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

FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G255 | A. BUILDING 00<br>B. WING | 08/25/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| RES CARE COMMUNITY ALTERNATIVES SE IN | 154 CHAD DR<br>VERSAILLES, IN 47042 |

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| W 0000<br>Bldg. 00 | This visit was for a pre-determined full recertification and state licensure survey.<br><br>Survey dates: 8/22/22, 8/23/22, 8/24/22 and 8/25/22.<br><br>Facility Number: 000775<br>Provider Number: 15G255<br>AIMS Number: 100248960<br><br>These deficiencies also reflect state findings in accordance with 460 IAC 9.<br>Quality Review of this report completed by #15068 and #27547 on 9/6/22. | W 0000 | | |
| W 0227<br>Bldg. 00 | 483.440(c)(4)<br>INDIVIDUAL PROGRAM PLAN<br>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.<br>Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to develop a health risk plan after client #1 was hospitalized on 8/4/22 and diagnosed with a urinary tract infection.<br><br>Findings include:<br><br>On 8/22/22 at 2:14 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) incident reports was conducted. The review indicated the following incident report which affected client #1:<br><br>BDDS incident report dated 8/4/22 indicated, "On | W 0227 | **W227:** Program Implementation<br><br>**Corrective Action:**<br>· Nurse created a High Risk Plan for Urinary Tract Infection for client (1). (**Attachment A** )<br>· All staff trained on client (1) High Risk Plan for Urinary Tract Infection. **(Attachment B)**<br>· Nurse completes weekly audit to ensure all medical plans are in place. **(Attachment C)** | 09/18/2022 |

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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| | 8/4/22 at 6:35 AM, [client #1] a [age], came out of his room and into the kitchen. Staff noticed he was having trouble standing and that his body, head, and face were leaning and dropping to the right. Staff called 911 and [client #1] was transported to [name] Hospital where he was admitted with dx (diagnosis) of UTI (urinary tract infection) and pneumonia".<br><br>On 8/23/22 at 11:08 AM, client #1's record was reviewed. The record indicated the following:<br><br>-Medical Consult dated 8/4/22 indicated, "Reason for Appointment: Stroke Symptoms/Right side weakness with facial droop. Results/Findings of Examination: UTI (Urinary Tract Infection) / Pneumonia ... suggested by labs (laboratory) and x-rays (electronic imaging) ... Physician/Consult Orders/Recommendations: Admit for management IV (Intravenous) fluids and antibiotics ...".<br><br>-Medical discharge summary dated 8/5/22 indicated, "Date of Admission: 8/4/22 ... Date of Discharge: 8/5/22 ... Plan: Urinanlysis (sic) is suspicious for infection ... Rocephin 1000 mg (milligrams) IV daily and monitor output ... Urinary tract infection type: acute cystitis (inflammation of the bladder) ...".<br><br>-Nursing Quarterly dated 8/22/22 indicated, "Hospitalized 8/4 / 8/5 (2022) for UTI/Pneumonia currently doing well ...".<br><br>-No Health Risk Plan to prevent UTI was available for review.<br><br>On 8/23/22 at 11:39 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client #1's recent hospitalization and if a health risk plan for UTI | | **Monitoring of Corrective Action:**<br>· Nurse will update all plans annually and as needed.<br>· Nurse weekly audit is sent to the IDT weekly for review.<br><br>**Completion Date: 9/18/22** | |

