STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREY SERVICES INC.	369 S SECOND ST UPLAND, IN 46989

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for an extended recertification and state licensure survey. Dates of Survey: March 26, 27, 28 and 30, 2012. Facility number: 000833 Provider number: 15G314 AIM number: 100243960 Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/3/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, for 1 of 4 sampled clients (client #4), the Condition of Participation of Client Protections was not met as the facility neglected to implement their neglect policy to ensure client #4 received nursing services according to his medical needs by not providing a timely assessment and medical intervention. Findings include: Please refer to W149. The facility failed to implement their neglect policy, for 1 of 4 sampled clients (client #4). The facility neglected to ensure client #4's medical condition was managed timely and neglected to ensure all staff were properly trained to ensure client #4's medical needs were met. Please refer to W154. The facility failed to assure a thorough and reproducible investigation for 1 of 1 allegation of neglect regarding 1 of 4 sampled client's (client #4) emergency medical treatment on 08/13/11. 9-3-2(a)	W0122	**W122** The facility must ensure that client protection requirements are met. Carey Services failed to meet this requirement for 1 of 4 clients by not assuring that staff was trained to meet the client's needs and by failing to thoroughly investigate this event. Specific corrections, preventative measures, and monitoring protocols will be addressed in tags W149 and W154.	04/13/2012

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W0149	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, the facility failed to implement their neglect policy, for 1 of 4 sampled clients (client #4). The facility neglected to ensure client #4's medical condition was managed timely and neglected to ensure all staff were properly trained to ensure client #4's medical needs were met. Findings include: On 03/26/12 at 11:45 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident: 08/13/11: A BDDS report submitted 08/13/11 for an incident on 08/13/11 at 7:20 AM indicated the following regarding client #4: "Writer received call this am at 7:20 to report that [client #4's] Blood Sugar was 412. Staff working at the time stated that they had never given insulin and were not willing to give it. [Client #4] is fully capable of giving his own insulin and manipulated the staff. It is not uncommon for him to do this and allow staff to draw up the insulin and	W0149	**W149** Carey Services must implement procedures that prohibit neglect of a client. The facility failed to meet this standard, as one client did not receive medication in a timely manner. The reason for this failure is that the staff on duty was not trained on his medical condition. Specifically, insulin was not given as scheduled. Upon investigation, it was determined that the staff did not give the insulin because she had not been trained in Client #4's diabetes management protocol. She was a replacement staff called to duty when the assigned staff failed to show up for work. Client #4 self-administers his insulin, but needs assistance to complete the task. This did not occur. <u>CORRECTION</u> All staff were retrained in diabetes protocol on 4/11/2012, to assure that there are no gaps in knowledge of Client #4's medical needs. A thorough review of both the BDDS report and the Emergency Room summary showed discrepancies in some areas. Upon review, it was not possible to determine how these discrepancies occurred, as neither the direct care staff nor the nurse on duty are currently employed by	04/12/2012

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	administer, especially with 'new' staff. [Client #4's] order is to call MD (medical doctor) or transport to ER (emergency room) if BS (blood sugar) > (greater than) 400. Writer instructed staff to transport [client #4] to ER. ER did not administer insulin but rather gave staff the instruction to return [client #4] to his home and give his ordered insulin. By the time [client #4] returned home (at 11:00 am),a staff member was present that has administered insulin before and was more familiar with [client #4's] POC (plan of care). It was 1/2 hour prior to his next dose and staff called NOD (nurse on duty) to report that his blood sugar had risen to 465 at this point. Staff had given the Lantus but was unsure whether to give the Humalog that close to the next dose. Writer phoned Dr. [name] and received the order to give routine Lantus 27 units (which had been given) and routine Humalog 6 units along with 14 extra units now x (times) 1, feed him well, and recheck blood sugar in one hour and report to NOD as long as it was 'around 300,' continue routine orders. This was done and [client #4's] blood sugar came down to 309. He remained alert and oriented with no untoward signs or symptoms. IDT (Inter-disciplinary team) aware per email and text." The plan to resolve indicated, "Writer emailed order from Dr. [name] to the home and		Carey Services. Current staff were retrained on 4/11/2012 on protocols for contacting the nurse on duty, residential manager on duty, etc, to avoid future problems of this nature. PREVENTION Previous Staffing at the facility covered waking hours with two staff, and night hours with one staff. Weekend schedules remain single staffed until later, as consumers sleep in. Any consumer that wakes early could potentially be at risk. As the home was single staffed at the time of the incident, the staffing schedule was revised on 4/12/2012 to begin double staffing several hours earlier on weekends. The staff called in to replace the scheduled staff was trained in diabetes, but not specifically in Client #4's plan. To avoid a future incident of this kind, any staff who works in a home as a direct support professional will be trained on the individual health and safety plans for each client. This will be the responsibility of the Residential Manager to verify. If no such staff is available, the Residential Manager will be required to provide the needed direct care. This protocol was put in place on 4/12/2012. MONITORING Any direct support staff not regularly working in the home will be required	

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	instructed staff to print it and place order in communication book. Writer also gave specific instructions for Diabetes Management for acutely high blood sugars via email and phone and instructed staff to print this as well and place in communication book for all staff to read and initial that they have done so. IDT aware of plan. Further training will take place per Group Home managers/nursing pertinent to this situation. Writer instructed staff to call me with any further concerns. [Client #4] taking a walk in the neighborhood with staff at this time. No immediate concerns at this time." 08/13/11: Written note from House Manager indicated she had discussed incident regarding client #4 with staff #1 who was in the home at the time of the incident. The note indicated staff #1 did not know how to administer insulin and had not been trained. Staff #1 indicated she was alone in the home with the clients because the 2nd staff for that shift did not show up to work. Client #4's records were reviewed on 03/27/12 at 2:00 PM. Client #4's record review included review of the following dated documents: 05/17/11: Lab Order indicated, "Comprehensive Metabolic Panel (CMP)		to document that they have been trained on individual consumer health and risk plans. It is the responsibility of the residential manager and residential nurse to assure that any needed training is complete prior to working in the home. A log of such documentation will be kept by the residential manager. Staff schedules will be reviewed each month to assure that it is still meeting consumers needs, and will be adjusted as required. This will be the responsibility of the residential manager.	

