

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/11/2013
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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: February 19, 20, 21, 22, 25, March 7, 8, and 11, 2013.</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>Provider Number: 15G799 Facility Number: 0012562 AIM Number: 201017540</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 19, 2013 by Dotty Walton, Medical Surveyor III.</p>	W000000		

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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W000104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 clients (clients #1, #2, #3, and #4) who lived in the group home, the governing body failed to exercise operating direction over the facility completing maintenance and repairs.</p> <p>Findings include:</p> <p>During observations on 2/19/13 from 3:15pm until 6:05pm and on 2/20/13 from 6:00am until 8:30am at the group home, clients #1, #2, #3, and #4 were. The following was observed with the RM (Residential Manager), Group Home Staff (GHS) #1, GHS #2, GHS #3, GHS #4, GHS #5, and GHS #6.</p> <p>-On 2/19/13 at 3:25pm, the RM indicated the wall by client bedrooms had six (6) patches of dry wall. Wall #1 had patched holes into the wall which were six feet tall by four feet wide (6'x4') and Wall #2 had an area seven feet tall by three feet wide (7'x3') that had dry wall patches.</p> <p>-On 2/19/13 at 3:25pm, the RM indicated one of two (1/2) bathrooms had a missing towel rack with the metal hinges from the</p>	W000104	<p><b>W 104</b></p> <p>Governing Body – Repairs &amp; Chairs</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The home is for people with significant behavior problems, which often result in property damage. The damages cited in the survey will be repaired, and sturdier chairs will be purchased.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Repairs made and sturdier chairs purchased.</p>	04/10/2013			

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	<p>towel rack still extended from the wall at the entry of the bathroom.</p> <p>-On 2/19/13 at 3:25pm, the RM indicated nine of nine (9/9) dining room chairs were missing and had been replaced by white plastic light weight folding chairs.</p> <p>-On 2/19/13 at 3:30pm, the living room had one of two (1/2) sofas that had the sofas with the fabric torn and exposed the stuffing.</p> <p>-On 2/19/13 at 3:30pm, the RM indicated an fifteen feet wide by eight feet tall (15'x8') area on the wall around the three (3) living room windows had the paint peeling from the wall. The RM indicated each area of maintenance needed repaired.</p> <p>On 2/19/13 at 4:00pm, GHS #1 indicated the washer did not have a temperature control knob and the metal post on the washer was exposed. GHS #1 indicated the washer instructions on the washer dials for temperature control, cycles, and size of loads were worn and not identifiable.</p> <p>On 2/20/13 at 4:25pm, the facility's maintenance items to be repaired and/or replaced was requested from the RM. There were none on file for the above indicated repair needs.</p>		<p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The Group Home Manager is responsible for maintenance needs, including repairs and furniture purchases. The Director supervises the Group Home Manager. At regular team meetings that include both the Director and Group Home Manager, there will be an agenda item on home maintenance.</p>				

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	<p>An interview with the Site Director (SD) was conducted on 3/7/13 at 3:37pm. At 3:37pm, the SD indicated client #1, #2, #3, and #4's group home had identified maintenance needs for needed repairs. The SD indicated the dining room chairs and the repairs to the group home had not been completed and there were no maintenance records.</p> <p>9-3-1(a)</p>						

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W000130	<p><b>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</b> The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, for 1 of 2 sampled clients (client #1) who had medication administered at the group home, the facility failed to provide privacy during medical monitoring and medication administration.</p> <p>Findings include:</p> <p>On 2/20/13 at 7:05am, Group Home Staff (GHS) #4 requested client #1 come to the medication room. Client #1 entered the medication room, GHS #4 administered client #1's oral medications, tested his blood sugar, and left the medication room. At 7:33am, client #1 was seated at the dining room table, GHS #6, GHS #7, and client #4 walked around and stood in the dining room. At 7:33am, GHS #4 sat down next to client #1 at the dining room table, took client #1's blood pressure in client #1's right arm, and administered client #1's unlabeled Victoza 10mg (milligrams) insulin pen for Diabetes. GHS #4 had requested client #1 raise his shirt and injected client #1's insulin pen into client #1's stomach area.</p> <p>On 2/25/13 at 12:15pm, an interview with</p>	W000130	<p><b>W 130</b></p> <p>Client Privacy during Medication Administration</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>A new process will be implemented that reduces distractions during medication administrations, and it will ensure client privacy as well.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>A new process to ensure client privacy during medication</p>	04/10/2013			

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	the agency nurse was conducted. The agency nurse indicated client #1 should be given privacy during his medication administration and medical monitoring.  9-3-2(a)		administration.  <b>How corrective actions will be monitored to ensure no recurrence</b>  The Nurse and Group Home Manager will implement training on the new process. Both are supervised by the Director who meets with them regularly.		

