment, new diagnosis, emergency health condition, change of medical status), nursing will complete the request and then provide training to all group home staff. The IDT notes will be completed by the Director of Supervised Living, or designee, and will be reviewed by the Chief Program Officer after each Interdisciplinary meeting, to ensure their completion and appropriate follow through for any necessary high risk protocol implementation and training.</p> <p>1.A Dilation Catheterization Protocol was written on 3/19/15 for individual #4 and on 3/27/15, the Group Home Nurse retrained all staff on the protocol. Any time the IDT determines that a high risk protocol needs to be developed or updated (for reasons including, but not limited to: follow up from physician appointment, new diagnosis, emergency health condition, change of medical status), nursing will complete the request and then provide training to all group home staff The IDT notes will be completed by the Director of Supervised Living, or designee, and will be reviewed by the Chief</p>	

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	[client #4] back in 1 year unless anything changes. He said to cancel [client #4]'s 4/18/14 appointment." Review of client #4's record indicated: "Indwelling Urinary Catheter Protocol" dated 3/31/14 which indicated: "Health Care Plan Issue: To maintain urinary tract health, to avoid contamination of the bladder and to prevent urinary tract infections. A catheter may be needed because of certain medical conditions. [Client #4] has (sic) difficulty in emptying his bladder completely. When urine is left in the bladder, it can cause urinary tract infections. Therefore, [client #4] doctor (sic) has ordered an indwelling catheter which means it is to stay in and be replaced according to the doctor's order. Issue Clarification: [Client #4] has a catheter. A urinary catheter is a flexible tube used to drain urine from the bladder when the client is unable to urinate or fully cannot empty their bladder. The catheter will be placed into the bladder by a nurse inserting in through the penis. When the catheter is in the bladder, a small balloon is inflated to keep the catheter in place. The catheter allows urine to drain from the bladder into a bag that is either attached to the client's leg or a larger bag that can be attached to the wheelchair or bed...." Review of client #4's Medication Administration Records (MAR) dated 10/1/14 to 12/31/14		Program Officer after each Interdisciplinary meeting, to ensure their completion and appropriate follow through for any necessary high risk protocol implementation and training. 2. Client #5 was hospitalized from 2/27/15 to 3/29/15, with the exception of an approximate 48 hour period and passed away on 3/29/15 in a Nursing Rehabilitation Facility from previously diagnosed cancer. Any time the IDT determines that a high risk protocol needs to be developed or updated (for reasons including, but not limited to: follow up from physician appointment, new diagnosis, emergency health condition, change of medical status), nursing will complete the request and then provide training to all group home staff The IDT notes will be completed by the Director of Supervised Living, or designee, and will be reviewed by the Chief Program Officer after each Interdisciplinary meeting, to ensure their completion and appropriate follow through for any necessary high risk protocol implementation and training. Conversations were had with the IDT regarding client #5's healthcare status but were not properly documented. The following steps will ensure future compliance: On 3/9/15, the Chief Program Officer met with the Lead Nurse, Group Home Nurse and Director of Supervised Living				

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	<p>indicated: "10/16/14 catheter not done d/t (due to) failure to order nurse and manager notified...12/16/14 Relief staff attempted to insert catheter, [client #4] complained of pain. Nurse notified advised it was ok to skip one night...12/26/14 catheter not signed for."</p> <p>Review of the record neglected to indicate client #4's catheter was inserted by the facility's nursing services. Review of "High Risk Acknowledgement" staff sign in sheets dated 5/14 and 8/14 neglected to indicate all staff who worked at the group home with client #4 were trained by the facility's nursing services on a protocol/risk plan for the use of a dilation catheter. Review of the record indicated client #4 had an order for daily use of a dilation catheter. Review of client #4's record did not indicate he was ordered the use of an indwelling catheter. The record neglected to indicate the facility's nursing services developed a protocol and/or risk plan specifically addressing the use of a dilation catheter to give staff guidance on client #4's daily use of a dilation catheter as ordered by the physician.</p> <p>A review of the facility's "Universal Policies and Procedures-Adult Services-Abuse and Neglect" policy dated 4/14/10 was conducted on 2/23/15</p>		<p>to discuss proper documentation on client medical information and communication into the medical records; development of risk plans and medical protocols; and ensuring all staff are properly trained on high risk plans/medical protocols. Lastly, it was discussed that the agency will ensure that nursing services and their recommendations are thoroughly documented in the IDT meeting notes, with the use of an additional supplemental notes pages. In the supplemental notes page, all conversation will be documented. The Director of Nursing, or designee, will conduct a check, once per month, of the Therap system, to ensure nursing is completing thorough and accurate documentation on each individual's health status and conversations had with physicians and family of the individuals. The IDT notes will be completed by the Director of Supervised Living, or designee, and will be reviewed by the Chief Program Officer after each Interdisciplinary meeting, to ensure their completion and appropriate follow through for any necessary high risk protocol implementation and training. The IDT meeting minutes and supplemental page process was begun at the 3/10/15 at Lute Road IDT. On April 2, 2015, Policy number #5080 (Nurses Monthly Report/NursingNotes) and #5075 (Health Care Documentation) were revised to</p>		

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	<p>at 4:30 P.M.. Review of the policy indicated: "Opportunity Enterprises, Inc. does not condone and will not tolerate physical, verbal or sexual abuse, neglect or exploitation of individuals served....Definition-Neglect: Includes the refusal or failure to provide appropriate care, food, medical care or supervision."</p> <p>An interview with the group home nurse assigned to the group home was conducted on 2/24/15 at 2:50 P.M.. The group home nurse indicated she did not insert client #4's dilating catheter daily and indicated the facility's nursing services had not trained the group home staff on the insertion of client #4's dilation catheter. The nurse indicated the GHAM trained the staff on the use of the catheter. When asked if the GHAM was a licensed medical professional, the nurse indicated she was not. The nurse indicated client #4's dilation catheter is inserted daily. When asked if client #4 had an order for the use of an indwelling catheter, the nurse indicated he did not. When asked if a protocol and /or risk plan had been developed for the use of a dilation catheter, the nurse indicated she was not sure.</p> <p>An interview with the Director of Nursing (DON) was conducted on 2/25/15 at 1:35 P.M.. The DON</p>		reflect the procedure for documentation of medical information.				

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	<p>indicated client #4 was prescribed the use of a catheter PRN (as needed). The DON indicated it was ok for staff to insert the catheter when needed for client #4.</p> <p>When asked if the group home staff were trained on the insertion of the dilation catheter, the DON stated "Yes, they have been trained by nursing staff." A request for written documentation was made to indicate all staff who worked with client #4 were trained on the insertion of the dilation catheter by licensed medical professionals. No documentation was submitted to indicate all group home staff were trained on the insertion of a dilation catheter.</p> <p>An interview with Direct Support Professionals (DSPs) #3 and #7 was conducted on 2/25/15 at 5:30 P.M..</p> <p>When asked if client #4 used a catheter, DSP #7 stated "Yes, we insert a catheter every night before he goes to bed so he can urinate, it used to be at 8 P.M. but now it's right before bed." When asked if client #4 was ordered the use of an indwelling catheter, DSP #7 indicated they did not know what an indwelling catheter was. DSP #7 stated "We insert the tube and then remove it when he is done urinating." When asked if the facility's nursing services trained the staff on the use of a dilation catheter, DSP #7 stated "No, the old GHM trained the</p>			

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	<p>Group Home Assistant Manager (GHAM) and then the GHAM trained all of the staff." When asked if the nurse inserts client #4's dilation catheter, DSP #7 stated "No." When asked if client #4 had a protocol and/or risk plan for the use of a dilation catheter, DSP #7 indicated he did not.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 A.M.. The QIDP indicated the QIDP trains the group home staff on each client's protocols. When asked who trained the staff on the use of client #4's dilation catheter, the QIDP indicated the GHAM trained the staff. When asked if client #4 was ordered an indwelling catheter, the QIDP indicated he was not. When asked if there was a protocol and/or risk plan developed by the facility's nursing services to give staff guidance for client #4's use of a dilation catheter, the QIDP indicated there was not.</p> <p>2. A review of the facility's records was conducted on 2/23/15 at 1:20 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports (GERs) (Internal Reports) and investigation records indicated:</p>				

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	-BDDS report dated 6/6/14 involving client #5 indicated: "Staff reports: On 6/6/14 at 4:00 A.M. I received a phone call from [Staff #20]. She stated that [client #5] was breathing fast and when she asked him if he was ok he just had a blank stare. She asked him if he wanted to stay in his room and he said 'no'. He came out to the living room and laid on the couch and curled up. He then started to say 'no, no, no'. I told her I was on my way. I then called her back and told her to call for an ambulance. I asked her to call nursing and QDDP (Qualified Developmental Disabilities Professional). I arrived at group home and the paramedics had [client #5] in ambulance. I followed the ambulance to [Hospital name]. Upon his arrival at the hospital [client #5]'s O2 (oxygen) was between 72-77. [Physician name] was Dr. on duty this morning. I told him that [client #5] had a CT scan (X-ray) done on 6/2/14 and we have not heard anything yet. He pulled up the results and said that [client #5]'s left lower lung is not getting oxygen because it is full of cancer and the cancer is spreading to the right lung. The Dr ordered an X-ray of lungs and blood work was drawn. He also ordered a blood test from the artery to see how much oxygen is in his blood. Nurse came in and stated that he was being			

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	<p>admitted and that they are waiting for a room. I left hospital at 1:15 P.M. and there was no more information. He is still waiting for a room....Follow up as of 6/13/14: 6/6/14 at 3:30 P.M. [client #5] was admitted to a hospital room due to labored breathing and possibility of cancer in his left lung, per a CT scan performed on 6/2/14. 6/7/14 [Physician] listened to [client #5]'s lungs and said the right upper portion of his lung sounds good, bottom right lung is diminished, entire left lung is diminished and has no air exchange at all. [Client #5] was put on 5 liters of oxygen and [Physician] ordered a bronchoscopy done in the morning of his lungs to see the extent of the blockage and if it was in fact cancer or just fluid. 4:30 P.M. all vitals were taken, within normal limits, no food or drink after midnight. Ultrasound of [client #5]'s back was performed, fluid found in lungs. A thorencentisis was performed to remove the fluid from [client #5]'s lungs. The fluid that was extracted was blood. A chest xray was performed to see level of fluid in the lungs. The doctor was unable to extract all the fluid from the lungs with the thorencentisis, so a chest tube had to be inserted in order to drain all of the fluid in the lungs. [Client #5] received Lidocaine to numb the area where the tube was inserted and Morphine</p>			

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	<p>afterwards for the pain. The bronchoscopy was canceled due to the blood drainage. The doctor didn't want to go in and scope the area without knowing where the blood was coming from, as to not exacerbate the bleeding further. 3 1/2 liters of blood was drained from his lungs. 6/8/14 [client #5] is doing well this morning; ate breakfast and was resting on and off all day. [Client #5] broke a blood vessel in his left eye; doctor is unsure how this happened. No medication or further action was taken for the eye at this time; continue to monitor. Vitals WNL (within normal limit) all day. Physical therapist came in to help [client #5] move around. He sat up on the side of the bed and was standing up with assistance of a walker. He got out of bed and sat up in a chair for a little while. [Client #5] looks pale and is very tired and weak today. [Client #5] slept on and off all day. Chest tube is still in place and blood is still draining from it, though not as much as previous day. [Client #5] ate breakfast, lunch and dinner without any issue; he is asking for food throughout the day. 6/9/14 [Physician] stated the blood is almost fully drained from [client #5]'s lungs and it will be tested for cancerous cells today. Still unsure what the cause of the bleeding is. Will possibly do the bronchoscopy if necessary. No changes</p>			