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	+ Lipid Profile. Note to Lab: Due in 8 weeks." 07/2011: Physician Orders indicated client #4's diagnosis included, but was not limited to Diabetes Type I (insulin dependent). The orders included Humalog and Lantus insulin. The orders indicated for a blood sugar greater than 400 to call client #4's Dr. The orders indicated client #4 was to have laboratory testing which included, "CBC (Complete Blood Count), CMP, Drug Levels Specific To Client Every 6 Months and Lipids, TSH (Thyroid Stimulating Hormone), UA (Urinalysis) Annually." 07/14/11: Quarterly Review Summary indicated client #4 was seen on 05/14/11 in the ER due to high blood sugar level. 08/13/11: ER Hospital Record of client #4 indicated he was seen and treated in the ER with an IV (intravenous), given insulin and blood sugars were monitored. The ER History of Present Illness indicated, "This is basically a [year old] developmentally delayed individual who also has diabetes. He is supposed to get insulin in the morning but the caregiver is not certified to give meds therefore he did not get his insulin therefore his blood sugar is elevated. Apparently the caregiver who was allowed to give the			

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	patient his insulin is out on medical leave in [sic] the company has not provided a caregiver qualified to give meds. The patient complains of a mild headache only...Random blood sugar at the bedside is 470...While in the emergency department this patient received 1 L (liter) of normal saline over about one hours duration. He was given regular insulin 7 units IV and placed on a 2 unit per hour insulin drip he remained asymptomatic in the emergency department with no critical symptoms. His blood glucose decreased from about 500-378 during the time he was here. A new staff member from his facility showed up who is able to give him his usual morning medications. The entire reason this patient is an (sic) emergency department as the staff was unable to give him his usual insulin doses therefore he was brought to the emergency department for his morning meds...Diagnosis: Hyperglycemia due to lack of meds being given by the staff...Additional Instructions: 1. Staff must be available who can administer this patient's medications per his doctor's orders. 2. Staff is to give this patient his usual insulin doses as prescribed by his physician. 3. Patient is to be seen by his primary care physician on Monday for a reevaluation of his insulin dosing. 4. Patient should be brought back to the emergency Department if new symptoms			

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	or problems develop." 10/18/11: Pharmacy Review of client #4 indicated, "It appears staff is NOT signing off on the 'tid' Humalog order. There are no times designated on MAR (Medication Administration Record) and staff does not appear to be following through with documenting administration of Humalog three times a day. (Spoke with nursing today upon audit.) May wish to make MD aware, in light of the fact that Lantus dose had been increased over the past few weeks, perhaps because of effect of Humalog not being administered (if this was the case)." 01/2012: Diabetes Management Plan indicated client #4 was on Lantus 30 units BID (twice a day). 03/03/12: Physician's Order indicated client #4's Lantus order had changed from 30 units BID to 25 units in the am and 30 units every evening. The facility's records were reviewed on 03/26/12 at 12:18 PM. A review of the facility's policy on, "Abuse, Neglect, and Exploitation," dated 06/15/11, indicated, "It is the policy of Carey Services to respect the rights of consumers served and protect them from possible abusive treatment, negligence, or exploitation of			

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	the part of staff, volunteers, or other consumers. Abusive treatment and/or negligence of responsibilities with respect to the welfare and safety of consumers are incompatible with the purpose of the agency....Definition: Neglect: includes, but is not limited to, failure to provide appropriate supervision, care, training, a safe/clean/sanitary environment, food, medical care, medical supplies and equipment (as indicated in the ISP (Individual Support Plan)." On 03/27/12 at 10:30 AM, an interview with the QDDP (Qualified Developmental Disability Professional) was conducted. The QDDP indicated the reports indicated there was only one staff on in the home at the time of the incident and she was not trained on giving insulin. The QDDP further indicated there should always be a minimum of two staff on duty at any time in that home. She indicated all staff should be familiar, trained and capable of taking care of the clients needs. On 03/26/12 at 6:00 PM, an interview with the House Manager (HM) was conducted. The HM indicated after the incident on 08/13/11 she had an inservice with all staff on 08/15/11 on how to administer insulin. On 03/27/12 at 10:30 AM, an interview			