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| | was available for review. The QIDP stated, "He has had a hospitalization for UTI, we should have a UTI plan for him". The QIDP indicated client #1 did not have a health risk plan for UTI available for review.<br><br>On 8/23/22 at 1:02 PM, the Qualified Intellectual Disability Professional Designee (QIDPD) was interviewed. The QIDPD was asked about client #1's recent hospitalization and if a health risk plan for UTI was available for review. The QIDPD stated, "No, I've not been informed about a diagnosis of UTI". The QIDPD indicated client #1 did not have a health risk plan for UTI available for review.<br><br>On 8/25/22 at 10:50 AM, the Nurse was interviewed. The Nurse was asked about client #1's hospitalization, diagnosis of UTI and need for health risk plan. The Nurse stated, "He developed that during rehab (rehabilitation) at the nursing facility". The Nurse was asked if client #1 had a diagnosis of UTI. The Nurse stated, "Yes". The Nurse was asked if client #1 had a health risk plan for UTI. The Nurse reviewed client #1 record and stated at 10:56 AM, "No, I don't see that". The Nurse was asked if client #1 needed a health risk plan for UTI. The Nurse stated, "Yes".<br><br>On 8/25/22 at 12:59 PM, the Program Manager was interviewed. The Program Manager was asked about client #1's need for a UTI health risk plan. The Program Manager stated, "Yes, there should be a formal plan. Something should have been put into place".<br><br>9-3-4(a) | | | |
| W 0252 | 483.440(e)(1)<br>PROGRAM DOCUMENTATION | | | |

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| Bldg. 00 | Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br>Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure staff documented on client #1's Medication Administration Record (MAR) the reason client #1 did not receive his nebulizer breathing treatment according to his physician's orders.<br><br>Findings include:<br><br>Observations were conducted at the group home on 8/22/22 from 3:56 PM to 6:15 PM and on 8/23/22 from 6:15 AM to 9:08 AM. During these observations, client #1 was supported by staff #3 during his evening medication administration on 8/22/22, and by staff #1 during his morning medications administration on 8/23/22. On 8/22/22 at 4:06 PM, staff #3 asked client #1 if he was ready for evening medications and to come to the medication administration room as she began to prepare client #1's medications. At 4:12 PM staff #3 stated, "We still don't have Ipratropium 3 ml (milliliters)". Staff #3 indicated she could not administer client #1's breathing treatment through his nebulizer due to a lack of medication supplies. Client #1 did not receive his breathing treatment by use of a nebulizer.<br><br>On 8/23/22 at 8:15 AM, staff #1 stated, "I had an issue with his nebulizer. It's on here (medication administration record), but I don't have it".<br><br>On 8/23/22 at 8:24 AM, the Team Leader (TL) was interviewed. The TL was asked about client #1's breathing treatment and not having the medication supplies to administer his breathing | W 0252 | **W252:** Program Implementation<br><br>**Corrective Action:**<br>· All staff trained on medication administration policy. (**Attachment B**)<br>· Area Supervisor trained on weekly medication audits. **(Attachment D)**<br>· Staff received disciplinary actions for failing to administer a prescribed medication. **(Attachment E)**<br>· All staff trained on correct way to document if a medication is not available in the home. **(Attachment B)**<br>· Area Supervisor will complete medication audits one time weekly on all medications in the home. **(Attachment D)**<br>· Nurse completes weekly check in the home. **(Attachment C)**<br><br>**Monitoring of Corrective Action:**<br>· Area Supervisor will send weekly medication audit to the Program Manager for review and to ensure completion.<br>· Nurse weekly check is sent to the IDT for review. | 09/18/2022 |

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treatment. The TL stated, "I called [name] to let them know I still needed the nebulizer. It's both the doctor and pharmacy issue. As far as I know, [pharmacy name] is supposed to send it over to [medical store]".

On 8/23/22 at 11:08 AM, client #1's record was reviewed. The record indicated the following:

-Physician's orders dated 7/12/22 indicated, "Ipratropium / Sol (solution) Albuter (asthma) ... Use 3 ml (milliliters) (one vial) via nebulizer three times daily ...".