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	<p>in status; waiting on results of blood testing. Physical Therapy came in to get [client #5] moving around...6/10/14 [Physician #1] and [Physician #2] came in to see [client #5] today. No results yet of the blood testing. Lungs sounded a little more open today; [client #5] will be doing breathing exercises more. Chest X-ray performed; minimal amount of blood still in lungs. No changes in status; still awaiting blood test results. 6/11/14 Results of blood testing came back as cancerous cells in the blood, related to the lung cancer. Fluid build up is most likely a result of the cancer cells bleeding in his lungs. [Physician #1] scheduled a left thoroscopy with talc pleurodesis to be performed 9:30 A.M. on 6/12/14. They will be inserting a port in order to administer chemotherapy and packing his lungs with a talc powder to help subside the bleeding cells. [Client #5] is still eating well and sleeping on and off all day. 6/12/14 at 9:30 A.M. [client #5] is pbeing (sic) prepped fro (sic) surgery. [Physician #1] will be performing a left thoroscopy with talc pleurodesis; inserting a port into [client #5]'s left chest in order to start administering chemotherapy and packing his lungs with talc powder to subside the cancer cells bleeding...[Physician #1] stated the surgery went well, but they had to insert the port on the right side chest instead of</p>			

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	<p>the left due to an abnormal vein on the left side....Health care professionals will be notified if [client #5]'s fever is over 101, redness at the port at cath or chest tube incision site, shortness of breath, unable to eat or gains more than 3 pounds per day, per hospital discharge orders. Emergency personnel will be notified for shortness of breath or chest pain, weakness of extremities, confusion, trouble seeing, dizziness or loss of balance/coordination, or severe headache with no known cause, per hospital discharge orders. Staff and nursing will continue to monitor for health and safety per agency policy as well as following any future doctor's orders." Further review of the record neglected to indicate the facility's nursing services developed a protocol and/or risk plan in regard to client #5's health status.</p> <p>-BDDS report dated 10/13/14 involving client #5 indicated: "[GHM] reports: [Client #5] was in the restroom when staff heard him yelling. Staff went into restroom to see if she could assist [client #5] with anything. Staff said that [client #5] was laying on the floor yelling and crying that his stomach hurt. Staff called me (GHM) and told me what was going on. I asked her to call the nursing pager and that I would meet her and [client #5] at the hospital. While at the hospital</p>			

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	<p>[client #5] had labs done, a CT scan and a UA (urine analysis) completed. Blood work came back ok. The CT scan showed Bladder inflammation and the intestinal wall was inflamed. The doctor said that the inflammation for the intestine could be a viral or bacterial infection. Dr said that there could be no way to tell without doing more testing. Dr gave [client #5] an IV (Intravenous) with antibiotics, Levaquin. [Client #5] finished all antibiotics and fluids and was discharged. ER (Emergency Room) recommendations were to follow up with general practitioner in 2-3 days. [Client #5] was prescribed naproxen 500 mg 1 tab BID (twice daily, Tylenol extra strength 500 mg every 4 hours, Flagyl 500 mg every 12 hours, Levaquin 750 mg 1 tablet every day for 14 days and Zofran 4 mg 1 tablet three times daily PRN (as needed).</p> <p>Further review of the record neglected to indicate the facility's nursing services developed a protocol and/or risk plan in regard to client #5's health status.</p> <p>A review of client #5's record was conducted on 2/24/15 at 1:50 P.M.. A review of client #5's medical appointment records indicated:</p> <p>-Medical notation dated 10/14/14</p>			

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	<p>documented by the GHAM indicated: "After his doctors appointment [client #5] seemed to be having trouble breathing and was shaking. Notified nurse instructed to take to the ER. Arrived to the ER at 4:30 P.M.. When he got there his B/P was 109/62, temp 99.0, pulse 94 and O2 was 100. EKG was completed at 4:39 P.M.. X-ray of his chest completed. He had labs drawn threw (sic) his port at 5:18 P.M. Aspirin 325 mg administered at 5:25 P.M.. B/P at 5:27 P.M. was 144/73. Morphine was administered threw (sic) his port at 6:30 P.M. for pain. At 6:30 P.M. B/P 128/66. At 7:00 P.M. B/P 127/66. At 7:30 P.M. B/P was 134/71. At 8:00 P.M. B/P was 133/80. At 8:30 P.M. B/P was 142/77. He had an IV put in his left arm bend that collapsed. The nurse then put another IV in his left arm bend under the first attempt. He went for a CT scan at 9:20 P.M.. [Client #5] was released from the hospital at 11:00 P.M.. The doctor stated that he could not find anything wrong with him other then (sic) the cancer he has already been diagnosed with follow up with primary physician with in 1-2 days. [Client #5] already has a doctor's appointment on 10/15/2014. Will follow up with doctor at that time. Administered all evening medication at 12:00 A.M. as instructed by [Nurse name]." Further review of the record neglected to indicate</p>			

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	<p>the facility's nursing services reviewed this information and discussed it with the IDT.</p> <p>-Doctor's visit notation dated 10/15/14 documented by the GHAM indicated: "[Client #5] went to [Physician] today he weighed 181.4 and b/p was 118/62. Blood taken in port. The type of lung cancer he has can be treated on the tarceva he is already taking. No chemo at this time. The cancer is not curable. He does have stage 3b cancer. There is a 1cm (centimeter) spot on lung that doesn't need to be worried about. Two main side effects, one diarrhea and two skin rash that we were already informed about. Continue taking 100 mg tarceva. There is a risk of getting blood clots in the legs with tamoxifen. [client #5] has a genetic defect that has a higher risk of developing cancer. Do not remove port. Port can be flushed every 6 weeks to 2 months. [Client #5] being tired is due to other medication that he is taking not caused by cancer. No need to do the bladder flush any more no mammograms. Stop testing for cholesterol problems. Conceder (sic) discontinuing HM COQ10 cap 100mg. Also conceder (sic) discontinuing pravastatin." Review of the record neglected to indicate the facility's nursing services developed a protocol and/or risk plan for client #5's health concerns.</p>			

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	<p>Further review of the record neglected to indicate the facility's nursing services reviewed this information and discussed it with the IDT.</p> <p>-Doctor's visit notation dated 12/23/14 documented by GHAM indicated: "[client #5] went to [Physician] today. Labs were completed in right arm bend. Weight 177.6, B/P 117/74, pulse 85 and temp 97.4. They wanted a CT Scan of his head completed today with and without contrast. On January 8th [client #5] will be having another CT Scan done at [Hospital name] at 7:30 am on his abdomen, pelvis, and chest. Follow up appointment 10:15 am on January 20. He will go over results at that time." Further review of the record neglected to indicate the facility's nursing services reviewed this information and discussed it with the IDT.</p> <p>-Doctor's visit notation dated 1/20/15 documented by GHAM indicated: "[Client #5] seen (sic) [Physician]'s [Nurse name] today. He had labs completed in his right arm. He had a CT scan on January 8, 2015 of his chest, abdomen and pelvis. They are seeing new changes in of multiple enlarged lymph nodes down his sternum. They are all converged together. Largest area is 2 inches by 1 1/2 inch. He has gall stones</p>			

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	<p>but they are not inflamed. On December 23rd [client #5] had a CT scan of the head and it came back normal. He needs to a PET Scan completed on Wednesday, January 28, 2015. He has a follow up appointment with [Physician] on February 3, 2015. We will find out more information after this appointment." Further review of the record failed to indicate the facility's nursing services reviewed this information and discussed it with the IDT.</p> <p>-Doctor's office notation dated 2/13/15 documented by GHAM indicated: "[Client #5] seen (sic) [Physician] today. He had labs completed in left arm bend....PET (position emission tomography) scan showed more lymph nodes that are cancer all over his chest region. On his sternum, lungs and glands. Chemo is the only option if the Tarceva (cancer medication) is not working. The family was given two options, continue Tarceva and complete another ct scan in one month to ensure the cancer is not progressing more or start chemo and have a cut (sic) scan in 2 months. The family is going to let me know Monday on what road they want to take. Until they make a decision [client #5] will continue Tarceva 100 mg 1 time a day. He does have a follow up appointment on 2/27/15 at 10:45 A.M..</p>			

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	<p>He also said the cancer cannot be cured, that it can only be controlled and keep [client #5] comfortable." Further review of the record failed to indicate the facility's nursing services reviewed this information, discussed the information with the IDT and failed to indicate what decision was made by client #5's family.</p> <p>-BDDS report dated 2/27/15 indicated: "On 2/27/15 at approximately 11:45 A.M., [GHAM name] transported the individual to a routine oncologist visit, due to lung cancer. She reports the individual seemed to be having trouble breathing since being picked up from the day program for the appointment. Upon arriving to the oncologist office, she notified the nurse of this trouble. The nurse took the individual's vitals; B/P (Blood Pressure) 89/60, temp 101.4, pulse 103 and his O2 (Oxygen) level was 78. The individual was placed on oxygen and the office called an ambulance. The individual was transported to [Hospital name] Emergency Room. At the ER, 2 sets of blood work were taken, a chest x-ray and CT Scan were completed. Pneumonia was discovered in his left lung and cardiac enzymes came back positive. He was admitted to the hospital and the attending physician will be involving a cardiologist for further evaluation. Plan to Resolve: Every</p>			
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	<p>member of the IDT was notified and given the details of the illness and recommendations from the attending physicians. The IDT will remain in contact with physicians and each other to relay all pertinent information. At least one member of the IDT will be present at the hospital at least once daily to receive updates and information from the attending physicians." Further review neglected to indicate a protocol and/or risk plan had been developed to address client #5's health concerns.</p> <p>Further review of client #5's group home record failed to indicate the facility's nursing services developed protocols and/or risk plans to give staff guidance on client #5's diagnoses and how to look for signs and symptoms of each diagnosis. Review of client #5's record neglected to indicate the facility's nursing services developed a medical care plan to address client #5's medical needs.</p> <p>A review of the facility's IDT records dated was conducted on 2/25/15 at 2:00 P.M.. Review of client #5's IDT summary dated 1/22/15 failed to indicate the IDT discussed client #5's 1/20/15 medical appointment and the results of his testing. Review of the IDT records dated 3/14 to current neglected to indicate the facility's nursing services</p>			

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	<p>discussed client #5's health issues and medical concerns with the IDT.</p> <p>An interview with the group home nurse assigned to the group home was conducted on 2/24/15 at 2:50 P.M.. The group home nurse indicated there was no written documentation to indicate she reviewed and discussed changes in the client's health status. The nurse indicated her communication was done via telephone. When asked if there was any written documentation to indicate she communicated with the physician or his office employees in regard to client #5's health status, the nurse indicated there was not. When asked if there was documentation she presented and discussed client #5's health concerns with the IDT, the nurse indicated only by telephone and email. No written documentation was submitted for review to indicate the nurse documented on client's ongoing health status. A request for emails and/or any documentation to indicate the facility's nursing services assessed, monitored, communicated and documented any medical information was made. No documentation was submitted.</p> <p>An interview with the Director of Nursing (DON) was conducted on 2/25/15 at 1:35 P.M.. The DON indicated nursing staff should</p>			