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	was conducted with the Licensed Practical Nurse (LPN). The LPN indicated she was unaware client #4 had been treated in the ER as she had been advised the ER had sent him home. She indicated client #4 was a diabetic and his blood sugars greatly fluctuated. She indicated she had not updated the 01/2012 Diabetic Management Plan to include the current dose of the insulin. She indicated all staff in the home should be trained and able to meet the needs of the clients. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed to assure a thorough and reproducible investigation for 1 of 1 allegation of neglect regarding 1 of 4 sampled client's (client #4) emergency medical treatment on 08/13/11. Findings include: On 03/26/12 at 11:45 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident: 08/13/11: A BDDS report submitted 08/13/11 for an incident on 08/13/11 at 7:20 AM indicated the following regarding client #4: "Writer received call this am at 7:20 to report that [client #4's] Blood Sugar was 412. Staff working at the time stated that they had never given insulin and were not willing to give it. [Client #4] is fully capable of giving his own insulin and manipulated the staff. It is not uncommon for him to do this and allow staff to draw up the insulin and administer, especially with 'new' staff. [Client #4's] order is to call MD (medical	W0154	**W154** Carey Services must have evidence that all alleged violations are thoroughly investigated. The facility failed to provide such evidence upon review. Specifically, there was an allegation of neglect for failing to assure client #4's medical needs were met, and there was no evidence of a thorough investigation. An investigation did take place, and the staff in question was no longer allowed to work in the facility, but the details of the investigation, beyond notes, were not available. CORRECTION All documentation and investigative notes were reviewed on 4/9/2012 by the Chief Program Officer. There are discrepancies between the Emergency Room Report and the BDDS report. These were unable to be resolved, as both the direct support professional and the residential nurse who was on call at the time of the incident are no longer employed by the agency. A meeting was held with the Chief Program Officer, QDDP/Director of Group Homes, Residential Manager, and Residential Nurse on 4/9/2012 to discuss the events in detail. Residential Manager and Residential Nurse were trained on how to	04/12/2012

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	doctor) or transport to ER (emergency room) if BS (blood sugar) > (greater than) 400. Writer instructed staff to transport [client #4] to ER. ER did not administer insulin but rather gave staff the instruction to return [client #4] to his home and give his ordered insulin. By the time [client #4] returned home (at 11:00 am),a staff member was present that has administered insulin before and was more familiar with [client #4's] POC (plan of care). It was 1/2 hour prior to his next dose and staff called NOD (nurse on duty) to report that his blood sugar had risen to 465 at this point. Staff had given the Lantus but was unsure whether to give the Humalog that close to the next dose. Writer phoned Dr. [name] and received the order to give routine Lantus 27 units (which had been given) and routine Humalog 6 units along with 14 extra units now x (times) 1, feed him well, and recheck blood sugar in one hour and report to NOD as long as it was 'around 300,' continue routine orders. This was done and [client #4's] blood sugar came down to 309. He remained alert and oriented with no untoward signs or symptoms. IDT (Inter-disciplinary team) aware per email and text." The plan to resolve indicated, "Writer emailed order from Dr. [name] to the home and instructed staff to print it and place order in communication book. Writer also gave		identify the need for a thorough investigation, including indications of neglect. PREVENTION Although an investigation took place, the documentation available did not contain a thorough accounting of events. Although the circumstances surrounding this event were unique, there is the potential for this to impact other consumers if the Residential Manager does not have a clear understanding of investigation procedures. The Residential Manager was in-serviced by the Corporate Compliance Officer on 4/12/2012 on how to complete an investigation that gives full details and is compliant with all internal and external policies and regulations. MONITORING All BDDS reports now indicate specifically if there is and suspicion of abuse, neglect, or exploitation. Each report will be reviewed by the Chief Program Officer or QDDP/Director of Group Homes to verify that there are no such suspicions. If such is suspected, the Corporate Compliance Officer and Residential Manager will be immediately notified to begin the investigation.	

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	specific instructions for Diabetes Management for acutely high blood sugars via email and phone and instructed staff to print this as well and place in communication book for all staff to read and initial that they have done so. IDT aware of plan. Further training will take place per Group Home managers/nursing pertinent to this situation. Writer instructed staff to call me with any further concerns. [Client #4] taking a walk in the neighborhood with staff at this time. No immediate concerns at this time." 08/13/11: Written note from House Manager (HM) indicated she had discussed incident regarding client #4 with staff #1 who was in the home at the time of the incident. The note indicated staff #1 did not know how to administer insulin and had not been trained. Staff #1 indicated she was alone in the home with the clients because the 2nd staff for that shift did not show up to work. The note also indicated, "I met with [staff #1] on the 15th and coached/counseled on proper procedure on how to do insulin assist with clients. On Aug. (August) 15th & 16th in-serviced staff on insulin assistance." The HM indicated she was the one that had trained staff on insulin administration. On 03/27/12 at 10:30 AM, an interview			

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	with the QDDP (Qualified Developmental Disability Professional) was conducted. The QDDP indicated there were no additional documents available to indicate a thorough investigation had been completed. 9-3-2(a)			

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989	

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W0186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview, the facility failed for 1 of 4 sampled clients requiring staff assistance (client #4) to provide sufficient numbers of direct care staff to supervise and provide necessary medical care. Findings include: On 03/26/12 at 11:45 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident: 08/13/11: A BDDS report submitted 08/13/11 for an incident on 08/13/11 at 7:20 AM indicated the following regarding client #4: "Writer received call this am at 7:20 to report that [client #4's] Blood Sugar was 412. Staff working at the time stated that they had never given insulin and were not willing to give it. [Client#4] is fully capable of giving his	W0186	**W186** Carey Services must assure that sufficient staff are present to provide needed care to clients. The facility failed to provide appropriate staffing to meet the needs of client #4. Specifically, the direct support professional at the facility was not trained in the diabetes management plan for client #4, resulting in the need for treatment in an emergency room. CORRECTION All staff were retrained in diabetes protocol on 4/11/2012, to assure that there are no gaps in knowledge of Client #4's medical needs. Current staff were retrained on 4/11/2012 on protocols for contacting the nurse on duty, residential manager on duty, etc, to avoid future problems of this nature. PREVENTION Previous Staffing at the facility covered waking hours with two staff, and night hours with one staff. Weekend schedules remain single staffed until later, as consumers sleep in. Any consumer that wakes early could potentially be at risk. As the	04/12/2012

