

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G724	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2015
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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307
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W000000	<p>This visit was for the post certification revisit to the investigation of Complaint #IN00158472 conducted on 11/14/14.</p> <p>This visit was in conjunction with the full recertification and state licensure survey.</p> <p>Complaint #IN00158472: Not corrected.</p> <p>Dates of Survey: January 6, 7, 8 and 9, 2015</p> <p>Facility number: 004837 Provider number: 15G724 AIM number: 200803700</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 1/20/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, for 2 of 3 sampled clients (clients B and</p>	W000104	Management staff will be re-trained to ensure that client's do not pay for sensory	02/06/2015

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>C), the governing body failed to exercise general policy and operating direction over the facility to ensure it developed and implemented a policy and procedure to give group home and facility staff guidance on checking in client medications when delivered by the pharmacy to prevent medication errors. The governing body failed to exercise general policy and operating direction over the facility to ensure client B did not pay for sensory equipment. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted investigations in regard to an allegation of abuse/injuries of unknown origin and an incident of staff neglect.</p> <p>Findings include:</p> <p>1. A financial record review was conducted on 1/8/15 at 1:30 P.M.. A review of client B's financial record indicated: Online order dated 3/30/14 in the amount of \$268.03 for the purchase of "20 pound Weighted Vest...\$47.97...Bean Bag Chair...\$52.04...Weighted Blanket...\$74.18 and Rocking Chair Cushion Set...\$59.98." Further review of the record failed to indicate he had been reimbursed for the expenditures.</p>		<p>equipment. Responsible person: Sheila O'Dell, Group Home Director. Client B will be reimbursed in the amount of \$268.03. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, the QIDP will review client finances. Responsible person: Traci Hardesty, QIDP. All staff are trained upon hire and annually their after, which includes medication procedures. Responsible person: Ruth Estrada, training Coord, Sherri DiMarco, RN & Traci Hardesty, QIDP. To ensure future compliance, a protocol was developed on how to check in medication when delivered from the pharmacy. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP. All staff will be trained on the protocol on how to check in medication when delivered from the pharmacy. Responsible person: Traci Hardesty, QIDP. To ensure future compliance, a check in/tracking sheet has been put into place. Responsible person: Traci Hardesty, QIDP & Airielle Roger, Grou</p> <p>All management staff will be re-trained on the abuse/neglect policy, Responsible person: Sheila O'Dell, Group Home Director.</p> <p>All staff will bere-trained on the abuse/neglect policy. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, the</p>		

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	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/8/15 at 1:50 P.M.. The QIDP indicated the cushions were purchased for a rocking chair for client B's bedroom and living room. The QIDP indicated the bean bag was not at the group home and further indicated she believes it is at the day program. The QIDP indicated the other items were sensory items for client B's programming and further indicated clients should not pay for sensory equipment.</p> <p>2. A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg</p>		<p>Manager will review all internal incident reports daily when present for medication errors, injury of unknown origin, falls and significant injuries &/or allegations. Responsible person: Airielle Rogers, Group Home Manager.</p> <p>To ensure future compliance, the QIDP will review in the home three times a month, all internal incident reports for medication error, injury of unknown origin, falls and significant injuries &/or allegations the first month and then monthly thereafter. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, all incident reports will be reviewed at least monthly during the program status review and at least monthly by our Nurse to ensure that the facility's abuse and neglect policy has been followed. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarcco, RN.</p> <p>All management staff will be re-trained on the abuse/neglect policy, which includes thorough investigation. Responsible person: Sheila O'Dell, Group Home Director.</p> <p>All staff will be re-trained on the abuse/neglect policy, which includes thorough investigation. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, the Manager will review all internal incident reports daily when present</p>	

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	<p>(milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C] was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the</p>		<p>for medication error, injury of unknown origin, falls and significantinjuries &/or allegations. Responsible person: Airielle Rogers, Group HomeManager. To ensure futurecompliance, the QIDP will review in the home three times a month, all internalincident reports for medication errors, injury of unknown, origin, falls andsignificant injuries &/or allegations the first month and then monthly thereafter.Responsible person: Traci Hardesty, QIDP. To ensure futurecompliance, all incident reports will be reviewed at least monthly during theprogram status review and at least monthly by our Nurse to ensure that thefacility's abuse and neglect policy has been followed. Responsible person:Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarco,RN.</p>	