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W 189	<p>immediately document into the facility's computer system under a T-Log each time she is made aware of any client's health status and when reviewing any client's medical notations and records and when notified by staff.</p> <p>A review of the facility's computer system was conducted on 2/24/15 at 6:00 P.M.. There was no documentation by the group home nurse in the facility's T-log system in regard to client #5's changes in health and medical concerns.</p> <p>9-3-2(a)</p> <p>483.430(e)(1)</p>			

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Bldg. 00	<p>STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients and 3 additional clients (clients #1, #2, #4, #5, #7 and #8), to ensure staff were sufficiently trained to 1. assure competence in proper administration of medications as ordered, and 2. to assure competency in implementing client #7's low blood sugar protocol.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 2/23/15 at 1:20 P.M.. Review of the facility's General Event Reports (GERs) (Internal Reports) indicated:</p> <p>-GER dated 12/25/14 involving client #5 indicated: "Medication not passed." Further review of the report indicated client #5 did not receive his Tarceva 100 mg (milligram) (cancer) medication on 12/24/14 at 8:00 P.M. and on 12/25/14 at 8:00 P.M..</p> <p>-GER dated 12/26/14...Event Date: 12/25/14 involving client #4 indicated: "Medication error type:</p>	W 189	All staff were retrained on medication administration on Jan. 15, 2015 to ensure they are competent in the administration of medications for all clients (including the 6 rites of medication administration). Staff will continue to receive annual retraining in medication administration (Med Review) at minimum or more frequently as needed. There were additional retrainings on 2/3/15 and 2/10/15 for individual staff who committed further med errors. Staff was retrained on client #7's low bloodsugar protocol on 3/19/14. To ensure further compliance in this area, the QDDP will conduct random monthly home visits and will observe staff during med administration, nursing will monitor when completing random home visits, and the manager will monitor med passes by the certified med passer while on shift. Documentation will maintained of these observations and competency will need to be demonstrated by certified med passers. If it is determined at anytime, that staff fail to follow the policy for med administration, they will be required to retake Med Core A and B within 30 days taught by a certified nursing	03/31/2015			

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	<p>Omission...Olanzapine 5 mg (bipolar), Depakote 200 mg (bipolar), Gas Relief 125 mg, Liquid Blue Mint Oral Rinse 30 ml (milliliter) and Catheter 1 (urinate)...Not given."</p> <p>-GER dated 1/1/15 involving client #2 indicated: "When passing bedtime medications, I found that no one dispensed [client #2]'s Oxybutynin (overactive bladder). This used to be a 2 P.M. medication. The new system started today and was confusing. I called [Nurse name] and the medication should have been passed by 3 P.M.. I did not start my shift until 4 P.M....Oxybutynin 5 mg...Oxybutynin 5 mg...[Nurse name] I was called at 7 P.M. which is out of med pass time allowed so an error was to be reported. He (client #2) also receives a dose at bedtime and staff to give that."</p> <p>-GER dated 1/1/15 involving client #1 indicated: "When passing medications, med passer noticed that [client #1]'s Clonazepam .5 mg (epilepsy) was not in the medications. It was double checked by another staff member and [Nurse name] was called. She informed staff to sign and circle and to write on the back that the medication was not available because the doctor did not reorder the medication. There was (sic) 2 more medications that were not available to</p>		<p>instructor. He/she will be suspended from med passes during this time. The certified Nurse trainer will ensure the appropriate measures have occurred.</p>	

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	<p>administer Clozapine 100 mg (schizophrenia) and hydro cort 2.5% ointment (dry skin). The nurse was also notified about these. The instructions were the same."</p> <p>-GER dated 1/1/15 involving client #8 indicated: "when (sic) dispensing bedtime medications, med passer noticed that [client #8]'s Clozapine ODT (orally disintegrating) 100 mg (dementia), ear drops solution 6.5 and Lorazepam .5 mg (anxiety disorder) was (sic) not here. They were not delivered to us. I contacted [Nurse name]. She advised me to sign, circle and write on the back sheet of MAR (Medication Administration Record) that the medication was (sic) not available."</p> <p>-GER dated 1/2/15 involving client #1 indicated: "Lorazepam .5 mg (anxiety disorder) given to wrong participant. Should have have been given to [client #8] P.M. dose....Wrong individual...."</p> <p>-GER dated 1/3/15 involving client #1 indicated: "Medication is not available to dispense....Medication not available....Clozapine 100 mg, Clozapine 100 mg at 7:00 P.M....Medication was not delivered to group home."</p> <p>-GER dated 1/5/15 involving client #8</p>			

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	<p>indicated: "Medication not available...Clozapine 100 mg, Clozapine 100 mg 7:30 P.M.."</p> <p>-GER dated 1/5/15 involving client #1: "Medication not available...Clozapine 10 mg, Clozapine 10 mg at 7:00 P.M.."</p> <p>-GER dated 1/6/15 involving client #8 indicated: "Medication not available...Clozapine 100 mg, Clozapine 200 mg at 7:30 P.M.."</p> <p>-GER dated 1/7/15 involving client #8 indicated: "Medication Error Type: Omission...Lorazepam .5 mg (anxiety disorder), Lorazepam .5 mg at 7:00 P.M.."</p> <p>-GER dated 1/7/15 involving client #1 indicated: "Medication Error Type: Omission...Clozapine 100 mg, Clozapine 100 mg at 7:00 A.M.."</p> <p>-GER dated 1/7/15 involving client #1 indicated: "Medication Error Type: Omission...Clozapine 100 mg, Clozapine 100 mg at 7:00 P.M.."</p> <p>-GER dated 1/11/15 involving client #4 indicated: "When passing [client #4]'s bedtime medications, I noticed his P.M. medications had not been signed for. His P.M. medications were packed this</p>			

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	<p>morning to go with him to his dad's house."</p> <p>-GER dated 1/14/15 involving client #1 indicated: "Medication Error Type: Omission...Clozapine 1 mg, Clozapine .5 mg, Clozapine 100 mg, Clozapine 100 mg at 10:00 P.M....On 1/14/15, [Direct Support Professional (DSP) #2] failed to administer the full dosage of [client #1]'s bedtime (7 P.M. to 10 P.M.) Clozapine 1 mg. The order calls for 2-.5 mg pills to be given at bedtime for a total of 1 mg; only 1-.5 mg pill was administered. [DSP #4] failed to check the medication was properly administered. [DSP #13] failed to sign the MAR indicating [client #1]'s bedtime (7 P.M. to 10 P.M.) Clozapine 100 mg dosage was administered. Due to the packaging of this medication from the pharmacy, it is unknown whether the medication was administered. [DSP #4] failed to check the medication was properly administered."</p> <p>-GER dated 1/15/15 involving client #8 indicated: "Medication Error Type: Omission...Lorazepam .5 mg, Lorazepam .5 mg, at 6:00 P.M., Lorazepam 1 mg, Lorazepam 1 mg at 10:00 P.M.. On 1/14/15, [DSP #14] failed to administer client's P.M. (3p-6p) Lorezepam (sic) .5 mg. [DSP #4] failed to check that the</p>			

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	<p>medication was administered properly.</p> <p>On 1/14/15 [DSP #14] failed to administer the complete dosage of client's bedtime (7p-10p) Lorezepam (sic) 1 mg (2-.5 mg pills). Only one of the pills was administered (.5 mg). [DSP #4] failed to check the medication was properly administered."</p> <p>-GER dated 1/17/15 involving client #5 indicated: "Please note: The event date is 1/16/15, during bedtime medication administration. The discovered date is 1/17/15. Medication Error Type: Omission...Tarceva 100 mg, Tarceva 100 mg at 10:00 P.M....On 1/16/15 at bedtime (7p-10p), [DSP #16] failed to administer client's Tarceva 100 mg."</p> <p>-GER dated 1/20/15 involving client #1 indicated: "As I was passing PM meds I noticed that [client #1]'s Metronidazol Gel (skin) was not signed on the day before Medication Error Type: Charting error."</p> <p>-GER dated 1/20/15 involving client #7 indicated: "Please note the event date is 1/19/15, the discovered date is 1/20/15. As I was passing pm meds, I noticed that [client #7]'s Chlorhexidine Rinse had not been signed for."</p> <p>2. A morning observation was conducted</p>			

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	<p>at the group home on 2/23/15 from 6:30 A.M. until 8:00 A.M.. At 7:10 A.M., Direct Support Professional (DSP) #2 began administering client #7's prescribed oral medications. DSP #2 began administering client #7's "Polyethyl Glycol Powder 3350 (constipation)" with a small plastic solo cup of water. Review of the medication label and the Medication Administration Record (MAR) dated 2/1/15 to 2/28/15 was conducted on 2/23/15 at 7:15 A.M. and indicated: "Polyethyl Glycol Powder 3350...Mix in 8 ounces of water daily."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 A.M.. The QIDP indicated client #7's medication should have been administered as directed on the MAR. The QIDP further indicated client #7 should have taken her medications with at least 8 ounces of water.</p> <p>A review of the facility's "Universal Policies and Procedures-Medication Administration" dated 8/8/13 was conducted on 2/23/15 at 4:30 P.M.. Review of the policy indicated: "Opportunity Enterprises clients will receive medications as prescribed by the individuals attending physician's to maintain optimum health....B.</p>			

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	<p>Guidelines for dispensing medications for all consumers:</p> <p>1. Prescription medications will be administered as instructed on the pharmacy label and non-prescription medications will be administered using labeled instructions unless changed by the ordering physician.</p> <p>8. Medications will be verified 3 times against the Medication Administration Record. This includes medications that are set in the weekly pill dispenser.</p> <p>C. Dispensing of Medications:</p> <p>4. The medication should be checked three times in accordance with med core training.</p> <p>a. When taking out the medication.</p> <p>b. After pouring or punching out the medication.</p> <p>c. Before administering the medication to the client.</p> <p>6. The 6 rights of medication administration should be followed.</p> <p>a. Right medication is given to the;</p> <p>b. Right person at the;</p> <p>c. Right time;</p> <p>d. Right dose/strength;</p> <p>e. Right route."</p>			

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	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 A.M.. The QIDP indicated staff should have administered the clients' medications as ordered. The QIDP indicated when medications are documented as an "omission", it indicates staff did not pass the medication. The QIDP indicated the facility should have ensured the clients' medications were available as ordered for administration. The QIDP indicated staff are supposed to notify the nurse when medications are down to a seven day supply. The QIDP further indicated all staff are trained upon hire, annually and as needed on medication administration.</p> <p>3. A review of the facility's investigation records was conducted on 2/23/15 at 4:30 P.M.. Review of the investigation records indicated:</p> <p>-Investigation record dated 3/12/14 involving client #7 indicated: "It was reported staff did not appropriately follow [client #7]'s low blood sugar protocol...[Staff #25] stated when [client #7]'s blood sugar was taken it was 55. When his blood sugar is below 60 the nurse should be notified. [Staff #25] stated no nurse was available. She provided [client #7] with his lunch.</p>			

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	<p>[Staff #25] explained in the past when his blood sugar has been low the nurse has directed her to feed him lunch and then it is checked a while after that. When asked if his blood sugar had been checked again after eating she said she didn't know. When asked if she knew his blood sugar protocol she said she did and provided a copy of the physician's documentation to the investigator. When asked if [Staff #25] knew the nurse was supposed to be notified so she could then contact [client #7]'s doctor, she said she did not know that-only that she was to contact the nurse when it fell below 60...'Client Incident Report' dated 3/12/14: 'We arrived at [Day Program location] at 3:00 P.M.. [Staff #25] started to bring out our participants. While they were getting onto the van [Staff #25] informed me that they did not give [client #7] his food on time and his blood sugar level was 55. Per doctor's orders if his sugar drops below 60 the Dr's office has to be called. She said the nurse was not there at the time. She stated that as soon as they took his sugar they fed him quickly after that and his sugar was fine.'...Endocrinologist Physician's Order dated 8/21/13: 'Patient must check blood sugar 4 x (times) daily and call office if blood sugar is less than 60.'...It is recommended that the allegation of neglect be substantiated. It</p>			