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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. Based on record review and interview for 1 of 36 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's policy and procedure to prohibit neglect to supervise client #4 during medication administration.</p> <p>Findings include:</p> <p>On 2/19/13 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/12 through 2/19/13 were reviewed and indicated the following.</p> <p>-On 2/11/13 a BDDS report for an incident on 2/10/13 at 8:00pm, indicated client #4 was inside the medication room with staff receiving a treatment and had already received his oral medications. The report indicated when client #4 was "exiting the med (medication) room, he picked up a medication cup that was set up for another housemates and took the medications before staff could redirect him to stop (sic)." Nurse and Physician were contacted. No medications were listed on the BDDS report.</p>	W000149	<p><b>W 149</b> Supervision of Client during Medication Administration <b>Corrective action for resident(s) found to have been affected</b> The staff member who made the error allowing a client to take another client's medication has been retrained. Provider also is implementing a new process to reduce distractions, such as having clients in the same room when setting up medication. That process would have prevented this incident, and it will prevent recurrence. <b>How facility will identify other residents potentially affected &amp; what measures taken</b> All residents potentially affected, and corrective measures address the needs of all clients. <b>Measures or systemic changes facility put in place to ensure no recurrence</b> Retraining of staff who made error and new process to prevent recurrence. <b>How corrective actions will be monitored to ensure no recurrence</b> The Nurse and Group Home Manager will implement training on the new process. Both are supervised by the Director who meets with them regularly.</p>	04/10/2013			

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	<p>On 2/25/13 at 12:15pm, an interview with the agency nurse was conducted. The agency nurse indicated staff neglected to implement the agency's policy and procedure to supervise client #4 during medication administration. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders and should have. The agency nurse indicated medications should not have been pre set for another client in advance of the medication pass.</p> <p>On 2/25/13 at 12:15pm, a review of the facility's 11/30/12 Medication Administration Policy and Procedure was conducted. The Medication Policy indicated staff were not to have pre set medications prior to administration of the medications.</p> <p>On 2/25/13 at 12:15pm, a review of the agency's 8/2008 "Group Home Abuse and Neglect" policy and procedure was conducted. The policy/procedure indicated "Purpose: To educate and inform staff of definitions, define reporting requirements, and stress that AWS (Anthony Wayne Services) will not</p>			

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	<p>tolerate abuse, neglect, or exploitation of any kind." The policy/procedure indicated "Neglect includes failure to provide appropriate care, food, medical care, or supervision."</p> <p>On 2/25/13 at 12:15pm, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs...." The facility neglected to ensure implementation of their policy and procedures to prohibit abuse, neglect, and mistreatment of individuals.</p> <p>9-3-2(a)</p>			

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W000227	<p><b>483.440(c)(4)</b> <b>INDIVIDUAL PROGRAM PLAN</b> The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 2 of 2 sampled clients (clients #1 and #2), the facility failed to initiate programming in client #1 and #2's Individual Support Plans (ISPs) to address toileting issues.</p> <p>Findings include:</p> <p>1. On 2/20/13 from 6:00am until 8:30am, observation and interview was conducted at the group home. At 6:40am, client #1 exited his bedroom carrying a bundle of clothing, blankets, and sheets. Client #1 walked to the laundry room, placed his items into the soiled laundry into a basket. At 6:50am, Group Home Staff (GHS) #5 and GHS #5 both indicated client #1 was incontinent of urine during the night. GHS #4 stated client #1 was "Always wet. Sometimes (you) can see the urine running off the sides of the bed." At 6:50am, GHS #5 stated client #1 "Refuses to get up to go to the bathroom."</p> <p>On 2/22/13 at 11:45am, and on 2/25/13 at 10:10am, client #1's record was reviewed. Client #1's 4/19/12 ISP (Individual</p>	W000227	<p><b>W 227</b></p> <p>Toileting Goal</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Toileting goal will be added to ISP for client with overnight enuresis. Although this was reportedly witnessed for the other client, that is not a common occurrence for him. The IDT will meet and evaluate whether an ISP toileting goal is appropriate for him.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p>	04/10/2013			

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	<p>Support Plan) indicated client #1 was an emancipated adult. Client #1's ISP did not indicate a toileting goal and did not indicate a toileting schedule.</p> <p>An interview with the Residential Manager (RM) and the agency Nurse was conducted on 2/25/13 at 12:15pm. The RM and the agency Nurse both indicated client #1 did not have a a toileting goal or schedule. The RM indicated client #1 was continent of urine during the day and toileted independently.</p> <p>2. On 2/20/13 from 6:00am until 8:30am, observation and interview was conducted at the group home. At 6:30am, GHS #4 administered client #2's medication in client #2's bedroom. At 6:30am, GHS #4 knocked on the door, opened the door, and GHS #4 indicated there was a urine odor. Client #2 sat up in his bed and his sheets were wet. GHS #4 administered the medication and left the room. At 8:15am, client #2 was still in bed.</p> <p>On 2/22/13 at 12:20pm, and on 2/25/13 at 8:40am, client #2's record was reviewed. Client #2's 11/29/12 ISP did not indicate a toileting goal and did not indicate a toileting schedule for client #2's night time toileting needs.</p> <p>An interview with the Residential</p>		<p>Toileting goal in ISP.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>QDDP presents ISP goals to IDT, which monitors the plan through regular meetings.</p>				