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	own insulin and manipulated the staff. It is not uncommon for him to do this and allow staff to draw up the insulin and administer, especially with 'new' staff. [Client #4's] order is to call MD (medical doctor) or transport to ER (emergency room) if BS (blood sugar) > (greater than) 400. Writer instructed staff to transport [client #4] to ER. ER did not administer insulin but rather gave staff the instruction to return [client #4] to his home and give his ordered insulin. By the time [client #4] returned home (at 11:00 am),a staff member was present that has administered insulin before and was more familiar with [client #4's] POC (plan of care). It was 1/2 hour prior to his next dose and staff called NOD (nurse on duty) to report that his blood sugar had risen to 465 at this point. Staff had given the Lantus but was unsure whether to give the Humalog that close to the next dose. Writer phoned Dr. [name] and received the order to give routine Lantus 27 units (which had been given) and routine Humalog 6 units along with 14 extra units now x (times) 1, feed him well, and recheck blood sugar in one hour and report to NOD as long a it was 'around 300,' continue routine orders. This was done and [client #4's] blood sugar came down to 309. He remained alert and oriented with no untoward signs or symptoms. IDT (Inter-disciplinary team)		home was single staffed at the time of the incident, the staffing schedule was revised on 4/12/2012 to begin double staffing several hours earlier on weekends. The staff called in to replace the scheduled staff was trained in diabetes, but not specifically in Client #4's plan. To avoid a future incident of this kind, any staff who works in a home as a direct support professional will be trained on the individual health and safety plans for each client. This will be the responsibility of the Residential Manager to verify. If no such staff is available, the Residential Manager will be required to provide the needed direct care. This protocol was put in place on 4/12/2012. MONITORING Any direct support staff not regularly working in the home will be required to document that they have been trained on individual consumer health and risk plans. It is the responsibility of the residential manager and residential nurse to assure that any needed training is complete prior to working in the home. A log of such documentation will be kept by the residential manager. Staff schedules will be reviewed each month to assure that it is still meeting consumers' needs, and will be adjusted as required. This will be the responsibility of the residential manager.	

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	aware per email and text." The plan to resolve indicated, "Writer emailed order from Dr. [name] to the home and instructed staff to print it and place order in communication book. Writer also gave specific instructions for Diabetes Management for acutely high blood sugars via email and phone and instructed staff to print this as well and place in communication book for all staff to read and initial that they have done so. IDT aware of plan. Further training will take place per Group Home managers/nursing pertinent to this situation. Writer instructed staff to call me with any further concerns. [Client #4] taking a walk in the neighborhood with staff at this time. No immediate concerns at this time." 08/13/11: Written note from House Manager indicated she had discussed incident regarding client #4 with staff #1 who was in the home at the time of the incident. The note indicated staff #1 did not know how to administer insulin and had not been trained. Staff #1 indicated she was alone in the home with the clients because the 2nd staff for that shift did not show up to work. Client #4's records were reviewed on 03/27/12 at 2:00 PM. Client #4's record review included review of the following dated documents:			

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	07/2011: Physician Orders indicated client #4's diagnosis included, but was not limited to, Diabetes Type I (insulin dependent). The orders included Humalog and Lantus insulin. The orders indicated for a blood sugar greater than 400 to call client #4's Dr. 08/13/11: ER Hospital Record of client #4 indicated he was seen and treated in the ER with an IV (intravenous), given insulin and blood sugars were monitored. The ER History of Present Illness indicated, "This is basically a [year old] developmentally delayed individual who also has diabetes. He is supposed to get insulin in the morning but the caregiver is not certified to give meds therefore he did not get his insulin therefore his blood sugar is elevated. Apparently the caregiver who was allowed to give the patient his insulin is out on medical leave in [sic] the company has not provided a caregiver qualified to give meds. The patient complains of a mild headache only...Random blood sugar at the bedside is 470...While in the emergency department this patient received 1 L (liter) of normal saline over about one hours duration. He was given regular insulin 7 units IV and placed on a 2 unit per hour insulin drip he remained asymptomatic in the emergency department with no critical			

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	symptoms. His blood glucose decreased from about 500-378 during the time he was here. A new staff member from his facility showed up who is able to give him his usual morning medications. The entire reason this patient is an (sic) emergency department as the staff was unable to give him his usual insulin doses therefore he was brought to the emergency department for his morning meds...Diagnosis: Hyperglycemia due to lack of meds being given by the staff...Additional Instructions: 1. Staff must be available who can administer this patient's medications per his doctor's orders. 2. Staff is to give this patient his usual insulin doses as prescribed by his physician. 3. Patient is to be seen by his primary care physician on Monday for a reevaluation of his insulin dosing. 4. Patient should be brought back to the emergency Department if new symptoms or problems develop." On 03/27/12 at 10:30 AM, an interview with the QDDP (Qualified Developmental Disability Professional) was conducted. The QDDP indicated the reports indicated there was only one staff on in the home at the time of the incident and she was not trained on giving insulin. The QDDP further indicated there should always be a minimum of two staff on duty at any time in that home. She indicated all staff			