-Medication Administration Record (MAR) dated 7/1/22 through 7/31/22 indicated, "Ipratropium / Sol (solution) Albuter ... Use 3 ml (one vial) via nebulizer three times daily...7 AM, 4 PM and 8 PM". Client #1's MAR indicated circles around staff initials for a lack of administration from July 7/13/22 through 7/31/22 after client #1 had returned from nursing facility placement. In review of the backside of client #1's MAR, staff failed to document the reason client #1's breathing was not completed on the following dates and times during the month of July 2022:
"7/13 at 4 PM and 8 PM,
7/15 at 7 AM,
7/16 at 7AM and 4 PM,
7/17 at 4 PM and 8 PM,
7/18 at 4 PM and 8 PM,
7/19 at 4 PM and 8 PM,
7/20 at 4 PM and 8 PM,
7/21 at 7 AM, 4 PM and 8 PM,
7/22 at 7 AM, 4 PM and 8 PM,
7/23 at 7 AM, 4 PM and 8 PM,
7/24 at 4 PM and 8 PM,
7/25 at 4 PM and 8 PM,
7/26 at 4 PM and 8 PM,
7/27 at 4 PM and 8 PM,

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| | 7/28 at 7 AM, 4 PM and 8 PM,<br>7/29 at 7 AM, 4 PM and 8 PM,<br>7/30 at 7 AM, 4 PM and 8 PM, and<br>7/31 at 4 PM and 8 PM".<br><br>-Medication Administration Record (MAR) dated 8/1/22 through 8/31/22 indicated, "Ipratropium / Sol (solution) Albuter ... Use 3 ml (one vial) via nebulizer three times daily... 7 AM, 4 PM and 8 PM". Client #1's MAR indicated circles around staff initials for a lack of administration from 8/1/22 through 8/23/22. In review of the backside of client #1's MAR, staff failed to document the reason client #1's breathing was not completed on the following dates and times during the month of August 2022:<br>8/1 at 7 AM, 4 PM and 8 PM,<br>8/2 at 7 AM, 4 PM and 8 PM,<br>8/3 at 7 AM, 4 PM and 8 PM,<br>8/4 at 7 AM, 4 PM and 8 PM,<br>8/5 at 7 AM, 4 PM and 8 PM,<br>8/6 at 7 AM, 4 PM and 8 PM,<br>8/7 at 7 AM, 4 PM and 8 PM,<br>8/8 at 7 AM, 4 PM and 8 PM,<br>8/9 at 7 AM, 4 PM and 8 PM,<br>8/10 at 7 AM, 4 PM and 8 PM,<br>8/11 at 7 AM, 4 PM and 8 PM,<br>8/12 at 7 AM, 4 PM and 8 PM,<br>8/13 at 7 AM, 4 PM and 8 PM,<br>8/14 at 7 AM, 4 PM and 8 PM,<br>8/15 at 7 AM, 4 PM and 8 PM,<br>8/16 at 7 AM, 4 PM and 8 PM,<br>8/17 at 7 AM, 4 PM and 8 PM,<br>8/18 at 7 AM, 4 PM and 8 PM,<br>8/19 at 7 AM, 4 PM and 8 PM,<br>8/20 at 7 AM, 4 PM and 8 PM,<br>8/21 at 7 AM, 4 PM and 8 PM,<br>8/22 at 7 AM, 4 PM and 8 PM, and<br>8/23 at 7 AM". | | | |

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| | On 8/23/22 at 1:23 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about staff documentation of client #1's breathing treatment on the backside of MAR. The QIDPD stated, "We don't have the meds (medication supplies) and we've not documented why we're circling the meds not given". The QIDPD was asked if this was a documentation error by staff on client #1's MAR. The QIDPD stated, "Yes".<br><br>On 8/23/22 at 1:37 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the lack of staff documentation on client #1's MAR for when he did not receive his breathing treatment. The QIDP stated, "Yes" and indicated staff should document on the backside of client #1's MAR the reason his breathing treatment did not occur.<br><br>On 8/25/22 at 10:50 AM, the Nurse was interviewed. The Nurse was asked about client #1's documentation for his breathing treatment not administered during the months of July and August of 2022. The Nurse indicated staff should consistently document on the backside of the MAR the reason a medication was not given. The Nurse was asked if staff should document for each date and time client #1 had not received his breathing treatment. The Nurse stated, "Yes".<br><br>On 8/25/22 at 12:59 PM, the Program Manager was interviewed. The Program Manager was asked about client #1's documentation for his breathing treatment not administered during the months of July and August of 2022. The Program Manager stated, "It should be documented for every single one". The Program Manager was asked if staff should document the reason client #1 had not received his breathing treatment on his MAR for | | | |