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	<p>Manager (RM) and the agency Nurse was conducted on 2/25/13 at 12:15pm. The RM and the agency Nurse both indicated client #2 did not have a a toileting goal or schedule. The RM indicated client #2 was continent of urine during the day and toileted independently.</p> <p>9-3-4(a)</p>				

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W000249	<p><b>483.440(d)(1) PROGRAM IMPLEMENTATION</b></p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #2) and for two additional clients (clients #3 and #4), the facility failed to teach and train clients about their medications when opportunities existed.</p> <p>Findings include:</p> <p>Observations were as follows:</p> <p>1. On 2/20/13 at 6:12am, Group Home Staff (GHS) #4 read client #4's 2/2013 MAR (Medication Administration Record), compared (it with medication pack) client #4's "Synthroid 137mcg, (micrograms) 1 tablet 1 time a day for Hypothyroidism, give on a empty stomach," punched out the tablet into a medication cup, took the pill and a glass of water into client #4's bedroom. GHS #4 woke client #4 up, handed client #4 his medication, and asked client #4 to take the medication. Client #4 took the medication and no teaching or training for medication identification, dose, side</p>	W000249	<p><b>W 249</b></p> <p>Teaching Opportunities during Medication Administration</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>A new process will be implemented that reduces distractions during medication administrations. The new process will consist of several steps, including that staff should be utilizing medication pass as an opportunity to teach clients about some aspect of their medication.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p>	04/10/2013			

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	<p>effects, or reason for the medication was provided by GHS #4.</p> <p>On 2/25/13 at 9:40am, client #4's 2/10/13 "Physician's Order" indicated "Synthroid 137mcg tablet, give 1 tablet orally once a day for Hypothyroidism, give on empty stomach at least 30 min (minutes) before food."</p> <p>2. On 2/20/13 at 6:18am, GHS #4 selected client #1's medication and compared the medication card to client #1's 2/2013 MAR (Medication Administration Record) which indicated "Omeprazole DR 40mg (milligrams) 1 cap 1 time daily for Esophageal Reflux, 1 hour before food." GHS #4 punched out the capsule into a medication cup, took the medication with water to client #1's bedroom. GHS #4 woke client #1 up, handed client #1 his medication, and asked client #1 to take the medication. Client #1 took the medication and no teaching or training for medication identification, dose, side effects, or reason for the medication was provided by GHS #4.</p> <p>On 2/25/13 at 10:10am, client #1's 2/10/13 "Physician's Order" indicated "Omeprazole DR 40mg capsule, give 1 capsule orally once a day for Esophageal Reflux, give one hour before meal."</p>		<p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>A new process for medication pass will be implemented, and staff will be trained.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The Nurse and Group Home Manager will implement training on the new process. Both are supervised by the Director who meets with them regularly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G799		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013	
NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
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	<p>On 2/22/13 at 11:45am, client #1's 4/19/12 ISP (Individual Support Plan) indicated a medication goal to state two medication side effects at 8:00am.</p> <p>3. On 2/20/13 at 6:23am, GHS #4 selected client #3's medication and compared the medication card to client #3's 2/2013 MAR (Medication Administration Record) which indicated "Omeprazole DR 20mg (milligrams) 1 cap every morning for Acute Esophagitis, 1 hour before meal." GHS #4 punched out the capsule into a medication cup, took the medication with water to client #3's bedroom. GHS #4 woke client #3 up, handed client #3 his medication, and asked client #3 to take the medication. Client #3 took the medication and no teaching or training for medication identification, dose, side effects, or reason for the medication was provided by GHS #4.</p> <p>On 2/25/13 at 9:15am, client #3's 2/10/13 "Physician's Order" indicated "Omeprazole DR 20mg capsule, give 1 capsule orally every morning, give 1 hour before meal for acute Esophagitis."</p> <p>4. On 2/20/13 at 6:30am, GHS #4 selected client #2's medication and compared the medication card to client</p>						