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	should be familiar, trained and capable of taking care of the clients needs. On 03/27/12 at 10:30 AM, an interview was conducted with the Licensed Practical Nurse (LPN). The LPN indicated she was unaware client #4 had been treated in the ER as she had been advised the ER had sent him home. She indicated client #4 was a diabetic and his blood sugars greatly fluctuated. She indicated there should be enough staff in the home to meet the needs of the clients. 9-3-3(a)			

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W0312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #1, #3 and #4) who were on psychiatric/behavior medications (meds) by not ensuring clients #1, #3 and #4's Behavior Support Plans (BSP) included the medication in the plan and included a titration plan for the medication. Findings include: Client #1's records were reviewed on 03/27/12 at 10:48 AM. Client #1's Physician Orders dated 03/2012 indicated client #1 was on, but not limited to, the following psychiatric medications: 1. Invega 3 mg (milligram); give 1 tablet by mouth every morning (antipsychotic) ; Client #1's 05/14/11 BSP did not include the psychiatric medication for client #1. The BSP did not include a titration plan for reduction or elimination of the medication. Client #3's record was reviewed on 03/27/12 at 1:25 PM. Client #3's	W0312	**W312** Carey Services must ensure that psychiatric medications have a titration plan. Although all of the medications have such plans, the facility failed to assure that the behavior support plan was updated to include medication changes. Carey Services contracts with an outside vendor for behavior support, and the corrective and preventative measures were determined jointly with the vendor. CORRECTION All changes to medications that are not included on the behavior plan are documented on a Behavior Support Plan Appendix/Psychotropic Medication Review signed by the physician. A titration plan, as directed by the physician, will be included on these documents. These addenda were attached to the behavior plan on 4/11/2012. PREVENTION Several clients have regular changes to psychotropic medications. A new procedure was created to assure that titration plans and medication changes are kept current on	04/11/2012

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	Physician Orders dated 03/2012 indicated client #3 was on, but not limited to, the following medication: 1. Depakote 250 mg; give one tablet by mouth twice daily (for mood disorder); Client #3's 07/14/11 BSP did not include the psychiatric medication for client #3. The BSP did not include a titration plan for reduction or elimination of the medication. Client #4's record was reviewed on 03/27/12 at 2:40 PM. Client #4's Physician Orders dated 03/2012 indicated client #4 was on, but not limited to, the following medication: 1. Abilify 5 mg; give one tablet by mouth daily for depression; Client #4's 05/14/11 BSP did not include the psychiatric medication for client #4. The BSP did not include a titration plan for reduction or elimination of the medication. On 03/27/12 at 10:30 AM, an interview with the QDDP (Qualified Developmental Disability Professional) was conducted. The QDDP indicated client #1, #3 and #4's BSPs did not contain the medications or any reference to them and there were no further documents available for review. 9-3-5(a)		behavior support plans on 4/10/2012. The procedure adapts a medication review graph to act as an addendum to the BSP. When a client is seen by a psychiatrist, or changes are made to psychotropic medications, these medications are listed on the form, along with a titration plan or documentation of contraindication. The form is sent to the physician for signature. While awaiting signature, a copy of the dated, unsigned form will be kept with the BSP. MONITORING A tracking sheet was developed on 4/11/2012 to assure that these addenda are tracked. The date of the appointment, the date the form was faxed, the date returned, and the date filed will be recorded to assure that medication documentation remains up to date.	

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W0318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate health care monitoring and nursing services for 4 of 4 sample clients (clients #1, #2, #3 and #4). Findings include: Please refer to W331. The facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) by not ensuring clients received nursing services according to their medical needs, by not ensuring staff were trained in client #4's insulin administration, by not updating client #4's diabetic management plan; by not obtaining laboratory tests as ordered for clients #1, #2, #3 and #4, by not obtaining client #3's mammogram as ordered and by not ensuring the MAR (Medication Administration Record) and medication bottle instructions matched. Please refer to W340. The facility failed for 1 of 4 sampled clients (client #4) by not ensuring staff were trained in client #4's insulin administration.	W0318	**W318** Carey Services must assure that adequate health care services are provided to clients. The facility failed to meet this condition. Specific findings include failing to train staff on a client's diabetes plan, not updating a client's diabetes plan, failing to obtain client laboratory tests, and not ensuring that the MAR matched the instructions on a medication bottle. Specific corrections, preventative measures, and monitoring protocols will be addressed in tags W331 and W340.	04/13/2012

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4) by not ensuring clients received nursing services according to their medical needs, by not ensuring staff were trained in client #4's insulin administration, by not updating client #4's diabetic management plan; by not obtaining laboratory tests as ordered for clients #1, #2, #3 and #4, by not obtaining client #3's mammogram as ordered and by not ensuring the MAR (Medication Administration Record) and medication bottle instructions matched. Findings include: 1. Observations were conducted in the group home on 03/26/12 from 4:30 PM to 6:45 PM. The observation included a medication administration with client #1 and staff #2 at 5:26 PM. Client #1's 03/2012 MAR was reviewed on 03/26/12 at 5:50 PM. The MAR contained a hand written order which indicated client #1 was to received, Fish Oil 1000 mg (milligram); take one capsule twice daily. The bottle contained a hand written order which indicated client #1 was to receive	W0331	**W331** Carey Services must provide clients with nursing services in accordance to their needs. The facility failed to meet this standard. Specific findings include failing to train staff on a client's diabetes plan, not updating a client's diabetes plan, failing to obtain client laboratory tests, failing to obtain a mammogram, and not ensuring that the MAR matched the instructions on a medication bottle. CORRECTION Client #4's Diabetes Management Plan was updated by the residential nurse on 3/30/2012. All staff were retrained in diabetes protocol on 4/11/2012, to assure that there are no gaps in knowledge of Client #4's medical needs. Upon review, it was determined that the laboratory tests referenced in the survey were not physician orders, but served as a reminder to the attending provider. Clarifying documentation was provided by the attending provider on 4/11/2012. A review of the mismatch between the MAR and the label on the bottle of OTC Fish Oil determined that the MAR held the inaccurate information. This was corrected on 3/30/2012. Staff were retrained on	04/12/2012