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	<p>incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going to submit the report." Further review of the report failed to indicate this incident was immediately reported and investigated.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/6/15 at 2:55 P.M.. A request was made for the facility's policy and procedure which gave staff guidance on how to check medications in when delivered from the pharmacy. The QIDP indicated the facility did not have a developed policy and procedure which gave staff guidance on checking in medications when delivered from the pharmacy. The QIDP stated "We verbally tell staff how to check in medications."</p> <p>3. Please refer to W149: The governing body failed for 1 of 3 sampled clients (client C), to implement written policy and procedures to provide written evidence thorough investigations were conducted in regard to an allegation of abuse and an incident of staff neglect.</p> <p>4. Please refer to W154: The governing body failed to exercise general policy and</p>				

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	<p>operating direction over the facility for 1 of 3 sampled clients (client C) to ensure the facility provided written evidence thorough investigations were conducted in regard to an allegation of abuse and an incident of staff neglect.</p> <p>5. Please refer to W189: The governing body failed for 1 of 3 sampled clients (client C) to ensure all staff who worked with client C were sufficiently trained to assure competence in checking in medications when delivered from the pharmacy to prevent medication errors.</p> <p>This deficiency was cited on 11/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00158472.</p> <p>9-3-1(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 2 of 2 incidents, involving 1 of 3 sampled clients (client C), the facility failed to implement policy and procedure to provide written evidence thorough investigations were conducted in regard to an allegation of abuse and an incident of staff neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-IR dated 12/21/14 involving client C indicated: "Injury: Unknown: While assisting [client C] with dinner, [client C] pulled his arm sleeve up and showed staff a red mark on his right wrist, [client C] stated that he was bitten, when staff asked [client C] who bit him he replied 'My Dad.' [Client C has a 2 inch by 1 inch red mark on his right wrist." The record failed to indicate there was written</p>	W000149	<p>All management staff will be re-trained on the abuse/neglectpolicy, Responsible person: Sheila O'Dell, Group Home Director.</p> <p>All staff will bere-trained on the abuse/neglect policy. Responsible person: Traci Hardesty,QIDP.</p> <p>To ensure future compliance, the Manager will review allinternal incident reports daily when present for medication errors, injury ofunknown origin, falls and significant injuries &/or allegations.Responsible person: Airielle Rogers, Group Home Manager.</p> <p>To ensure future compliance, the QIDP will review in thehome three times a month, all internal incident reports for medication error, injuryof unknown, origin, falls and significant injuries &/or allegations thefirst month and then monthly thereafter. Responsible person: Traci Hardesty,QIDP.</p> <p>To ensure future compliance, all incident reports will bereviewed at least monthly during the program status review and at least monthlyby our Nurse to ensure that the</p>	02/06/2015

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	<p>documentation to indicate the facility conducted a thorough investigation in regard to this incident.</p> <p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client</p>		<p>facility's abuse and neglect policy has been followed. Responsible person: Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarco, RN.</p>	

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	<p>C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C] was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going to submit the report." Further review of the report failed to indicate this incident was immediately reported and investigated.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/6/15 at 2:55 P.M.. A request for all investigations for this group home was made for the second time. The QIDP indicated investigation records are attached to the BDDS reports along with the IR. No written documentation was submitted for review</p>						

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	<p>to indicate the facility conducted an investigation in regard to the abuse allegation and the incident of neglect.</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 1:30 P.M.. Review of the facility's "28. POLICY ON REPORTING AND INVESTIGATING INCIDENTS AND ALLEGATIONS OF ABUSE AND NEGLECT", no date noted, indicated, in part, the following: "... Consumers must not be subjected to abuse by anyone, including, but not limited to, facility staff, other consumers...Until the incident is reported and investigated, one may not be able to determine whether it is abuse (willful), neglect, or mistreatment but the incident must be treated as an allegation of abuse, neglect or mistreatment and follow the regulations for reporting, responding, investigating and correcting... The term 'willful' does not have to do with 'competence' but with 'intent' to cause harm. Someone with a mental illness or mental retardation can willfully inflict harm to someone who has been bothering them, even though they may not be considered 'competent'... It is mandatory in all situations involving abuse, neglect, exploitation, mistreatment of an individual or the violation of an individual's rights that there is</p>			