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NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
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	<p>#2's 2/2013 MAR (Medication Administration Record) which indicated "Levothyroxine 50mg, 1 tab (tablet) 1 time daily for Hypothyroidism." GHS #4 punched out the capsule into a medication cup, took the medication with water to client #2's bedroom. GHS #4 woke client #2 up, handed client #2 his medication, and asked client #2 to take the medication. Client #2 asked GHS #4 "Is the pill white?" GHS #4 indicated it was and client #2 took the medication and no teaching or training for medication identification, dose, side effects, or reason for the medication was provided by GHS #4.</p> <p>On 2/25/13 at 8:40am, client #2's 2/10/13 "Physician's Order" indicated "Levothyroxine 50mcg tablet, give 1 tablet orally once a day for Hypothyroidism."</p> <p>On 2/22/13 at 12:20pm, client #2's 11/29/13 ISP (Individual Support Plan) indicated a medication goal/objective to identify his 8:00pm medications daily with verbal cues.</p> <p>On 2/25/13 at 12:15pm, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication</p>						

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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940
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	<p>Administration" page 22, indicated "...Responsibilities during the administration of medications: Identify the individual, explain the procedure to the individual, administer the medication correctly." Page 36 indicated "...Every medication given must be charted for the correct individual and include the following information: Name and dosage of medication, time of administration, route of administration..."</p> <p>On 2/25/13 at 12:15pm, an interview with the agency Nurse was conducted. The agency Nurse indicated clients #1, #2, #3, and #4 should have been taught about their medications during formal and informal opportunities.</p> <p>9-3-4(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review, and interview, for 3 of 4 clients (clients #1, #3, and #4) living in the group home, the facility failed to administer medications without error and as prescribed by the clients' personal physician.</p> <p>Findings include:</p> <p>On 2/19/13 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/12 through 2/19/13 were reviewed and indicated the following for client #1, #3, and #4's medication errors.</p> <p>1. For client #1.</p> <p>-On 2/1/13 a BDDS report for an incident on 1/30/13 at 12:00am, indicated on "1/30/13 [client #1] was on a home visit and family failed to give him the 12:00am dose of Klonidine (for behaviors) (sic)."</p> <p>-On 1/31/13 a BDDS report for an incident on 1/29/13 at 8:00pm, indicated the BC (Behavior Consultant) was "notified that [client #1's] 8:00pm dose of Simvastatin (for Cholesterol) on 1/29/13 was not punched out of the bubble pack of medications." The report indicated</p>	W000368	<p><b>W 368</b></p> <p>Medication Errors</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>All staff receive training on medication administration prior to giving clients medications. Additionally, staff are retrained whenever a medication error occurs. A new procedure will be implemented that includes sequential actions for all future medication errors. The first error will require retraining. Subsequent errors will include disciplinary action that can lead to suspension from work without pay and eventual termination.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p>	04/10/2013			

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NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
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	<p>client #1 was on a home visit from 1/28/13 until 1/30/13. The report indicated "During the investigation into this medication error, another medication error was reported for a missed dose of Klonidine at 12am on 1/30/13."</p> <p>-On 7/12/12 a BDDS report for an incident on 7/11/12 at 8:00am, indicated client #1 "receives 75mg (a 25mg and a 50mg tablet) of Sertraline HCL (Zoloft) (for Anxiety) at 8am. Staff at the 8am med (medication) pass today noticed that on 7/11/12 [client #1] was given 2 of the 50mg and the 25mg tablets giving a total of 125mg."</p> <p>-On 6/25/12 a BDDS report for an incident on 6/23/12 at 8:00am, indicated client #1 "is prescribed Clozapine (for Schizophrenia) 100mg two tabs at 8:00am. On 6/23/12 [client #1] did not receive his full 8:00am dose of Clozapine. He received only one tab of Clozapine when he should have received two tabs."</p> <p>-On 6/25/12 a BDDS report for an incident on 6/15/12 at 8:00pm, indicated "The incident happened on 6/15/12 at 8pm. AWS nurse and staff found medication error on 6/24/12 at 5:00pm. [Client #1] is prescribed Topamax (for Anxiety Disorder) 100mg one tab twice a day (for behaviors). On 6/15/12 [client</p>		<p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>A new procedure of sequential actions that will make staff members more accountable for errors committed. Additionally, a new process is being implemented to reduce the likelihood of errors occurring. This will include reducing distractions whenever staff are administering medication.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>Staff are supervised by the Group Home Manager who will keep track of medication errors and will implement any discipline up to and including possible termination. The Group Home Manager is supervised by the Director who monitors all disciplinary action. They meet regularly.</p>				

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NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
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	<p>#1] did not receive his 8:00pm dose of Topamax."</p> <p>-On 6/13/12 a BDDS report for an incident on 6/13/12 at 8:00am, indicated client #1 "has a physician's order for Alcohol/Vinegar 1:1 (one part to one part each) apply 3 drops into both ears 3 days per week (for ear wax). Today staff gave [client #1] his ear drops at 8am (sic) this morning instead of 8pm this evening."</p> <p>-On 6/12/12 a BDDS report for an incident on 6/11/12 at 8:00pm, indicated "This evening staff discovered that [client #1's] 8am dose of Diazepam (for anxiety disorder) 5mg had not been given to him."</p> <p>-On 5/16/12 a BDDS report for an incident on 5/15/12 at 8am, indicated client #1 missed one 100mg (milligrams) Docusate Sodium (for constipation), the medication card was labeled incorrectly was to have received 2 capsules of 100mg of Docusate Sodium.</p> <p>-On 4/12/12 a BDDS report for an incident on 4/12/12 at 6:19am, indicated client #1 had complained of knee pain, staff administered "Acetaminophen" for pain, and "After punching out the tabs in the med cards and giving [client #1] 2 tabs, staff realized the med card was different than the MARs (Medication</p>						