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	two capsules twice daily. A prescription written by client #1's physician and dated 03/14/12 in the MAR indicated client #1 was to receive Fish Oil gelcaps 2 grams (2000 mg) orally by mouth twice daily. An interview with the LPN (Licensed Practical Nurse) on 03/26/12 at 5:30 PM was conducted. She indicated the MAR and the label did not match. She further indicated she had written a label for administration and placed it on the bottle which was obtained over the counter. She indicated she had consulted with the pharmacy and they advised her she could label the bottle as long as it did not come from the pharmacy and was purchased over the counter and as long as she had a physician's order for the over the counter medication. 2. On 03/26/12 at 11:45 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident: 08/13/11: A BDDS report submitted 08/13/11 for an incident on 08/13/11 at 7:20 AM indicated the following regarding client #4: "Writer received call this am at 7:20 to report that [client #4's] Blood Sugar was 412. Staff working at the time stated that they had never given		the MAR on 4/11/2012. The most recent mammogram for client #3 was in January of 2012. It was not within the annual timeframe recommended by the physician. The residential nurse that was responsible for the facility is no longer with the agency, and Client #3 was sent for the mammogram immediately upon discovery that it was overdue. PREVENTION It is critical that all client needs are met by fully trained staff. To avoid a future incident similar to that on August 13, 2011, any staff who works in a home as a direct support professional will be trained on the individual health and safety plans for each client. This will be the responsibility of the Residential Manager to verify. If no such staff is available, the Residential Manager will be required to provide the needed direct care. This protocol was put in place on 4/12/2012. To avoid confusion on laboratory orders, the healthcare provider has agreed to remove non-order language from her notes when patients are seen in the future. This discussion took place on 4/11/2012, and will be effective for all future visits to the practice. To assure that the bottle, MAR, and	

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	insulin and were not willing to give it. [Client#4] is fully capable of giving his own insulin and manipulated the staff. It is not uncommon for him to do this and allow staff to draw up the insulin and administer, especially with 'new' staff. [Client #4's] order is to call MD (medical doctor) or transport to ER (emergency room) if BS (blood sugar) > (greater than) 400. Writer instructed staff to transport [client #4] to ER. ER did not administer insulin but rather gave staff the instruction to return [client #4] to his home and give his ordered insulin. By the time [client #4] returned home (at 11:00 am),a staff member was present that has administered insulin before and was more familiar with [client #4's] POC (plan of care). It was 1/2 hour prior to his next dose and staff called NOD (nurse on duty) to report that his blood sugar had risen to 465 at this point. Staff had given the Lantus but was unsure whether to give the Humalog that close to the next dose. Writer phoned Dr. [name] and received the order to give routine Lantus 27 units (which had been given) and routine Humalog 6 units along with 14 extra units now x (times) 1, feed him well, and recheck blood sugar in one hour and report to NOD as long a it was 'around 300,' continue routine orders. This was done and [client #4's] blood sugar came down to 309. He remained alert and		order for all medications match, a MAR check was added to the existing "Buddy Check" system utilized to verify that medication administration and documentation are checked by a separate employee. This addition was made on 4/11/2012. Client #3's mammogram was added to the list of recurring appointments to assure that the annual test is not missed. This will be kept up to date by the residential nurse. Additionally, charts were reviewed to assure that no other appointments are at risk. This occurred on 4/12/2012. MONITORING Any direct support staff not regularly working in the home will be required to document that they have been trained on individual consumer health and risk plans. It is the responsibility of the residential manager and residential nurse to assure that any needed training is complete prior to working in the home. A log of such documentation will be kept by the residential manager. Staff schedules will be reviewed each month to assure that it is still meeting consumers' needs, and will be adjusted as required. This will be the responsibility of the residential manager.	

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	oriented with no untoward signs or symptoms. IDT (Inter-disciplinary team) aware per email and text." The plan to resolve indicated, "Writer emailed order from Dr. [name] to the home and instructed staff to print it and place order in communication book. Writer also gave specific instructions for Diabetes Management for acutely high blood sugars via email and phone and instructed staff to print this as well and place in communication book for all staff to read and initial that they have done so. IDT aware of plan. Further training will take place per Group Home managers/nursing pertinent to this situation. Writer instructed staff to call me with any further concerns. [Client #4] taking a walk in the neighborhood with staff at this time. No immediate concerns at this time." 08/13/11: Written note from House Manager indicated she had discussed incident regarding client #4 with staff #1 who was in the home at the time of the incident. The note indicated staff #1 did not know how to administer insulin and had not been trained. Staff #1 indicated she was alone in the home with the clients because the 2nd staff for that shift did not show up to work. Client #4's records were reviewed on 03/27/12 at 2:00 PM. Client #4's record		"Buddy check" forms are reviewed by the residential manager and residential nurse to assure that they are taking place. As a part of the monthly review, the Residential Nurse will verify that any ordered labs or procedures are documented in the calendar.	