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| | all dates and times client #1 missed his treatment. The Program Manager stated, "Yeah".<br><br>9-3-4(a) | | | |
| W 0368<br><br>Bldg. 00 | 483.460(k)(1)<br>DRUG ADMINISTRATION<br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br>Based on record review and interview for 1 of 3 sampled clients (#3), and 2 additional clients (#4 and #6), the facility failed to administer clients #3, #4 and #6's medications according to their physician's orders.<br><br>Findings include:<br><br>On 8/22/22 at 2:14 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) incident reports was conducted. The review indicated the following incidents which affected clients #3, #4 and #6:<br><br>1) BDDS incident report dated 7/6/22 indicated, "[Client #6] is ordered Sertraline (antidepressant) 100 mg (milligrams) daily in the AM. Today while the nurse was completing a weekly audit she found a med (medication) error. The med error is on 7/2/22 [client #6] did not receive the Sertraline 100 mg or the Sertraline 50 mg at the 7 AM med pass ...".<br><br>2) BDDS incident report dated 6/27/22 indicated, "[Client #6] is ordered Hyoscyamine (irritable bowel syndrome) 0.125 mg ... 3 times daily. The Hyoscyamine was scheduled to be delivered at the home in the monthly cycle refill delivery on 6/25/22. The monthly cycle refill was not delivered to the home on 6/25/22, [Client #6] did not have | W 0368 | **W368:** The facility for drug administration must assure that all drugs, including those that are self-administered are administered without error.<br><br>**Corrective Action:**<br><br>· Staff received a medication error as a result of not administering client (3) medications (**Attachment F)**<br>· Staff received a medication error as a result of not administering client (4) medications (**Attachment G)**<br>· Staff received a medication error as a result of not administering client (6) medications (**Attachment H)**<br>· All staff trained on Medication Administration. **(Attachment B)**<br>· Area Supervisor will conduct 2 medication administration observations weekly for no less than 60 days. **(Attachment D)**<br>· Nurse Manager or Designee will complete 1 medication | 09/18/2022 |

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| | the Hyoscyamine 0.125 mg in the home for administration today 6/27/22 at the 7 AM. He did not receive Hyoscyamine 0.125 mg (2 tablets) at 7 AM onn (sic) 6/27/22. [Client #6] has not experienced any negative effects from this med error".<br><br>3) BDDS incident report dated 6/26/22 indicated, "[Client #6] is ordered Hyoscyamine 0.125 mg ... 3 times daily. The Hyoscyamine was scheduled to be delivered at the home in the monthly cycle refill delivery on 6/25/22 ... He did not receive Hyoscyamine 0.125 mg (2 tablets) at 4 PM and 8 PM on 6/26/22. [Client #6] did not experience any negative effects from the med error".<br><br>4) BDDS incident report dated 3/25/22 indicated, "[Client #3] is ordered Divalproex (anticonvulsant) 500 mg DR (delayed release) (3 tablets) at 8 PM. Last night (3/24/22) while completing the 8 PM med pass staff found a med error. The med error is: On 3/23/22 at 8 PM [client #3] received Divalproex 500 mg ER (extended release) (1 tablet) instead of the 3 tablets that are ordered. [Client #3] has not experienced any negative effects from this med error".<br><br>5) BDDS incident report dated 2/20/22 indicated, "[Client #4] is ordered Lovastatin (cholesterol) 20 mg. Tonight when the staff was passing meds staff found a med error. The med error is: On 2/19/22 [client #4] was given Lovastatin 20 mg at 6 PM and then given the Lovastatin 20 mg again at 8 PM for an extra 20 mg dose for the day. [Client #4] has not experienced any negative effects from this med error".<br><br>On 8/23/22 at 10:14 AM, client #3's record was reviewed. The record indicated the following: | | administration observation weekly for no less than 60 days.<br>**(Attachment I)**<br><br>**Monitoring of Corrective Action:**<br>· Area Supervisor will conduct med pass observations 2 times a week for no less than 60 days and submit the observation to the Program Manager for review and to ensure completion.<br>· Area Supervisor will report any issues with medication administration to the Program Manager and Nurse immediately.<br>· Nurse retrained all staff on medication administration.<br>· Nurse completes weekly medication pass observations.<br>· Nurse sends completed medication observations to Nurse Manager.<br><br>**Completion Date: 9/18/22** | |