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	<p>is recommended that staff receive a corrective action for not following the policy correctly."</p> <p>A review of client #7's record was conducted on 2/24/15 at 12:20 P.M.. Review of client #7's "Abnormal/Low Blood Sugar" dated 3/31/14 indicated: "To maintain normal limits of blood sugars (sic) levels. [Client #7] has abnormal/low blood sugar...If [client #7]'s blood sugar is less than 60, call [Endocrinologist name] office for further instructions....Take blood sugar levels as ordered by the physician."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 A.M.. The QIDP submitted documentation which indicated staff are trained on client specific protocols annually and as needed. The QIDP indicated staff should follow doctor's orders and protocols as written.</p> <p>9-3-3(a)</p>			

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W 318 Bldg. 00	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate nursing services for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #7 and #8).</p> <p>Findings include:</p> <p>1. Please refer to W331. The facility's nursing services neglected to ensure clients' prescribed medications were available at the group home for administration to prevent medication errors. The facility's nursing services neglected to ensure facility staff were adequately trained and showed competency in regard to administering medications as ordered by the physician.</p>	W 318	<p>On 3/9/15 , the Chief Program Officer met with the Lead Nurse, Group Home Nurse and Director of Supervised Living to discuss proper documentation on client medical information and communication into the medical records; development of risk plans and medical protocols; and ensuring all staff are properly trained on high risk plans/medical protocols. During the facilitation of this meeting, it was also discussed that nursing will ensure all client's medications are available for administration. Lastly, it was discussed that the agency will ensure that nursing services and their recommendations are thoroughly documented in the IDTmeeting notes, with the use of an additional supplemental notes pages. In the supplemental notes page, all conversation will be documented. The IDT meeting minutes and supplemental page</p>	04/02/2015

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	<p>The facility's nursing services neglected to ensure the pharmacist's recommendations were reported to the physician and Interdisciplinary Team (IDT). The facility's nursing services neglected to develop a medical protocol to specifically address client #4's physician ordered daily use of a dilation catheter and failed to ensure all staff who worked directly with client #4 were trained by a licensed medical professional on the use of a dilation catheter. The facility's nursing services neglected to maintain a reproducible written system on documentation of when the nursing services was notified of medical concerns for each client who resided at the group home, when the group home nurse assessed clients and when the group home nurse communicated with the clients' physicians in regard to medical conditions. The facility's nursing services neglected to discuss medical concerns at the clients' IDT meetings, when changes in clients' health status occurred.</p> <p>2. Please refer to W342. The facility's nursing services failed for 1 of 4 sampled clients (client #4), to ensure staff were trained in regard to the client's medical needs.</p> <p>3. Please refer to W362. The facility</p>		<p>process was begun at the 3/10/15 at Lute Road IDT. A Dilation Catheterization Protocol was written on 3/19/15 for individual #4 and on 3/27/15, the Group Home Nurse retrained all staff on the protocol. On April 2, 2015, Policy number #5080 (NursesMonthly Report/Nursing Notes) and #5075 (Health Care Documentation) were revised to reflect the procedure for documentation of medical information. To ensure ongoing compliance, the following steps will be taken: The Director of Nursing, or designee, will conduct a check, once per month, of the Therap system, to ensure nursing is completing thorough and accurate documentation on each individual's health status Any time the IDT determines that a high risk protocol needs to be developed or updated (for reasons including, but not limited to: follow up from physician appointment, new diagnosis, emergency health condition, change of medical status), nursing will complete the request and then provide training to all group home staff. As medications are ordered/delivered from the pharmacy, member(s) of nursing will conduct a check-in of the medication to ensure proper delivery as well as the accuracy of the medications. They will then ensure the medication gets to the home for ongoing</p>	

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	<p>failed for 8 of 8 clients living at the group home, (clients #1, #2, #3, #4, #5, #6, #7 and #8) to ensure the pharmacist reviewed clients' medications on a quarterly basis.</p> <p>4. Please refer to W368. The facility failed to assure drugs administered to 3 of 4 sampled clients and 3 additional clients (clients #1, #2, #4, #5, #7 and #8) were administered in compliance with the physician's orders.</p> <p>5. Please refer to W391. The facility failed for 1 of 11 medications administered to 1 of 2 clients observed during the morning medication administration (client #5), to remove from use the medication container with a worn label.</p> <p>9-3-6(a)</p>		<p>administration. The IDT notes will be completed by the Director of Supervised Living, or designee, and will be reviewed by the Chief Program Officer after each Interdisciplinary meeting, to ensure their completion and appropriate follow through for any necessary high risk protocol implementation and training. All staff were retrained on medication administration on Jan. 15, 2015 to ensure they are competent in the administration of medications for all clients (including the 6 rites of medication administration). Staff will continue to receive annual retraining in medication administration (Med Review) at minimum or more frequently as needed. There were additional retrainings on 2/3/15 and 2/10/15 for individual staff who committed a further med errors. To ensure further compliance in this area, the QDDP will conduct random monthly home visits and will observe staff during med administration, nursing will monitor when completing random home visits, and the manager will monitor med passes by the certified med passer while on shift. Documentation will be maintained of these observations and competency will need to be demonstrated by certified med passers. If it is determined at any time, that staff fail to follow the policy for med administration, they will be required to retake</p>		

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W 331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing		Med Core A and B within 30 days taught by a certified nursing instructor. He/she will be suspended from med passes during this time. The certified Nurse trainer will ensure the appropriate measures have occurred. Nursing will continue to send the quarterly pharmacy reviews to the physician's for follow up. All recommendations will be sent to the appropriate physician with a letter of request for follow up. Further, the nurse will document the pharmacy recommendations on her monthly summary so the recommendations can be discussed by the interdisciplinary team. The QA coordinator will conduct random checks with the nursing office to ensure these pharmacy checks are being sent to the physicians. The med cart will be checked by the nurse during monthly home visits for appropriate medications and to ensure all labels are in clean and legible order. If the label is worn or illegible, the medication will be removed from the cart and replaced immediately. This will be part of a checklist that the nurse completes on her visit. The completed checklists will be submitted to the Chief Program Officer after each visit to ensure completion.		

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	<p>services in accordance with their needs. Based on record review and interview for 3 of 4 sampled clients and 3 additional clients (clients #1, #2, #4, #5, #7 and #8), the facility's nursing services failed to ensure clients' prescribed medications were available at the group home for administration to prevent medication errors. The facility's nursing services failed to ensure facility staff were adequately trained and showed competency in regard to administering medications as ordered by the physician. The facility's nursing services failed to ensure the pharmacist's recommendations were reported to the physician and Interdisciplinary Team (IDT). The facility's nursing services failed to develop a medical protocol to specifically address client #4's physician ordered daily use of a dilation catheter and failed to ensure all staff who worked directly with client #4 were trained by a licensed medical professional on the use of a dilation catheter. The facility's nursing services failed to maintain a reproducible written system on documentation of when the nursing services was notified of medical concerns for each client who resided at the group home, when the group home nurse assessed clients and when the group home nurse communicated with the clients' physicians in regard to medical</p>	W 331	<p>During the facilitation of a meeting on 3/19/15, it was discussed that nursing will ensure all client's medications are available for administration. As medications are ordered/delivered from the pharmacy, member(s) of nursing will conduct a check-in of the medication to ensure proper delivery as well as the accuracy of the medications. They will then ensure the medication gets to the home for ongoing administration. All staff were retrained on medication administration on Jan. 15, 2015 to ensure they are competent in the administration of medications for all clients (including the 6 rites of medication administration). Staff will continue to receive annual retraining in medication administration (Med Review) at minimum or more frequently as needed. There were additional retraining's on 2/3/15 and 2/10/15 for individual staff who committed a further med errors. To ensure further compliance in this area, the QDDP will conduct random monthly home visits and will observe staff during med administration, nursing will monitor when completing random home visits, and the manager will monitor med passes by the certified med passer while on shift. Documentation will maintained of these observations and competency will need to be</p>	04/02/2015

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	<p>conditions. The facility's nursing services failed to discuss medical concerns at the clients' IDT meetings, when changes in clients' health statuses occurred.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 2/23/15 at 1:20 P.M.. Review of the facility's General Event Reports (GERs) (Internal Reports) indicated:</p> <p>-GER dated 12/25/14 involving client #5 indicated: "Medication not passed." Further review of the report indicated client #5 did not receive his Tarceva 100 mg (milligram) (cancer) medication on 12/24/14 at 8:00 P.M. and on 12/25/14 at 8:00 P.M..</p> <p>-GER dated 12/26/14...Event Date: 12/25/14 involving client #4 indicated: "Medication error type: Omission...Olanzapine 5 mg (bipolar), Depakote 200 mg (bipolar), Gas Relief 125 mg, Liquid Blue Mint Oral Rinse 30 ml (milliliter) and Catheter 1 (urinate)...Not given."</p> <p>-GER dated 1/1/15 involving client #2 indicated: "When passing bedtime medications, I found that no one</p>		<p>demonstrated by certified med passers. If it is determined at any time, that staff fail to follow the policy for med administration, they will be required to retake Med Core A and B within 30 days taught by a certified nursing instructor. He/she will be suspended from med passes during this time. The certified Nurse trainer will ensure the appropriate measures have occurred. Nursing will continue to send the quarterly pharmacy reviews to the physician's for follow up. All recommendations will be sent to the appropriate physician with a letter of request for follow up. Further, the nurse will document the pharmacy recommendations on her monthly summaries so the recommendations can be discussed by the interdisciplinary team. The QA coordinator will conduct random checks with the nursing office to ensure these pharmacy checks are being sent to the physicians. On 3/9/15, the Chief Program Officer met with the Lead Nurse, Group Home Nurse and Director of Supervised Living to discuss proper documentation on client medical information and communication into the medical records; development of risk plans and medical protocols; and ensuring all staff are properly trained on high risk plans/medical protocols. Lastly, it was discussed that the agency</p>	