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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940
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	<p>Administration Record). The MARs order is give 1 tab q 4 hrs. (1 tablet every 4 hours) for pain/fever and the card had two tabs packaged together. No dose size for the medication was indicated.</p> <p>On 2/25/13 at 10:10am, client #1's 1/16/13 "Physician's Order" was reviewed and indicated the following. "Clonidine HCL 0.2mg Tablet, give 1 table orally every 8 hours for HTN (Hypertension), Clozapine 100mg tablet, give 2 tabs (200mg) orally every morning for Schizophrenia, Clozapine 100mg tablet, give 3 tabs (300mg) orally at bedtime for Schizophrenia, Clozapine 50mg tablet, give 1 tablet orally every morning w/ (with) 200mg to = (to equal) 250mg for Schizophrenia, Diazepam 5mg tablet, give 1 tablet orally 2 times a day for generalized Anxiety Disorder, Docusate Sodium 100mg capsule, give 2 capsules orally once a day for Constipation, Ibuprofen 800mg tablet, give 1 tablet orally 2 times a day (for pain), Simvastatin 20mg tablet, give 1 tablet orally at Bedtime for Cholesterol, Topamax 100mg tablet, give 1 tablet orally 2 times a day for Anxiety Disorder, Vinegar/Alcohol/Colace Drops, instill 4 drops into both ears weekly for impacted cerumen, Acetaminophen 325mg tablet, give 1 tablet orally every 4 hours PRN (as needed) for pain or elev. (elevated) temp</p>			

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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940
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	<p>call nurse for temp., Sertraline HCL 100mg tablet, give 1 tablet orally once a day for Anxiety."</p> <p>2. For client #3. -On 9/26/12 a BDDS report for an incident on 9/26/12 at 8:00am, indicated "Staff was preparing [client #3's] medication and then was called away while waiting for [client #3] to come in. Staff locked the medications in the med cart. Staff then forgot to come back and pass [client #3's] medications. Staff had initialed the MARs. The second shift found the medications." The report indicated the medications were "Benztropine Mesylate (for side effects of medications) 0.5mg 1 tab 2 x day, Fluticasone Prop (for allergies) 50mg one spray in each nostril once a day, Isoniazied (for Tuberculosis) 300mg 1 tab once a day, Risperidone (for Schizoaffective Disorder) 2mg 1 tab 2 x day, and Vitamin B-6 (for nutritional support) 50mg 1 tab once a day."</p> <p>-On 9/12/12 a BDDS report for an incident on 9/11/12 at 8:00am, indicated "At the 8am med pass today it was noted that the AM medication card (unidentified) was signed and dated but the pill was not punched out and given for yesterday morning (9/10/12) at 8am."</p>			

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NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
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	<p>-On 9/9/12 a BDDS report for an incident on 9/8/12 at 3:00pm, indicated a medication pill was "found in the medication cart was Vitamin B6."</p> <p>-On 8/31/12 a BDDS report for an incident on 8/31/12 at 8:00am, indicated client #3 was not given his 8am medications of "Benztropine Mesylate 0.5mg 1 tab 2 x day, Fluticasone Propionate 50mg one spray in each nostril once a day, Isoniazid 300mg 1 tab once a day, Risperidone 2mg 1 tab 2 x day, and vitamin B-6 50mg 1 tab once a day."</p> <p>-On 6/18/12 a BDDS report for an incident on 6/17/12 at 8:00am, indicated client #3 did not receive his 8am medication of "Isoniazid 300mg 1 tab daily."</p> <p>Client #3's 1/16/13 "Physician's Order" were reviewed on 2/25/13 at 9:15am, and indicated the following. "Benztropine Mesylate 0.5mg tablet (for EPS/Side effects) 1 tab 2 times a day, Fluticasone Propionate (for Allergic Rhinitis) 50mg one spray into each nostril once a day, Risperidone (for Schizoaffective Disorder) 2mg 1 tab 2 x day, and Vitamin B-6 (for nutritional support) 50mg 1 tab once a day." Doctor notified.</p>						