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	<p>notification made to legal representative, guardian/parent, if applicable, Case Manager, if applicable, BDDS (Bureau of Developmental Disabilities Services), APS/CPS (Adult Protection Services/Child Protection Services) and other person the (sic) designated by the consumer...Physical-includes willful infliction of injury, unnecessary physical or chemical restraints or isolation, and punishment with resulting physical harm or pain....b. Neglect-includes failure to provide appropriate care, food, medical care or supervision...13. Medication errors....b. Wrong dose given that place (sic) an individual's health and safety in jeopardy as determined by the personal physician....Incident Reporting: In-Pact requires that all staff immediately verbally report all incidents as defined in this policy to their Program Director/Administrator. Under no conditions may an employee leave the work site without reporting and documenting any incident which occurred during his/her shift or for which an allegation was communicated to him/her during his/her shift."</p> <p>An interview with the Group Home Director (GHD) and the QIDP was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated all allegations of abuse and neglect should be investigated.</p>						

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W000154	<p>When asked if the above incidents were investigated, the QIDP indicated if the incidents were investigated the investigations would have been attached to the BDDS reports. The QIDP stated "I'm pretty sure I did an investigation about this incident (12/21/14), but I'm not sure if [Clerical Staff] or I gave it to you (GHD)." When asked if an investigation was conducted in regard to the medication error, the GHD stated "No, because we knew what happened." No written documentation was submitted for review to indicate investigations were conducted in regards to the mentioned incidents.</p> <p>This deficiency was cited on 11/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00158472.</p> <p>9-3-2(a)</p>						
483.420(d)(3)							

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	<p>STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 2 incidents, involving 1 of 3 sampled clients (client C), the facility failed to provide written evidence thorough investigations were conducted in regard to an allegation of abuse and an incident of neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-IR dated 12/21/14 involving client C indicated: "Injury: Unknown: While assisting [client C] with dinner, [client C] pulled his arm sleeve up and showed staff a red mark on his right wrist, [client C] stated that he was bitten, when staff asked [client C] who bit him he replied 'My Dad.' [Client C has a 2 inch by 1 inch red mark on his right wrist." The record failed to indicate there was written documentation to indicate the facility conducted a thorough investigation in regard to this allegation of abuse.</p>	W000154	<p>All management staff will be re-trained on the abuse/neglectpolicy, which includes thorough investigation. Responsible person: SheilaO'Dell, Group Home Director.</p> <p>All staff will bere-trained on the abuse/neglect policy, which includes thorough investigation.Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure futurecompliance, the Manager will review all internal incident reports daily whenpresent for medication error, injury of unknown origin, falls and significantinjuries &/or allegations. Responsible person: Airielle Rogers, Group HomeManager.</p> <p>To ensure futurecompliance, the QIDP will review in the home three times a month, all internalincident reports for medication errors, injury of unknown, origin, falls andsignificant injuries &/or allegations the first month and then monthly thereafter.Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure futurecompliance, all incident reports will be reviewed at least monthly during theprogram status review and at least monthly by our Nurse to ensure that thefacility's abuse and neglect policy</p>	02/06/2015

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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9321 SULLIVAN LN CROWN POINT, IN 46307
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	-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C]		has been followed. Responsible person:Traci Hardesty, QIDP, Sheila O'Dell Group Home Director, and Sherri Dimarco,RN.	

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	<p>was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going to submit the report." Further review of the report failed to indicate an investigation was conducted in regard to this incident of neglect.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/6/15 at 2:55 P.M.. A request for all investigations for this group home was made for the second time. The QIDP indicated investigation records are attached to the BDDS reports along with the IR. No written documentation was submitted for review to indicate the facility conducted investigations in regard to the abuse allegation and incident of neglect.</p>			

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	<p>An interview with the Group Home Director (GHD) and the QIDP was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated all allegations of abuse and neglect should be investigated. When asked if the above incidents were investigated, the QIDP indicated if the incidents were investigated the investigations would have been attached to the BDDS reports. The QIDP stated "I'm pretty sure I did an investigation about this incident (12/21/14), but I'm not sure if [Clerical Staff] or I gave it to you (indicating the GHD)." When asked if an investigation was conducted in regard to the medication error, the GHD stated "No, because we knew what happened." No written documentation was submitted for review to indicate investigations were conducted in regards to the mentioned incidents.</p> <p>This deficiency was cited on 11/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00158472.</p> <p>9-3-2(a)</p>						