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	<p>dispensed [client #2]'s Oxybutynin (overactive bladder). This used to be a 2 P.M. medication. The new system started today and was confusing. I called [Nurse name] and the medication should have been passed by 3 P.M.. I did not start my shift until 4 P.M....Oxybutynin 5 mg...Oxybutynin 5 mg...[Nurse name] I was called at 7 P.M. which is out of med pass time allowed so an error was to be reported. He (client #2) also receives a dose at bedtime and staff to give that."</p> <p>-GER dated 1/1/15 involving client #1 indicated: "When passing medications, med passer noticed that [client #1]'s Clonazepam .5 mg (epilepsy) was not in the medications. It was double checked by another staff member and [Nurse name] was called. She informed staff to sign and circle and to write on the back that the medication was not available because the doctor did not reorder the medication. There was 2 more medications that were not available to administer Clozapine 100 mg (schizophrenia) and hydro cort 2.5% ointment (dry skin). The nurse was also notified about these. The instructions were the same."</p> <p>-GER dated 1/1/15 involving client #8 indicated: "when (sic) dispensing bedtime medications, med passer noticed</p>		<p>will ensure that nursing services and their recommendations are thoroughly documented in the monthly IDT meeting notes, with the use of an additional supplemental notes pages. In the supplemental notes page, all conversation will be documented. The IDT meeting minutes and supplemental page process was begun at the 3/10/15 at Lute Road IDT. A Dilation Catheterization Protocol was written on 3/19/15 for individual #4 and on 3/27/15, the Group Home Nurse retrained all staff on the protocol. Client #5 was hospitalized from 2/27/15 to 3/29/15, with the exception of an approximate 48 hour period and passed away on 3/29/15 in a Nursing Rehabilitation Facility from previously diagnosed cancer. On April 2, 2015, Policy number #5080(Nurses Monthly Report/Nursing Notes) and #5075 (Health Care Documentation) were revised to reflect the procedure for documentation of medical information. To ensure ongoing compliance, the following steps will be taken: The Director of Nursing, or designee, will conduct a check, once per month, of the Therap system, to ensure nursing is completing thorough and accurate documentation on each individual's health status, along with any conversation with physicians/families regarding the clients' medical condition. Any</p>	

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	<p>that [client #8]'s Clozapine ODT (orally disintegrating) 100 mg (dementia), ear drops solution 6.5 and Lorazepam .5 mg (anxiety disorder) was not here. They were not delivered to us. I contacted [Nurse name]. She advised me to sign, circle and write on the back sheet of MAR (Medication Administration Record) that the medication was (sic) not available."</p> <p>-GER dated 1/2/15 involving client #1 indicated: "Lorazepam .5 mg (anxiety disorder) given to wrong participant. Should have have been given to [client #8] P.M. dose....Wrong individual...."</p> <p>-GER dated 1/3/15 involving client #1 indicated: "Medication is not available to dispense....Medication not available....Clozapine 100 mg, Clozapine 100 mg at 7:00 P.M....Medication was not delivered to group home."</p> <p>-GER dated 1/5/15 involving client #8 indicated: "Medication not available...Clozapine 100 mg, Clozapine 100 mg 7:30 P.M.."</p> <p>-GER dated 1/5/15 involving client #1: "Medication not available....Clozapine 10 mg, Clozapine 10 mg at 7:00 P.M.."</p> <p>-GER dated 1/6/15 involving client #8</p>		<p>time the IDT determines that a high risk protocol needs to be developed or updated (for reasons including, but not limited to: follow up from physician appointment, new diagnosis, emergency health condition, change of medical status), nursing will complete the request and then provide training to all group home staff. As medications are ordered/delivered from the pharmacy, member(s) of nursing will conduct a check-in of the medication to ensure proper delivery as well as the accuracy of the medications. They will then ensure the medication gets to the home for ongoing administration. The IDT notes will be completed by the Director of Supervised Living, or designee, and will be reviewed by the Chief Program Officer after each Interdisciplinary meeting, to ensure their completion and appropriate follow through for any necessary high risk protocol implementation and training.</p>		

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	<p>indicated: "Medication not available...Clozapine 100 mg, Clozapine 200 mg at 7:30 P.M.."</p> <p>-GER dated 1/7/15 involving client #8 indicated: "Medication Error Type: Omission...Lorazepam .5 mg (anxiety disorder), Lorazepam .5 mg at 7:00 P.M.."</p> <p>-GER dated 1/7/15 involving client #1 indicated: "Medication Error Type: Omission...Clozapine 100 mg, Clozapine 100 mg at 7:00 A.M.."</p> <p>-GER dated 1/7/15 involving client #1 indicated: "Medication Error Type: Omission...Clozapine 100 mg, Clozapine 100 mg at 7:00 P.M.."</p> <p>-GER dated 1/11/15 involving client #4 indicated: "When passing [client #4]'s bedtime medications, I noticed his P.M. medications had not been signed for. His P.M. medications were packed this morning to go with him to his dad's house."</p> <p>-GER dated 1/14/15 involving client #1 indicated: "Medication Error Type: Omission...Clozapine 1 mg, Clozapine .5 mg, Clozapine 100 mg, Clozapine 100 mg at 10:00 P.M....On 1/14/15, [Direct Support Professional (DSP) #2] failed to</p>			

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	<p>administer the full dosage of [client #1]'s bedtime (7 P.M. to 10 P.M.) Clozapine 1 mg. The order calls for 2-.5 mg pills to be given at bedtime for a total of 1 mg; only 1-.5 mg pill was administered. [DSP #4] failed to check the medication was properly administered. [DSP #13] failed to sign the MAR indicating [client #1]'s bedtime (7 P.M. to 10 P.M.) Clozapine 100 mg dosage was administered. Due to the packaging of this medication from the pharmacy, it is unknown whether the medication was administered. [DSP #4] failed to check the medication was properly administered."</p> <p>-GER dated 1/15/15 involving client #8 indicated: "Medication Error Type: Omission...Lorazepam .5 mg, Lorazepam .5 mg, at 6:00 P.M., Lorazepam 1 mg, Lorazepam 1 mg at 10:00 P.M.. On 1/14/15, [DSP #14] failed to administer client's P.M. (3p-6p) Lorezepam (sic) .5 mg. [DSP #4] failed to check that the medication was administered properly. On 1/14/15 [DSP #14] failed to administer the complete dosage of client's bedtime (7p-10p) Lorezepam (sic) 1 mg (2-.5 mg pills). Only one of the pills was administered (.5 mg). [DSP #4] failed to check the medication was properly administered."</p>			

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	<p>-GER dated 1/17/15 involving client #5 indicated: "Please note : The event date is 1/16/15, during bedtime medication administration. The discovered date is 1/17/15. Medication Error Type: Omission...Tarceva 100 mg, Tarceva 100 mg at 10:00 P.M....On 1/16/15 at bedtime (7p-10p), [DSP #16] failed to administer client's Tarceva 100 mg."</p> <p>-GER dated 1/20/15 involving client #1 indicated: "As I was passing PM meds I noticed that [client #1]'s Metronidazol Gel (skin) was not signed on the day before Medication Error Type: Charting error."</p> <p>-GER dated 1/20/15 involving client #7 indicated: "Please note the event date is 1/19/15, the discovered date is 1/20/15. As I was passing pm meds, I noticed that [client #7]'s Chlorhexidine Rinse had not been signed for."</p> <p>A morning observation was conducted at the group home on 2/23/15 from 6:30 A.M. until 8:00 A.M.. At 7:10 A.M., Direct Support Professional (DSP) #2 began administering client #7's prescribed oral medications. DSP #2 began administering client #7's "Polyethyl Glycol Powder 3350 (constipation)" with a small plastic solo cup of water. Review of the medication</p>			

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	<p>label and the Medication Administration Record (MAR) dated 2/1/15 to 2/28/15 was conducted on 2/23/15 at 7:15 A.M. and indicated: "Polyethyl Glycol Powder 3350...Mix in 8 ounces of water daily."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 A.M.. The QIDP indicated client #7's medication should have been administered as directed on the MAR. The QIDP further indicated client #7 should have taken her medications with at least 8 ounces of water.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 A.M.. The QIDP indicated staff should have administered the clients medications as ordered. The QIDP indicated when medications are documented as an "omission", it indicates staff did not pass the medication. The QIDP indicated the facility should have ensured the clients' medications were available as ordered for administration. The QIDP indicated staff are supposed to notify the nurse when medications are down to a seven day supply. The QIDP further indicated all staff are trained upon hire, annually and as needed on medication administration.</p>			

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	<p>2. A review of the facility's pharmacy reviews was conducted on 2/26/15 at 11:25 A.M.. The consulting pharmacist indicated:</p> <p>Consultation Report for Recommendation Created 7/30/14:</p> <p>-Client #1: "The risk of Clonazepam (epilepsy, panic disorder)-related toxicity may be increased by coadministration of Valproic Acid (bipolar, epilepsy). Coadministration of Clonazepam and Valproic Acid may also decrease the antiepileptic effect of both agents. Consider discontinuing this drug combination if seizure frequency increases or excess drowsiness occurs." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"[Client #5] is currently prescribed Prevastatin (high cholesterol) and Gemfibrozil (high blood cholesterol). The risk of myopathy ((muscle disease) and rhabdomyolysis (break down of muscle tissue) may be increased by co-administration of statins and gemfibrozil. Specifically, co-administration of lovastatin or simvastatin with gemfibrozil should be</p>			

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	<p>avoided or is contraindicated in official package labeling. Although the use of this statin with gemfibrozil is not specifically contraindicated in official package labeling, this combination should be avoided if possible. Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"I have reviewed [client #8]'s med sheets and have found a significant drug interaction between Clonazepam and Lorazepam. Summary: Delirium (decreased awareness), sedation, sialorrhea (drooling), and ataxia (loss of bodily movements) may occur when Lorazepam and Clozapine are co-administered. Severe orthostatic hypotension (low blood pressure) and respiratory depression (respiration of below 12 breathes per minute) may occur when Clozapine is added to or started with Benzodiazepines. Management: Clozapine and Lorazepam should not be started or given simultaneously. Close monitoring is necessary. Consider dosing medication(s) at separate times or remove one from the regimen altogether." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p>			

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	<p>Consultation Report for Recommendation Created 10/31/14:</p> <p>"[Client #1] has been taking Clonazepam for the past 6 months without a dosage reduction. Please evaluate and consider reducing dose if appropriate." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"[Client #7] has been taking Clonazepam for the past 6 months without a dosage reduction. Please evaluate and consider reducing dose if appropriate." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 P.M.. The QIDP indicated there was no documentation available for review to indicate the pharmacist's recommendations were not reported to the prescribing physician or the IDT by the assigned person.</p> <p>3. A review of client #4's record was conducted on 2/24/15 at 4:45 P.M..</p>			

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	<p>Review of client #4's record indicated an Individual Support Plan (ISP) dated 11/1/14 which indicated: "Other chronic conditions: ...HX (History) of Urinary retention, Urethral Stricture (narrowing of the urethra caused by injury or disease such as urinary tract infection may cause decreased urine output)...4/12/13 [client #4] went to have a cystoscopy completed but unsuccessful due to urethral stricture. Dilation and cysto(scopy) to be completed at hospital. 4/23/13 [client #4] went to [Hospital name] and tip of urethra was dilated. Everything else looked good and procedure went well. 5/13/13 [client #4] saw [Physician name] for follow up from cystoscopy and urethral dilation. Ultrasound of bladder shows bladder is not emptying completely. Urethra is starting to close. A catheter will need to be inserted daily to keep urethra opened. Will need to be done for at least 6 months-possibly for life. 6/17/13 [client #4] saw [Physician name] due to staff having difficulty inserting the catheter. [Physician name] notes that the urethra has closed again. Schedule for another dilation for 7/3/13. 7/3/13 [client #4] went to [Hospital name] for cystoscopy and urethra dilation. Needs to have catheter inserted and stay in for 10 days to ensure the opening does not close again. 7/12/13 [client #4] saw [Physician name] and</p>			