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NAME OF PROVIDER OR SUPPLIER  AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940		
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	<p>3. For client #4.</p> <p>-On 2/11/13 a BDDS report for an incident on 2/10/13 at 8:00pm, indicated client #4 was inside the medication room with staff receiving a treatment and had already received his oral medications. The report indicated when client #4 was "exiting the med room, he picked up a medication cup that was set up for another housemates and took the medications before staff could redirect him to stop (sic)." No medications were listed on the BDDS report.</p> <p>-On 9/17/12 a BDDS report for an incident on 8/12/12 at 4:30pm, indicated client #4 went on a home visit on 8/10, 8/11, and 8/12/12, client #4's medications were sent inside a locked box to client #4's mother. The staff dropped off and picked up client #4 for his home visit. The report indicated "Today, staff got the med box down to pack meds for another individual (to go on a home visit) and found [client #4's] 8/12 4:30pm, Bupropion (for Schizophrenia) 200mg tablet still in the box."</p> <p>-On 4/20/12 a BDDS report for an incident on 4/15/12 at 8:00am, indicated client #4's "8pm dosage of Baclofen (for Spasmodic Torticollis - a painful spasm of the neck muscles that forces the head to rotate and tilt forward, backward, or</p>				

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	<p>sideways) had not been administered."</p> <p>On 2/25/13 at 9:40am, client #4's 1/16/13 "Physician's Order" was reviewed and indicated "Baclofen 20mg tablet, give 1 tablet orally 3 times a day for Spasmodic Torticollis, Bupropion HCL SR 200mg tab, give 1 tablet orally 2 times a day for Schizophrenia."</p> <p>On 2/25/13 at 12:15pm, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders.</p> <p>On 2/25/13 at 12:15pm, a review of the facility's 11/30/12 Medication Administration Policy and Procedure was conducted. The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>9-3-6(a)</p>				

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NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
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W000391	<p><b>483.460(m)(2)(ii)</b> <b>DRUG LABELING</b> 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 22 medications observed administered (client #1) during the morning medication administration, the facility failed to ensure each medication was labeled.</p> <p>Findings include:</p> <p>On 2/20/13 at 7:05am, Group Home Staff (GHS) #4 requested client #1 come to the medication room. Client #1 entered the medication room, GHS #4 administered client #1's oral medications, tested his blood sugar, and client #1 left the medication room. At 7:33am, GHS #4 selected from the top drawer of the medication cart and commingled with the markers and ink pens an unlabeled Victoza 10mg (milligram) insulin pen for Diabetes. GHS #4 left the medication room and approached client #1 who was seated at the dining room table. At 7:33am, GHS #4 sat down next to client #1 at the dining room table, took client #1's blood pressure in client #1's right arm, and administered client #1's unlabeled Victoza 10mg insulin pen for Diabetes. GHS #4 had requested client #1 raise his shirt and injected client #1's</p>	W000391	<p><b>W 391</b>  Medication Labeling</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>The medication cited will have a label added by the nurse unless its use is discontinued prior to the date this plan of correction is to be completed. Staff will receive a training that all medications need a label and that the nurse needs to be notified if a medication is unlabeled or a label becomes illegible.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p>	04/10/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G799		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013	
NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
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	<p>insulin via insulin pen into client #1's stomach area. At 7:42am, client #1's 2/2013 MAR (Medication Administration Record) indicated "Victoza 2-pak 10mg/3ml (milliliters) pen, inject 0.2mg (1.2mg) Sub-Q (injection) once a day for Diabetes Uncomplicated Adult."</p> <p>On 2/25/13 at 10:10am, client #1's 1/16/13 "Physician's Order" indicated "Victoza 2-pak 10mg/3ml (milliliters) pen, inject 0.2mg (1.2mg) Sub-Q (injection) once a day for Diabetes Uncomplicated Adult."</p> <p>On 2/25/13 at 12:15pm, an interview with the agency Nurse was conducted. The agency Nurse indicated client #1's medication should have had a pharmacy label on the medication and should have been dated. The agency Nurse indicated client #1's medication did not have a pharmacy label on it. The agency Nurse indicated client #1's insulin pen medication should not have been commingled with markers and ink pens inside the medication cart.</p> <p>9-3-6(a)</p>		<p>Label corrected and staff trained. Additionally, the nurse will conduct a label audit of all medications across the home to ensure that all medications have proper labeling.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The staff and the Nurse are responsible to ensure that all medications are appropriately labeled. The Nurse is responsible for training staff on medication related requirements. The Director supervises the Nurse, and they meet regularly.</p>				