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	review included review of the following dated documents: 05/17/11: Lab Order indicated, "Comprehensive Metabolic Panel (CMP) + Lipid Profile. Note to Lab: Due in 8 weeks." 07/2011: Physician Orders indicated client #4's diagnosis included, but was not limited to, Diabetes Type I (insulin dependent). The orders included Humalog and Lantus insulin. The orders indicated for a blood sugar greater than 400 to call client #4's Dr. The orders indicated client #4 was to have laboratory testing which included, "CBC (Complete Blood Count), CMP, Drug Levels Specific To Client Every 6 Months and Lipids, TSH (Thyroid Stimulating Hormone), UA (Urinalysis) Annually." 07/14/11: Quarterly Review Summary indicated client #4 was seen on 05/14/11 in the ER due to high blood sugar level. 08/13/11: ER Hospital Record of client #4 indicated he was seen and treated in the ER with an IV (intravenous), given insulin and blood sugars were monitored. The ER History of Present Illness indicated, "This is basically a [year old] developmentally delayed individual who also has diabetes. He is supposed to get			

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	insulin in the morning but the caregiver is not certified to give meds therefore he did not get his insulin therefore his blood sugar is elevated. Apparently the caregiver who was allowed to give the patient his insulin is out on medical leave in [sic] the company has not provided a caregiver qualified to give meds. The patient complains of a mild headache only...Random blood sugar at the bedside is 470...While in the emergency department this patient received 1 L (liter) of normal saline over about one hours duration. He was given regular insulin 7 units IV and placed on a 2 unit per hour insulin drip he remained asymptomatic in the emergency department with no critical symptoms. His blood glucose decreased from about 500-378 during the time he was here. A new staff member from his facility showed up who is able to give him his usual morning medications. The entire reason this patient is an (sic) emergency department as the staff was unable to give him his usual insulin doses therefore he was brought to the emergency department for his morning meds...Diagnosis: Hyperglycemia due to lack of meds being given by the staff...Additional Instructions: 1. Staff must be available who can administer this patient's medications per his doctor's orders. 2. Staff is to give this patient his usual insulin doses as prescribed by his			

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	physician. 3. Patient is to be seen by his primary care physician on Monday for a reevaluation of his insulin dosing. 4. Patient should be brought back to the emergency Department if new symptoms or problems develop." 10/18/11: Pharmacy Review of client #4 indicated, "It appears staff is NOT signing off on the 'tid' Humalog order. There are no times designated on MAR (Medication Administration Record) and staff does not appear to be following through with documenting administration of Humalog three times a day. (Spoke with nursing today upon audit.) May wish to make MD aware, in light of the fact that Lantus dose had been increased over the past few weeks, perhaps because of effect of Humalog not being administered (if this was the case)." 01/2012: Diabetes Management Plan indicated client #4 was on Lantus 30 units BID (twice a day). 03/03/12: Physician's Order indicated client #4's Lantus order had changed from 30 units BID to 25 units in the am and 30 units every evening. 3. Client #2's records were reviewed on 03/27/12 at 12:53 PM. Client #2's record review included review of the following			

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	dated document: 03/2011: Physician' Orders indicated client #2 was to have laboratory testing which included, "CBC (Complete Blood Count), CMP, Drug Levels Specific To Client Every 6 Months and Lipids, TSH (Thyroid Stimulating Hormone), UA (Urinalysis) Annually." A review of the remainder of client #2's record did not indicate he had the lab testing as ordered. 4. Client #3's records were reviewed on 03/27/12 at 1:25 PM. Client #3's record review included review of the following dated document: 03/2011: Physician' Orders indicated client #3 was to have laboratory testing which included, "CBC (Complete Blood Count), CMP, Drug Levels Specific To Client Every 6 Months, Lipids, TSH (Thyroid Stimulating Hormone), UA (Urinalysis) Annually and HGB A1C (Hemoglobin) every 6 months." A review of the remainder of client #3's record did not indicate she had the lab testing as ordered. 04/06/10: Bilateral mammogram report indicated screening completed and			

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	indicated, "Benign findings as described. Yearly mammogram recommended." 01/05/12: Mammogram screening report indicated, "Comparison: April 6, 2010...Benign findings as described. Yearly mammogram recommended." 5. Client #1's records were reviewed on 03/27/12 at 10:48 PM. Client #1's record review included review of the following dated document: 03/2011: Physician' Orders indicated client #1 was to have laboratory testing which included, "CBC (Complete Blood Count), CMP, Drug Levels Specific To Client Every 6 Months and Lipids, TSH (Thyroid Stimulating Hormone), UA (Urinalysis) Annually." A review of the remainder of client #1's record did not indicate she had the lab testing as ordered. On 03/27/12 at 10:30 AM, an interview was conducted with the Licensed Practical Nurse (LPN). The LPN indicated she was unaware client #4 had been treated in the ER as she had been advised the ER had sent him home. She indicated client #4 was a diabetic and his blood sugars greatly fluctuated. She indicated she had not done the teaching			

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	with the staff in regarding to insulin administration on 08/15-16/11, nor had she updated the 01/2012 Diabetic Management Plan to include the current dose of the insulin. She further indicated she had not obtained the lab tests as per the physician's orders on a routine basis. She further indicated she had not obtained the lab tests as per the physician's orders on a routine basis for clients #1, #2, #3 and #4 and client #3's mammogram was not completed timely. 9-3-6(a)			