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	<p>catheter was removed. Insert the dilation catheter every night. Since dilation has been completed frequent urination and accidents have no longer continued."</p> <p>Review of client #4's record indicated a "Medical Appointment Form" dated 7/12/13 which indicated: "Start back up catheter inserting once daily." A review of a "Medical Appointment Form" dated 2/14/14 indicated: Reason for Appointment: Resistance of catheter...Collected urine sample. Dr. (Doctor) took an ultrasound of his bladder. Inserted catheter wants us to insert catheter all the way until we see urine. He said [client #4] was tight when he inserted the catheter. He wants to see [client #4] back in 1 year unless anything changes. He said to cancel [client #4]'s 4/18/14 appointment." Review of client #4's record indicated: "Indwelling Urinary Catheter Protocol" dated 3/31/14 which indicated: "Health Care Plan Issue: To maintain urinary tract health, to avoid contamination of the bladder and to prevent urinary tract infections. A catheter may be needed because of certain medical conditions. [Client #4] has (sic) difficulty in emptying his bladder completely. When urine is left in the bladder, it can cause urinary tract infections. Therefore, [client #4] doctor (sic) has ordered an indwelling catheter</p>			

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	<p>which means it is to stay in and be replaced according to the doctor's order. Issue Clarification: [Client #4] has a catheter. A urinary catheter is a flexible tube used to drain urine from the bladder when the client is unable to urinate or fully cannot empty their bladder. The catheter will be placed into the bladder by a nurse inserting in through the penis. When the catheter is in the bladder, a small balloon is inflated to keep the catheter in place. The catheter allows urine to drain from the bladder into a bag that is either attached to the client's leg or a larger bag that can be attached to the wheelchair or bed..." Review of client #4's Medication Administration Records (MAR) dated 10/1/14 to 12/31/14 indicated: "10/16/14 catheter not done d/t (due to) failure to order nurse and manager notified...12/16/14 Relief staff attempted to insert catheter, [client #4] complained of pain. Nurse notified advised it was ok to skip one night...12/26/14 catheter not signed for." Review of the record neglected to indicate client #4's catheter was inserted by the facility's nursing services. Review of "High Risk Acknowledgement" staff sign in sheets dated 5/14 and 8/14 neglected to indicate all staff who worked at the group home with client #4 were trained by the facility's nursing services on a protocol/risk plan for the use of a</p>			

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	<p>dilation catheter. Review of the record indicated client #4 had an order for daily use of a dilation catheter. Review of client #4's record did not indicate he was ordered the use of an indwelling catheter. The record neglected to indicate the facility's nursing services developed a protocol and/or risk plan specifically addressing the use of a dilation catheter to give staff guidance on client #4's daily use of a dilation catheter as ordered by the physician.</p> <p>An interview with the group home nurse assigned to the group home was conducted on 2/24/15 at 2:50 P.M.. The group home nurse indicated she did not insert client #4's dilating catheter daily and indicated the facility's nursing services had not trained the group home staff on the insertion of client #4's dilation catheter. The nurse indicated the GHAM trained the staff on the use of the catheter. When asked if the GHAM was a licensed medical professional, the nurse indicated she was not. The nurse indicated client #4's dilation catheter is inserted daily. When asked if client #4 had an order for the use of an indwelling catheter, the nurse indicated he did not. When asked if a protocol and /or risk plan had been developed for the use of a dilation catheter, the nurse indicated she was not sure.</p>			

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	<p>An interview with the Director of Nursing (DON) was conducted on 2/25/15 at 1:35 P.M.. The DON indicated client #4 was prescribed the use of a catheter PRN (as needed). The DON indicated it was ok for staff to insert the catheter when needed for client #4. When asked if the group home staff were trained on the insertion of the dilation catheter, the DON stated "Yes, they have been trained by nursing staff." A request for written documentation was made to indicate all staff who worked with client #4 were trained on the insertion of the dilation catheter by licensed medical professionals. No documentation was submitted to indicate all group home staff were trained on the insertion of a dilation catheter.</p> <p>An interview with Direct Support Professionals (DSPs) #3 and #7 was conducted on 2/25/15 at 5:30 P.M.. When asked if client #4 used a catheter, DSP #7 stated "Yes we insert a catheter every night before he goes to bed so he can urinate, it used to be at 8 P.M. but now it's right before bed." When asked if client #4 was ordered the use of an indwelling catheter, DSP #7 indicated they did not know what an indwelling catheter was. DSP #7 stated "We insert the tube and then remove it when he is</p>			

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	<p>done urinating." When asked if the facility's nursing services trained the staff on the use of a dilation catheter, DSP #7 stated "No, the old GHM trained the Group Home Assistant Manager (GHAM) and then the GHAM trained all of the staff." When asked if the nurse inserts client #4's dilation catheter, DSP #7 stated "No." When asked if client #4 had a protocol and/or risk plan for the use of a dilation catheter, DSP #7 indicated he did not.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 A.M.. The QIDP indicated the QIDP trains the group home staff on each client's protocols. When asked who trained the staff on the use of client #4's dilation catheter, the QIDP indicated the GHAM trained the staff. When asked if client #4 was ordered an indwelling catheter, the QIDP indicated he was not. When asked if there was a protocol and/or risk plan developed by the facility's nursing services to give staff guidance for client #4's use of a dilation catheter, the QIDP indicated there was not.</p> <p>4. A review of the facility's records was conducted on 2/23/15 at 1:20 P.M.. Review of the facility's Bureau of</p>			

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	<p>Developmental Disabilities Services (BDDS) reports, General Event Reports (GERs) (Internal Reports) and investigation records indicated:</p> <p>-BDDS report dated 6/6/14 involving client #5 indicated: "Staff reports: On 6/6/14 at 4:00 A.M. I received a phone call from [Staff #20]. She stated that [client #5] was breathing fast and when she asked him if he was ok he just had a blank stare. She asked him if he wanted to stay in his room and he said 'no'. He came out to the living room and laid on the couch and curled up. He then started to say 'no, no, no'. I told her I was on my way. I then called her back and told her to call for an ambulance. I asked her to call nursing and QDDP (Qualified Developmental Disabilities Professional). I arrived at group home and the paramedics had [client #5] in ambulance. I followed the ambulance to [Hospital name]. Upon his arrival at the hospital [client #5]'s O2 (oxygen) was between 72-77. [Physician name] was Dr. on duty this morning. I told him that [client #5] had a CT scan (X-ray) done on 6/2/14 and we have not heard anything yet. He pulled up the results and said that [client #5]'s left lower lung is not getting oxygen because it is full of cancer and the cancer is spreading to the right lung. The Dr ordered an X-ray of lungs and blood</p>			

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	work was drawn. He also ordered a blood test from the artery to see how much oxygen is in his blood. Nurse came in and stated that he was being admitted and that they are waiting for a room. I left hospital at 1:15 P.M. and there was no more information. He is still waiting for a room....Follow up as of 6/13/14: 6/6/14 at 3:30 P.M. [client #5] was admitted to a hospital room due to labored breathing and possibility of cancer in his left lung, per a CT scan performed on 6/2/14. 6/7/14 [Physician] listened to [client #5]'s lungs and said the right upper portion of his lung sounds good, bottom right lung is diminished, entire left lung is diminished and has no air exchange at all. [Client #5] was put on 5 liters of oxygen and [Physician] ordered a bronchoscopy done in the morning of his lungs to see the extent of the blockage and if it was in fact cancer or just fluid. 4:30 P.M. all vitals were taken, within normal limits, no food or drink after midnight. Ultrasound of [client #5]'s back was performed, fluid found in lungs. A thorenticentisis was performed to remove the fluid from [client #5]'s lungs. The fluid that was extracted was blood. A chest xray was performed to see level of fluid in the lungs. The doctor was unable to extract all the fluid from the lungs with the thorenticentisis, so a chest tube had to be			

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	<p>inserted in order to drain all of the fluid in the lungs. [Client #5] received Lidocaine to numb the area where the tube was inserted and Morphine afterwards for the pain. The bronchoscopy was canceled due to the blood drainage. The doctor didn't want to go in and scope the area without knowing where the blood was coming from, as to not exacerbate the bleeding further. 3 1/2 liters of blood was drained from his lungs. 6/8/14 [client #5] is doing well this morning; ate breakfast and was resting on and off all day. [Client #5] broke a blood vessel in his left eye; doctor is unsure how this happened. No medication or further action was taken for the eye at this time; continue to monitor. Vitals WNL (within normal limit) all day. Physical therapist came in to help [client #5] move around. He sat up on the side of the bed and was standing up with assistance of a walker. He got out of bed and sat up in a chair for a little while. [Client #5] looks pale and is very tired and weak today. [Client #5] slept on and off all day. Chest tube is still in place and blood is still draining from it, though not as much as previous day. [Client #5] ate breakfast, lunch and dinner without any issue; he is asking for food throughout the day. 6/9/14 [Physician] stated the blood is almost fully drained from [client #5]'s lungs and</p>			

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	<p>it will be tested for cancerous cells today. Still unsure what the cause of the bleeding is. Will possibly do the bronchoscopy if necessary. No changes in status; waiting on results of blood testing. Physical Therapy came in to get [client #5] moving around...6/10/14 [Physician #1] and [Physician #2] came in to see [client #5] today. No results yet of the blood testing. Lungs sounded a little more open today; [client #5] will be doing breathing exercises more. Chest X-ray performed; minimal amount of blood still in lungs. No changes in status; still awaiting blood test results. 6/11/14 Results of blood testing came back as cancerous cells in the blood, related to the lung cancer. Fluid build up is most likely a result of the cancer cells bleeding in his lungs. [Physician #1] scheduled a left thoroscopy with talc pleurodesis to be performed 9:30 A.M. on 6/12/14. They will be inserting a port in order to administer chemotherapy and packing his lungs with a talc powder to help subside the bleeding cells. [Client #5] is still eating well and sleeping on and off all day. 6/12/14 at 9:30 A.M. [client #5] is pbeing (sic) prepped fro (sic) surgery. [Physician #1] will be performing a left thoroscopy with talc pleurodesis; inserting a port into [client #5]'s left chest in order to start administering chemotherapy and packing his lungs with</p>			

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	<p>talc powder to subside the cancer cells bleeding....[Physician #1] stated the surgery went well, but they had to insert the port on the right side chest instead of the left due to an abnormal vein on the left side....Health care professionals will be notified if [client #5]'s fever is over 101, redness at the port a cath or chest tube incision site, shortness of breath, unable to eat or gains more than 3 pounds per day, per hospital discharge orders. Emergency personnel will be notified for shortness of breath or chest pain, weakness of extremities, confusion, trouble seeing, dizziness or loss of balance/coordination, or severe headache with no known cause, per hospital discharge orders. Staff and nursing will continue to monitor for health and safety per agency policy as well as following any future doctor's orders." Further review of the record neglected to indicate the facility's nursing services developed a protocol and/or risk plan in regard to client #5's health status.</p> <p>-BDDS report dated 10/13/14 involving client #5 indicated: "[GHM] reports: [Client #5] was in the restroom when staff heard him yelling. Staff went into restroom to see if she could assist [client #5] with anything. Staff said that [client #5] was laying on the floor yelling and crying that his stomach hurt. Staff called</p>			

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	<p>me (GHM) and told me what was going on. I asked her to call the nursing pager and that I would meet her and [client #5] at the hospital. While at the hospital [client #5] had labs done, a CT scan and a UA (urine analysis) completed. Blood work came back ok. The CT scan showed Bladder inflammation and the intestinal wall was inflamed. The doctor said that the inflammation for the intestine could be a viral or bacterial infection. Dr said that there could be no way to tell without doing more testing. Dr gave [client #5] an IV (Intravenous) with antibiotics, Levaquin. [Client #5] finished all antibiotics and fluids and was discharged. ER (Emergency Room) recommendations were to follow up with general practitioner in 2-3 days. [Client #5] was prescribed naproxen 500 mg 1 tab BID (twice daily, Tylenol extra strength 500 mg every 4 hours, Flagyl 500 mg every 12 hours, Levaquin 750 mg 1 tablet every day for 14 days and Zofran 4 mg 1 tablet three times daily PRN (as needed). Further review of the record neglected to indicate the facility's nursing services developed a protocol and /or risk plan in regard to client #5's health status.</p> <p>A review of client #5's record was conducted on 2/24/15 at 1:50 P.M.. A review of client #5's medical appointment records indicated:</p>			