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NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 2 sampled clients (client #1) who wore prescribed eye glasses, the facility failed to to teach and encourage client #1 to wear his prescribed eye glasses.</p> <p>Findings include:</p> <p>During observations on 2/19/13 from 3:15pm until 6:05pm at the group home, on 2/20/13 from 6:00am until 8:30am at the group home, on 2/20/13 from 10:50am until 12:15pm at the facility owned day service, and on 2/19/13 from 1pm until 1:20pm at the facility owned day service, client #1 was not prompted and was not encouraged to wear his prescribed eye glasses. Client #1 completed medication administration, colored outside the lines in coloring books/pages, watched television, pureed his foods, and completed math sheets and traced his name. Client #1 bent at the waist and leaned over closely to each item he worked with throughout the observation periods.</p>	W000436	<p><b>W 436</b></p> <p>Clients' Glasses</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>A reminder is now on the MAR for each client with glasses so staff will encourage wearing them daily. Glasses wearing is described on the ISP as is the prompting on the MAR.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents with glasses potentially affected, and corrective measures address the needs of all clients with glasses.</p> <p><b>Measures or systemic changes facility put in place to ensure</b></p>	04/10/2013			

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	<p>Client #1's record was reviewed on 2/22/13 at 11:45am, and on 2/25/13 at 10:10am. Client #1's 4/19/12 ISP (Individual Support Plan) did not include a goal/objective to wear his prescribed eye glasses. Client #1's 2012 vision assessment indicated he wore prescribed eye glasses. Client #1's 1/16/13 "Physician's Order" indicated "Glasses to be checked, cleaned every AM (morning), notify nurse if glasses need repair." Client #1's 2/2013 MAR (Medication Administration Record) indicated "Glasses to be checked &amp; (and) cleaned every AM" and indicated facility staff had initialed completed daily from 2/1/13 through 2/20/13.</p> <p>An interview with the Site Director (SD) was conducted on 3/7/13 at 3:37pm. At 3:37pm, the SD indicated client #1 should have been taught and encouraged to wear his prescribed eye glasses.</p> <p>9-3-7(a)</p>		<p><b>no recurrence</b></p> <p>Staff will encourage clients to wear their glasses daily during medication pass, and the prompt is on the MAR to remind staff.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The ISPs are monitored by the QDDP and the IDT at regular meetings.</p>				

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W000484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview for 2 of 2 sample clients (clients #1 and #2) and for two additional clients (clients #3 and #4) who lived in the facility, the facility failed to provide and teach the use of dining utensils. Findings include: On 2/19/13 from 3:15pm until 6:05pm, observation and interview were completed at the group home with clients #1, #2, #3, and #4. Knives and forks were locked inside the cabinet inside the locked plastic sharps container. At 5:35pm, clients #1, #2, #3, and #4 assisted staff to cook the supper meal of baked whole Chicken Patty, Sweet Potatoes, Green Beans, and fruit. At 5:50pm, client #4 set the table with a plate, spoon, and glass at each of the four place settings on the table. Group Home Staff (GHS) #2 prompted client #4 to "Make sure everyone gets a spoon to eat with." No forks, no knives, and no napkins were encouraged to be used. At 5:50pm, client #4 began to eat his baked chicken patty</p>	W000484	<p><b>W 484</b>  Utensil Usage  <b>Corrective action for resident(s) found to have been affected</b>  As the survey correctly points out, there was a previous client with sharps restrictions who no longer lives in the home. Another client who still resides in the home also has a sharps restriction in place, which is the purpose for the locked box. The other clients should be granted access to sharps, including utensils, as needed. The IDT will meet and evaluate whether the one client with the restriction might have this removed. Whether the restriction is removed or not, the other clients in the home will be provided access to utensils and encouraged to use them.  <b>How facility will identify other residents potentially affected &amp; what measures taken</b></p>	04/10/2013	

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NAME OF PROVIDER OR SUPPLIER  AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940		
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	<p>whole with his fingers. From 5:50pm until 6:05pm, clients #1, #2, #3, and #4 ate their baked chicken patty whole with their fingers. No redirection and no fork or knife utensils were provided. Client #1's foods were pureed and he used his fingers to scoop the foods onto his spoon. Clients #1, #2, #3, and #4 wiped their fingers on their pants and licked their fingers.</p> <p>On 2/25/13 at 12:15pm, an interview was conducted with the Residential Manager (RM). The RM indicated clients #1, #2, #3, and #4 should have been taught and encouraged to use forks and napkins. The RM indicated they have kept knives and forks locked inside the sharps container because of a previous client. The RM indicated the previous client was discharged in November, 2012.</p> <p>9-3-8(a)</p>		<p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>IDT will meet to determine if it is safe to remove the sharps restriction for one of the clients. Staff will be trained on ensuring that all clients have appropriate access to utensils per their ISP and that they encourage clients' use of utensils.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The ISPs are monitored by the QDDP and the IDT at regular meetings. The staff are supervised and trained by the Group Home Manager who is supervised by the Director. They meet regularly.</p>		