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM 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 for 1 of 3 sampled clients (client C), the facility failed to ensure all staff who worked with the client C were sufficiently trained to assure competence in checking in medications when delivered from the pharmacy.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 2:35 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated:</p>	W000189	<p>All staff are trained upon hire and annually thereafter, which includes medication procedures. Responsible person: Ruth Estrada, training Coord, Sherri DiMarco, RN & Traci Hardesty, QIDP.</p> <p>To ensure future compliance, a protocol was developed on how to check in medication when delivered from the pharmacy. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QIDP.</p> <p>All staff will be trained on the protocol on how to check in medication when delivered from the pharmacy. Responsible person: Traci Hardesty, QIDP.</p> <p>To ensure future compliance, a check in/tracking sheet has been put into place. Responsible person: Traci Hardesty, QIDP & Airielle Roger, Group Home Manager.</p>	02/06/2015

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	"[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic) notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C] was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get			

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	<p>clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going to submit the report."</p> <p>A review of the staff personnel records was conducted on 1/8/15 at 1:35 P.M.. Review of the personnel records and staff training records failed to indicate all staff who worked at the group home were trained prior to 1/7/15 on how to check in medications when delivered from the pharmacy.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/7/15 at 2:10 P.M.. The QIDP stated staff were trained "today" on how to check in medication when delivered from the pharmacy.</p> <p>This deficiency was cited on 11/14/14. The facility failed to implement a systemic plan of correction to prevent</p>			

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W009999	<p>recurrence.</p> <p>This federal tag relates to complaint #IN00158472.</p> <p>9-3-3(a)</p> <p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client C), to report a medication error to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p>	W009999	<p>All incident report will be reported to BDDS within 24hours. QIDP will be re-trained on reporting to BDDS within 24hours. Responsible person: Sheila O'Dell, Group Home Director.</p> <p>To ensure future compliance, when an incident is reported immediately; it will be stated/clarified who will be submitting the report. Responsible person: Sheila O'Dell, Group Home Director, Traci Hardesty, QIDP & Airielle Roger, Group Home Manager.</p>	02/06/2015	

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	<p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/6/15 at 3:50 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/2/15...Date of Knowledge: 1/3/15...Submitted Date: 1/5/15 involving client C indicated: "[Client C]'s seizure medication Onfi was delivered on 1/2/15 and staff put the bubble pack in his medication box without following the medication check in procedure. Per the script the pharmacy received from the doctor, the pharmacy did not send half tabs like usual but instead sent whole tabs. On 1/2/15 at 8 P.M., [client C] received 30 mg (milligrams) of Onfi instead of 15 mg. On 1/3/15 at 7 A.M., [client C] received 20 mg of Onfi instead of 10 mg. The error was noticed in the evening of 1/3/15 before 8 PM meds were passed. The copy of the script received at the home is hard to read due to it being faxed but it appears that the doctor ordered 10 mg in the AM and 20 mg in the PM-this is an increase of 5 mg per day in the PM based on previous prescriptions. The agency nurse and Administration was (sic)</p>				

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	<p>notified when the error was found. The nurse told staff not to pass [client C]'s evening meds since he had gotten too much in the past 24 hours. His regular scheduled passing of Onfi resumed on the morning of 1/4/15. As of 1/4/15, [client C] has received 10 mg on (sic) Onfi in the AM and 20 mg of Onfi in the PM, per the most recent prescription. [Client C] was sleepy all day on 1/3/15 but did not exhibit any other side effects from receiving too much medication. [Client C]'s doctor will be contacted today to get clarification on the correct dosage of Onfi and a new prescription will be requested if needed. Staff will be retrained on the check in procedure for all medications and a form will be created to document that the procedure has been done correctly and in a timely manner. The staff who did not properly check in the meds and the staff who passed the incorrect dosage will receive disciplinary action. The reason for the late submission of this report was miscommunication as to who was going to submit the report." Further review of the report failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March</p>			

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	<p>1, 2011 was conducted on 1/6/15 at 4:15 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS...16. A medication error or medical treatment error as follows: ...b. wrong medication dosage given."</p> <p>An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/9/15 at 11:30 A.M.. The QIDP indicated the incident should have been reported immediately to the administrator and within 24 hours to BDDS. The QIDP further indicated the incident was not reported/reported timely to BDDS.</p> <p>9-3-1(b)</p> <p>This state rule was cited on 11/14/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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