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	<p>-Medical notation dated 10/14/14 documented by the GHAM indicated: "After his doctors appointment [client #5] seemed to be having trouble breathing and was shaking. Notified nurse instructed to take to the ER. Arrived to the ER at 4:30 P.M.. When he got there his B/P was 109/62, temp 99.0, pulse 94 and O2 was 100. EKG was completed at 4:39 P.M.. X-ray of his chest completed. He had labs drawn threw (sic) his port at 5:18 P.M. Aspirin 325 mg administered at 5:25 P.M.. B/P at 5:27 P.M. was 144/73. Morphine was administered threw (sic) his port at 6:30 P.M. for pain. At 6:30 P.M. B/P 128/66. At 7:00 P.M. B/P 127/66. At 7:30 P.M. B/P was 134/71. At 8:00 P.M. B/P was 133/80. At 8:30 P.M. B/P was 142/77. He had an IV put in his left arm bend that collapsed. The nurse then put another IV in his left arm bend under the first attempt. He went for a CT scan at 9:20 P.M.. [Client #5] was released from the hospital at 11:00 P.M.. The doctor stated that he could not find anything wrong with him other then (sic) the cancer he has already been diagnosed with follow up with primary physician with in 1-2 days. [Client #5] already has a doctor's appointment on 10/15/2014. Will follow up with doctor at that time. Administered all evening medication at 12:00 A.M. as</p>			

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	<p>instructed by [Nurse name]." Further review of the record neglected to indicate the facility's nursing services reviewed this information and discussed it with the IDT.</p> <p>-Doctor's visit notation dated 10/15/14 documented by the GHAM indicated: "[Client #5] went to [Physician] today he weighed 181.4 and b/p was 118/62. Blood taken in port. The type of lung cancer he has can be treated on the tarceva he is already taking. No chemo at this time. The cancer is not curable. He does have stage 3b cancer. There is a 1cm (centimeter) spot on lung that doesn't need to be worried about. Two main side effects, one diarrhea and two skin rash that we were already informed about. Continue taking 100 mg tarceva. There is a risk of getting blood clots in the legs with tamoxifen. [client #5] has a genetic defect that has a higher risk of developing cancer. Do not remove port. Port can be flushed every 6 weeks to 2 months. [Client #5] being tired is due to other medication that he is taking not caused by cancer. No need to do the bladder flush any more no mammograms. Stop testing for cholesterol problems. Conceder (sic) discontinuing HM COQ10 cap 100mg. Also conceder (sic) discontinuing pravastatin." Review of the record neglected to indicate the facility's nursing</p>			

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	<p>services developed a protocol and/or risk plan for client #5's health concerns. Further review of the record neglected to indicate the facility's nursing services reviewed this information and discussed it with the IDT.</p> <p>-Doctor's visit notation dated 12/23/14 documented by GHAM indicated: "[client #5] went to [Physician] today. Labs were completed in right arm bend. Weight 177.6, B/P 117/74, pulse 85 and temp 97.4. They wanted a CT Scan of his head completed today with and without contrast. On January 8th [client #5] will be having another CT Scan done at [Hospital name] at 7:30 am on his abdomen, pelvis, and chest. Follow up appointment 10:15 am on January 20. He will go over results at that time." Further review of the record neglected to indicate the facility's nursing services reviewed this information and discussed it with the IDT.</p> <p>-Doctor's visit notation dated 1/20/15 documented by GHAM indicated: "[Client #5] seen [Physician]' [Nurse name] today. He had labs completed in his right arm. He had a CT scan on January 8, 2015 of his chest, abdomen and pelvis. They are seeing new changes in of multiple enlarged nymph nodes down his sternum. They are all</p>			

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	<p>converged together. Largest area is 2 inches by 1 1/2 inch. He has gall stones but they are not inflamed. On December 23rd [client #5] had a CT scan of the head and it came back normal. He needs to a PET Scan completed on Wednesday, January 28, 2015. He has a follow up appointment with [Physician] on February 3, 2015. We will find out more information after this appointment." Further review of the record failed to indicate the facility's nursing services reviewed this information and discussed it with the IDT.</p> <p>-Doctor's office notation dated 2/13/15 documented by GHAM indicated: "[Client #5] seen [Physician] today. He had labs completed in left arm bend....PET (position emission tomography) scan showed more lymph nodes that are cancer all over his chest region. On his sternum, lungs and glands. Chemo is the only option if the Tarceva (cancer medication) is not working. The family was given two options, continue Tarceva and complete another ct scan in one month to ensure the cancer is not progressing more or start chemo and have a cut (sic) scan in 2 months. The family is going to let me know Monday on what road they want to take. Until they make a decision [client #5] will continue Tarceva 100 mg 1 time</p>			

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	<p>a day. He does have a follow up appointment on 2/27/15 at 10:45 A.M.. He also said the cancer cannot be cured, that it can only be controlled and keep [client #5] comfortable." Further review of the record failed to indicate the facility's nursing services reviewed this information, discussed the information with the IDT and failed to indicate what decision was made by client #5's family.</p> <p>-BDDS report dated 2/27/15 indicated: "On 2/27/15 at approximately 11:45 A.M., [GHAM name] transported the individual to a routine oncologist visit, due to lung cancer. She reports the individual seemed to be having trouble breathing since being picked up from the day program for the appointment. Upon arriving to the oncologist office, she notified the nurse of this trouble. The nurse took the individual's vitals; B/P (Blood Pressure) 89/60, temp 101.4, pulse 103 and his O2 (Oxygen) level was 78. The individual was placed on oxygen and the office called an ambulance. The individual was transported to [Hospital name] Emergency Room. At the ER, 2 sets of blood work were taken, a chest x-ray and CT Scan were completed. Pneumonia was discovered in his left lung and cardiac enzymes came back positive. He was admitted to the hospital and the attending physician will be</p>			

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	<p>involving a cardiologist for further evaluation. Plan to Resolve: Every member of the IDT was notified and given the details of the illness and recommendations from the attending physicians. The IDT will remain in contact with physicians and each other to relay all pertinent information. At least one member of the IDT will be present at the hospital at least once daily to receive updates and information from the attending physicians." Further review neglected to indicate a protocol and/or risk plan had been developed to address client #5's health concerns.</p> <p>Further review of client #5's group home record failed to indicate the facility's nursing services developed protocols and/or risk plans to give staff guidance on client #5's diagnoses and how to look for signs and symptoms of each diagnoses. Review of client #5's record neglected to indicate the facility's nursing services developed a medical care plan to address client #5's medical needs.</p> <p>A review of the facility's IDT records dated was conducted on 2/25/15 at 2:00 P.M.. Review of client #5's IDT summary dated 1/22/15 failed to indicate the IDT discussed client #5's 1/20/15 medical appointment and the results of his testing. Review of the IDT records</p>			

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	<p>sated 3/14 to current neglected to indicate the facility's nursing services discussed client #5's health issues and medical concerns with the IDT.</p> <p>An interview with the group home nurse assigned to the group home was conducted on 2/24/15 at 2:50 P.M.. The group home nurse indicated there was no written documentation to indicate she reviewed and discussed changes in client's health status. The nurse indicated her communication was done via telephone. When asked if there was any written documentation to indicate she communicated with the physician or his office employees in regard to client #5's health status, the nurse indicated there was not. When asked it there was documentation she presented and discussed client #5's health concerns with the IDT, the nurse indicated only by telephone and email. No written documentation was submitted for review to indicate the nurse documented on client's on going health status. A request for emails and/or any documentation to indicate the facility's nursing services assessed, monitored, communicated and documented any medical information was made. No documentation was submitted.</p> <p>An interview with the Director of Nursing (DON) was conducted on</p>			

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	<p>2/25/15 at 1:35 P.M.. The DON indicated nursing staff should immediately document into the facility's computer system under a T-Log each time she is made aware of any client's health status and when reviewing any client's medical notations and records and when notified by staff.</p> <p>A review of the facility's computer system was conducted on 2/24/15 at 6:00 P.M.. There was no documentation by the group home nurse in the facility's T log system in regard to client #5's changes in health and medical concerns.</p> <p>9-3-6(a)</p>			

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W 362 Bldg. 00	<p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview, the facility failed for 8 of 8 clients living at the group home, (clients #1, #2, #3, #4, #5, #6, #7 and #8) to ensure the pharmacist reviewed clients' medications on a quarterly basis.</p> <p>Findings include:</p>	W 362	Nursing will continue to send the quarterly pharmacy reviews to the physician's for follow up. All recommendations will be sent to the appropriate physician with a letter of request for follow up. Further, the nurse will document the pharmacy recommendations on her monthly summary so the recommendations can be discussed by the interdisciplinary	03/25/2015

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	<p>The pharmacist's medication review record was reviewed on 2/26/15 at 11:25 A.M.. Review of the pharmacist's medication review record indicated no medication reviews for the first and second quarters of 2014 for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>A review of client #1's record was conducted on 2/24/15 at 11:40 A.M.. The record indicated client #1 was prescribed medications.</p> <p>A review of client #2's record was conducted on 2/24/15 at 4:00 P.M.. The record indicated client #2 was prescribed medications.</p> <p>A review of client #3's record was conducted on 2/24/15 at 4:30 P.M.. The record indicated client #3 was prescribed medications.</p> <p>A review of client #4's record was conducted on 2/24/15 at 4:45 P.M.. The record indicated client #4 was prescribed medications.</p> <p>A review of client #5's record was conducted on 2/24/15 at 1:50 P.M.. The record indicated client #5 was prescribed medications.</p> <p>A review of client #6's record was</p>		<p>team. The QA coordinator will conduct random checks with the nursing office to ensure these pharmacy checks are being sent to the physicians.</p>	

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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6381 LUTE RD PORTAGE, IN 46368
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W 368	<p>conducted on 2/24/15 at 12:10 P.M.. The record indicated client #6 was prescribed medications.</p> <p>A review of client #7's record was conducted on 2/24/15 at 12:20 P.M.. The record indicated client #7 was prescribed medications.</p> <p>A review of client #8's record was conducted on 2/24/15 at 12:40 P.M.. The record indicated client #8 was prescribed medications.</p> <p>An interview with the Registered Nurse (RN) was conducted on 2/24/15 at 2:50 P.M.. When asked how often medications are to be reviewed by the pharmacist, the RN stated "They should be reviewed quarterly." The RN further indicated there was no written documentation available for review to indicate medications were reviewed by the pharmacist.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p>			