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W009999	<p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(b) 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 interview and record review for 6 of 36 incidents reviewed, the facility failed to immediately report to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law.</p> <p>Findings include:</p> <p>On 2/19/13 at 1:30pm, the facility's BDDS (Bureau of Developmental Disability Services) reports from 2/1/12 through 2/19/13 were reviewed and indicated the following for late reporting.</p> <p>-On 2/1/13 a BDDS report for an incident on 1/30/13 at 12:00am, indicated on "1/30/13 [client #1] was on a home visit</p>	W009999	<p><b>W 9999</b></p> <p>Late Reporting</p> <p><b>Corrective action for resident(s) found to have been affected</b></p> <p>Nearly every instance cited on late reporting is from a medication error in which the report was made well within 24 hours of the QDDP knowing about an incident that occurred a day or more in the past. The main problem is that there are too many medication errors occurring, which also is addressed in the survey. We are putting measures in place to prevent medication errors, including a new procedure that makes staff more accountable, a process to reduce distractions during medication administration, and a physician order allowing for slight changes in medication administration time during family visits for one client whose mother has made several errors. In order to more directly address reporting, we will also train staff on the need to immediately report to supervisors if a medication still is remaining in a card from a previous administration time. This will improve our monitoring</p>	04/10/2013			

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	<p>and family failed to give him the 12:00am dose of Klonidine (for behaviors) (sic)."</p> <p>-On 1/31/13 a BDDS report for an incident on 1/29/13 at 8:00pm, indicated the BC (Behavior Consultant was "notified that [client #1's] 8:00pm dose of Simvastatin (for Cholesterol) on 1/29/13 was not punched out of the bubble pack of medications." The report indicated client #1 was on a home visit from 1/28/13 until 1/30/13. The report indicated "During the investigation into this medication error, another medication error was reported for a missed dose of Klonidine at 12am on 1/30/13."</p> <p>-On 9/17/12 a BDDS report for an incident on 8/12/12 at 4:30pm, indicated client #4 went on a home visit on 8/10, 8/11, and 8/12/12, client #4's medications were sent inside a locked box to client #4's mother. The staff dropped off and picked up client #4 for his home visit. The report indicated "Today, staff got the med box down to pack meds for another individual (to go on a home visit) and found [client #4's] 8/12 4:30pm, Bupropion (for Schizophrenia) 200mg tablet still in the box."</p> <p>-On 6/25/12 a BDDS report for an incident on 6/23/12 at 8:00am, indicated client #1 "is prescribed Clozapine (for</p>		<p>in addition to the "buddy check" system already in place.</p> <p><b>How facility will identify other residents potentially affected &amp; what measures taken</b></p> <p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p><b>Measures or systemic changes facility put in place to ensure no recurrence</b></p> <p>Several measures to reduce medication errors and a staff training on swift reporting.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The staff are supervised and trained by the Group Home Manager who is supervised by the Director. They meet regularly.</p>				

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	<p>Schizophrenia) 100mg two tabs at 8:00am. On 6/23/12 [client #1] did not receive his full 8:00am dose of Clozapine. He received only one tab of Clozapine when he should have received two tabs."</p> <p>-On 6/25/12 a BDDS report for an incident on 6/15/12 at 8:00pm, indicated "The incident happened on 6/15/12 at 8pm. The reason for the late report is due to the AWS nurse and staff did not find the medication error until 6/24/12 at 5:00pm. [Client #1] is prescribed Topamax (for Anxiety Disorder) 100mg one tab twice a day (for behaviors). On 6/15/12 [client #1] did not receive his 8:00pm dose of Topamax."</p> <p>-On 4/20/12 a BDDS report for an incident on 4/15/12 at 8:00am, indicated client #4's "8pm dosage of Baclofen (for Spasmodic Torticollis - a painful spasm of the neck muscles that forces the head to rotate and tilt forward, backward, or sideways) had not been administered." Nurse notified.</p> <p>On 3/7/13 at 3:37pm, an interview with the Site Director (SD) was conducted. The SD indicated the facility had implemented a buddy check system for medication administration to decrease the amount of medication errors. The SD indicated the incidents were reported late.</p>			
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	<p>The SD indicated staff should have caught the medication error at the time the incident occurred and reported the incident.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 2/25/13 at 12:15 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 BQIS include any event or occurrence characterized by risk or uncertainty resulting in of having the potential to result in significant harm or injury to an individual including but not limited to:</p> <p>...2. Alleged, suspected or actual neglect (which must also be reported to Adult Protective Services or Child Protective Services, as indicated) which includes but is not limited to:</p> <ul style="list-style-type: none"> <li>a. failure to provide appropriate supervision, care, or training;</li> <li>c. failure to provide food and medical services as needed;</li> <li>d. failure to provide medical supplies or safety equipment as indicated in the</li> </ul>						

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	<p align="center"><b>Individualized Support Plan (ISP)."</b></p> <p>The policy indicated "...Initial incident reporting to BQIS. Within 24 hours of initial discovery of a reportable incident, the reporting person shall file an incident initial report with BQIS using the DDRS approved electronic format...."</p> <p>9-3-1(b)</p>				