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W0340	483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #4) by not ensuring staff were trained in client #4's insulin administration. Findings include: 1. On 03/26/12 at 11:45 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident: 08/13/11: A BDDS report submitted 08/13/11 for an incident on 08/13/11 at 7:20 AM indicated the following regarding client #4: "Writer received call this am at 7:20 to report that [client #4's] Blood Sugar was 412. Staff working at the time stated that they had never given insulin and were not willing to give it. [Client #4] is fully capable of giving his own insulin and manipulated the staff. It is not uncommon for him to do this and allow staff to draw up the insulin and	W0340	**W340** Carey Services must assure that staff are trained in appropriate health and hygiene methods. The facility failed to assure adequate training on client #4's insulin administration. Specifically, the training was completed by the residential manager instead of the residential nurse. While this was an exception to normal practice (the training was part of a disciplinary meeting), a follow-up training with licensed personnel never took place. CORRECTION All staff were retrained on insulin administration by the residential LPN on 4/11/2012. Additional training was completed by the LPN on the specific needs of client #4's diabetes management plan. PREVENTION The residential nurse is responsible for training direct care professionals on all medical and nursing matters. MONITORING The Director of Group Homes will review all training verification sheets to assure that all medical and	04/11/2012

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	administer, especially with 'new' staff. [Client #4's] order is to call MD (medical doctor) or transport to ER (emergency room) if BS (blood sugar) > (greater than) 400. Writer instructed staff to transport [client #4] to ER. ER did not administer insulin but rather gave staff the instruction to return [client #4] to his home and give his ordered insulin. By the time [client #4] returned home (at 11:00 am), a staff member was present that has administered insulin before and was more familiar with [client #4's] POC (plan of care). It was 1/2 hour prior to his next dose and staff called NOD (nurse on duty) to report that his blood sugar had risen to 465 at this point. Staff had given the Lantus but was unsure whether to give the Humalog that close to the next dose. Writer phoned Dr. [name] and received the order to give routine Lantus 27 units (which had been given) and routine Humalog 6 units along with 14 extra units now x (times) 1, feed him well, and recheck blood sugar in one hour and report to NOD as long a it was 'around 300,' continue routine orders. This was done and [client #4's] blood sugar came down to 309. He remained alert and oriented with no untoward signs or symptoms. IDT (Inter-disciplinary team) aware per email and text." The plan to resolve indicated, "Writer emailed order from Dr. [name] to the home and		nursing topics are facilitated by nursing staff.	

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	instructed staff to print it and place order in communication book. Writer also gave specific instructions for Diabetes Management for acutely high blood sugars via email and phone and instructed staff to print this as well and place in communication book for all staff to read and initial that they have done so. IDT aware of plan. Further training will take place per Group Home managers/nursing pertinent to this situation. Writer instructed staff to call me with any further concerns. [Client #4] taking a walk in the neighborhood with staff at this time. No immediate concerns at this time." 08/13/11: Written note from House Manager (HM) indicated she had discussed incident regarding client #4 with staff #1 who was in the home at the time of the incident. The note indicated staff #1 did not know how to administer insulin and had not been trained. Staff #1 indicated she was alone in the home with the clients because the 2nd staff for that shift did not show up to work. The note also indicated, "I met with [staff #1] on the 15th and coached/counseled on proper procedure on how to do insulin assist with clients. On Aug. (August) 15th & 16th in-serviced staff on insulin assistance." The HM indicated she was the one that had trained staff on insulin administration. The HM indicated she			

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	was a non-licensed staff. On 03/27/12 at 10:30 AM, an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated she had not done the inservice training to the staff on 08/15-16/11 and the HM had completed the training. 9-3-6(a)			

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W0382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to maintain proper medication security for 1 of 2 clients (client #1) whose medications were stored in the refrigerator. Findings include: Observations were conducted in the group home on 03/26/12 from 4:30 PM to 6:45 PM. The observation included a medication administration with client #1 and staff #2 at 5:26 PM. Staff #2 obtained a bottle of Fish Oil gelcaps from the unlocked refrigerator located in the medication administration area. Staff #2 administered the Fish Oil to client #1 and placed the medication back in the refrigerator. An interview with the LPN (Licensed Practical Nurse) on 03/26/12 at 5:30 PM was conducted. She indicated the refrigerator was not locked and there was not a way to lock it. 9-3-6(a)	W0382	**W382** Carey Services must assure that all drugs and biologicals are kept in a locked area unless being prepared for administration. The Facility failed to keep 1 of 2 medications locked in the refrigerator. Specifically, a bottle of OTC Fish Oil gelcaps was stored in an unlocked area of the refrigerator. Upon investigation, it was determined that the Fish Oil was not required to be refrigerated, and a direct support professional had placed it in the refrigerator to so that the individual gelcaps would not stick together. CORRECTION On 3/30/2012, the bottle of OTC Fish Oil was removed from the refrigerator and placed into the locked medication cart. PREVENTION All staff were retrained on 4/11/2012 in the appropriate storage of medication. It was verified that all medications were stored correctly on 4/11/2012. The monthly nursing review has been updated to contain a check for proper storage of medications. MONITORING As a part of the monthly nursing	04/11/2012

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			review, the residential nurse will verify the correct storage of all drugs and biologicals.	