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Bldg. 00	<p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to assure drugs administered to 3 of 4 sampled clients and 3 additional clients (clients #1, #2, #4, #5, #7 and #8) were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 2/23/15 at 1:20 P.M.. Review of the facility's General Event Reports (GERs) (Internal Reports) indicated:</p> <p>-GER dated 12/25/14 involving client #5 indicated: "Medication not passed." Further review of the report indicated client #5 did not receive his Tarceva 100 mg (milligram) (cancer) medication on 12/24/14 at 8:00 P.M. and on 12/25/14 at 8:00 P.M..</p> <p>-GER dated 12/26/14...Event Date: 12/25/14 involving client #4 indicated: "Medication error type: Omission...Olanzapine 5 mg (bipolar), Depakote 200 mg (bipolar), Gas Relief 125 mg, Liquid Blue Mint Oral Rinse 30 ml (milliliter) and Catheter 1 (urinate)...Not given."</p>	W 368	All staff were retrained on medication administration on Jan. 15, 2015 to ensure they are competent in the administration of medications for all clients (including the 6 rites of medication administration). Staff will continue to receive annual retraining in medication administration (Med Review) at minimum or more frequently as needed. There were additional retrainings on 2/3/15 and 2/10/15 for individual staff who committed a further med errors. To ensure further compliance in this area, the QDDP will conduct random monthly home visits and will observe staff during medication administration, nursing will monitor when completing random home visits, and the manager will monitor med passes by the certified med passer while on shift. Documentation will maintained of these observations and competency will need to be demonstrated by certified med passers. If it is determined at anytime, that staff fail to follow the policy for medication administration, they will be required to retake Med Core A and B within 30 days taught by a certified nursing instructor. He/she will be suspended from med passes during this time. The certified Nurse trainer will ensure the appropriate measures have	03/31/2015			

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	<p>-GER dated 1/1/15 involving client #2 indicated: "When passing bedtime medications, I found that no one dispensed [client #2]'s Oxybutynin (overactive bladder). This used to be a 2 P.M. medication. The new system started today and was confusing. I called [Nurse name] and the medication should have been passed by 3 P.M.. I did not start my shift until 4 P.M....Oxybutynin 5 mg...Oxybutynin 5 mg...[Nurse name] I was called at 7 P.M. which is out of med pass time allowed so an error was to be reported. He (client #2) also receives a dose at bedtime and staff to give that."</p> <p>-GER dated 1/1/15 involving client #1 indicated: "When passing medications, med passer noticed that [client #1]'s Clonazepam .5 mg (epilepsy) was not in the medications. It was double checked by another staff member and [Nurse name] was called. She informed staff to sign and circle and to write on the back that the medication was not available because the doctor did not reorder the medication. There was 2 more medications that were not available to administer Clozapine 100 mg (schizophrenia) and hydro cort 2.5% ointment (dry skin). The nurse was also notified about these. The instructions were the same."</p>		occurred.	

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	<p>-GER dated 1/1/15 involving client #8 indicated: "when (sic) dispensing bedtime medications, med passer noticed that [client #8]'s Clozapine ODT (orally disintegrating) 100 mg (dementia), ear drops solution 6.5 and Lorazepam .5 mg (anxiety disorder) was not here. They were not delivered to us. I contacted [Nurse name]. She advised me to sign, circle and write on the back sheet of MAR (Medication Administration Record) that the medication was (sic) not available."</p> <p>-GER dated 1/2/15 involving client #1 indicated: "Lorazepam .5 mg (anxiety disorder) given to wrong participant. Should have have been given to [client #8] P.M. dose....Wrong individual...."</p> <p>-GER dated 1/3/15 involving client #1 indicated: "Medication is not available to dispense....Medication not available....Clozapine 100 mg, Clozapine 100 mg at 7:00 P.M....Medication was not delivered to group home."</p> <p>-GER dated 1/5/15 involving client #8 indicated: "Medication not available...Clozapine 100 mg, Clozapine 100 mg 7:30 P.M.."</p> <p>-GER dated 1/5/15 involving client #1:</p>			

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	<p>"Medication not available...Clozapine 10 mg, Clozapine 10 mg at 7:00 P.M.."</p> <p>-GER dated 1/6/15 involving client #8 indicated: "Medication not available...Clozapine 100 mg, Clozapine 200 mg at 7:30 P.M.."</p> <p>-GER dated 1/7/15 involving client #8 indicated: "Medication Error Type: Omission...Lorazepam .5 mg (anxiety disorder), Lorazepam .5 mg at 7:00 P.M.."</p> <p>-GER dated 1/7/15 involving client #1 indicated: "Medication Error Type: Omission...Clozapine 100 mg, Clozapine 100 mg at 7:00 A.M.."</p> <p>-GER dated 1/7/15 involving client #1 indicated: "Medication Error Type: Omission...Clozapine 100 mg, Clozapine 100 mg at 7:00 P.M.."</p> <p>-GER dated 1/11/15 involving client #4 indicated: "When passing [client #4]'s bedtime medications, I noticed his P.M. medications had not been signed for. His P.M. medications were packed this morning to go with him to his dad's house."</p> <p>-GER dated 1/14/15 involving client #1 indicated: "Medication Error Type:</p>			

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	<p>Omission...Clozapine 1 mg, Clozapine .5 mg, Clozapine 100 mg, Clozapine 100 mg at 10:00 P.M....On 1/14/15, [Direct Support Professional (DSP) #2] failed to administer the full dosage of [client #1]'s bedtime (7 P.M. to 10 P.M.) Clozapine 1 mg. The order calls for 2-.5 mg pills to be given at bedtime for a total of 1 mg; only 1-.5 mg pill was administered. [DSP #4] failed to check the medication was properly administered. [DSP #13] failed to sign the MAR indicating [client #1]'s bedtime (7 P.M. to 10 P.M.) Clozapine 100 mg dosage was administered. Due to the packaging of this medication from the pharmacy, it is unknown whether the medication was administered. [DSP #4] failed to check the medication was properly administered."</p> <p>-GER dated 1/15/15 involving client #8 indicated: "Medication Error Type: Omission...Lorazepam .5 mg, Lorazepam .5 mg, at 6:00 P.M., Lorazepam 1 mg, Lorazepam 1 mg at 10:00 P.M.. On 1/14/15, [DSP #14] failed to administer client's P.M. (3p-6p) Lorezepam (sic) .5 mg. [DSP #4] failed to check that the medication was administered properly. On 1/14/15 [DSP #14] failed to administer the complete dosage of client's bedtime (7p-10p) Lorezepam (sic) 1 mg (2-.5 mg pills). Only one of the pills was</p>			

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	<p>administered (.5 mg). [DSP #4] failed to check the medication was properly administered."</p> <p>-GER dated 1/17/15 involving client #5 indicated: "Please note : The event date is 1/16/15, during bedtime medication administration. The discovered date is 1/17/15. Medication Error Type: Omission...Tarceva 100 mg, Tarceva 100 mg at 10:00 P.M....On 1/16/15 at bedtime (7p-10p), [DSP #16] failed to administer client's Tarceva 100 mg."</p> <p>-GER dated 1/20/15 involving client #1 indicated: "As I was passing PM meds I noticed that [client #1]'s Metronidazol Gel (skin) was not signed on the day before Medication Error Type: Charting error."</p> <p>-GER dated 1/20/15 involving client #7 indicated: "Please note the event date is 1/19/15, the discovered date is 1/20/15. As I was passing pm meds, I noticed that [client #7]'s Chlorhexidine Rinse had not been signed for."</p> <p>A morning observation was conducted at the group home on 2/23/15 from 6:30 A.M. until 8:00 A.M.. At 7:10 A.M., Direct Support Professional (DSP) #2 began administering client #7's prescribed oral medications. DSP #2</p>			

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	<p>began administering client #7's "Polyethyl Glycol Powder 3350 (constipation)" with a small plastic solo cup of water. Review of the medication label and the Medication Administration Record (MAR) dated 2/1/15 to 2/28/15 was conducted on 2/23/15 at 7:15 A.M. and indicated: "Polyethyl Glycol Powder 3350...Mix in 8 ounces of water daily."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 A.M.. The QIDP indicated client #7's medication should have been administered as directed on the MAR. The QIDP further indicated client #7 should have taken her medications with at least 8 ounces of water.</p> <p>A review of the facility's "Universal Policies and Procedures-Medication Administration" dated 8/8/13 was conducted on 2/23/15 at 4:30 P.M.. Review of the policy indicated: "Opportunity Enterprises clients will receive medications as prescribed by the individuals attending physician's to maintain optimum health....B. Guidelines for dispensing medications for all consumers:</p> <p>1. Prescription medications will be administered as instructed on the</p>			

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	<p>pharmacy label and non-prescription medications will be administered using labeled instructions unless changed by the ordering physician.</p> <p>8. Medications will be verified 3 times against the Medication Administration Record. This includes medications that are set in the weekly pill dispenser.</p> <p>C. Dispensing of Medications:</p> <p>4. The medication should be checked three times in accordance with med core training.</p> <p>a. When taking out the medication.</p> <p>b. After pouring or punching out the medication.</p> <p>c. Before administering the medication to the client.</p> <p>6. The 6 rights of medication administration should be followed.</p> <p>a. Right medication is given to the;</p> <p>b. Right person at the;</p> <p>c. Right time;</p> <p>d. Right dose/strength;</p> <p>e. Right route."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 2/27/15 at 10:45 A.M.. The QIDP indicated staff should have administered the clients</p>			

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W 391 Bldg. 00	<p>medications as ordered. The QIDP further indicated staff should have followed the facility's medication administration policy.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 1 of 11 medications administered to 1 of 2 clients observed during the morning medication administration (client #5), the facility failed to remove from use the medication container with a worn label.</p> <p>Findings include:</p> <p>A morning observation was conducted on 2/23/15 from 6:30 A.M. until 8:00 A.M.. At 7:00 A.M., client #5 was observed during medication administration with Direct Support Professional (DSP) #2.</p>	W 391	<p>The Clindamycin Gel 1% for client #5 with a worn label has been removed from the med cart. The med cart will be checked by the nurse during monthly home visits for appropriate medications and to ensure all labels are in clean and legible order. If the label is worn, illegible, or missing, the medication will be removed from use and replaced immediately. This will be part of a checklist that the nurse completes on her visit. The completed checklists will be submitted to the Chief Program Officer after each visit to ensure completion.</p>	03/29/2015

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W 440 Bldg. 00	<p>DSP #2 retrieved a plastic bag with a tube of topical medication from client #5's medication drawer. The label on the plastic bag had the name of the medication peeled off. The medication tube did not have a label. Review of the Medication Administration Record (MAR) dated 2/1/15 indicated: "Clindamycin Gel 1% ...Apply topically daily."</p> <p>An interview with the facility's nurse was conducted on 2/24/15 at 3:00 P.M.. The nurse indicated all medications are to have a label and further indicated the labels are not to be worn.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills which affected 8 of 8 clients living in the facility (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>Findings include: The facility's records were reviewed on</p>	W 440	Evacuation drills will be conducted a minimum of once per quarter for each shift. The GHM will schedule these drills and see that they are completed. Once a drill is conducted, the drill form will be signed by the staff on shift and will include information on the client's in the home as far as their level of participation/assistance	04/01/2015			

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	<p>2/24/15 at 10:40 A.M.. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3, #4, #5, #6, #7 and #8 during the morning staff shift (6:00 A.M. to 2:00 P.M.) for the first quarter (January 1st through March 31st) of 2014.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 2/27/15 10:45 A.M.. The QIDP indicated evacuation drills are to be conducted during each quarter for each shift of personnel. The QIDP further indicated there was no written documentation to indicate the facility conducted evacuation drills during each quarter for each staff shift.</p> <p>9-3-7(a)</p>		<p>required in the dill. Once these forms are completed, they will be turned into the Executive Assistant to Programs. She/he will add this drill tracking to a checklist of monthly action items and will ensure that all drills are conducted within the regulatory timeframes.</p>	