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-Physician orders dated 6/6/22 indicated, "Divalproex Tab (tablet) 500 mg DR Sub (substitute) for Depakote (anticonvulsant): Give two (2) tablets (1000 mg) by mouth every morning DX (diagnosis): Seizures ...

-Divalproex Tab 500 mg DR ... give three (3) tablets (1500 mg) by mouth every evening. DX: Seizures ...".

On 8/24/22 at 2:15 PM, a focused review of client #4's record was conducted. The review indicated the following:

-Physician orders dated 6/6/22 indicated, "Lovastatin Tab 20 mg ... Give one tablet by mouth once daily for cholesterol give with meal ...".

On 8/24/22 at 2:19 PM, a focused review of client #6's record was conducted. The review indicated the following:

-Physician orders dated 6/6/22 indicated, "Sertraline Tab 100 mg Sub for Zoloft (antidepressant): Give one tablet by mouth every morning. Give with 50 mg to equal 150 mg.

-Sertraline Tab 100 mg ... Give **one half** tablet (=50 mg) by mouth every morning. Give with 100 mg to equal 150 mg ...

- Hyoscyamine 0.125 mg Give two (2) tablets by mouth three times daily before meals. DX: Diarrhea ...".

On 8/23/22 at 1:23 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about the incident history of medication errors for clients #3,

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| RES CARE COMMUNITY ALTERNATIVES SE IN | 154 CHAD DR<br>VERSAILLES, IN 47042 |

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#4 and #6. The QIDPD indicated a pattern of medication errors had occurred. The QIDPD indicated medications should be administered according to physician orders without error.

On 8/23/22 at 1:37 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the incident history of medication error for clients #3, #4 and #6. The QIDP indicated a pattern of medication errors had occurred. The QIDP was asked if missed medications and being given extra 20 milligram doses of medications were not according to clients #3, #4 and #6's physician orders. The QIDP stated, "Yes". The QIDP was asked if a pattern of medication errors had occurred. The QIDP stated, "Yes. It's errors according to our policy". The QIDP indicated medications should be administered according to the physician orders without error.

On 8/25/22 at 10:50 AM, the Nurse was interviewed. The Nurse was asked about a pattern of medication errors for clients #3, #4 and #6. The Nurse indicated she could recall client #6's incident of medication not being delivered. The Nurse stated, "Yes, I think he missed a dose. It was called into the back up pharmacy ...". The Nurse was asked about clients #3, #4 and #6's medications not given and/or an extra dose. The Nurse indicated she started in June of 2022 and some of the pattern of medication errors was before she began working with clients #3. #4 and #6. The Nurse was asked if medications should be administered according to their physician's order without error. The Nurse stated, "Yeah".

On 8/25/22 at 12:59 PM, the Program Manager was interviewed. The Program Manager was asked about the pattern of medication error history

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| | above. The Program Manager indicated she could recall client #6's medications had not been delivered in time and the other errors were related to staff failing to administer according to their physician orders. The Program Manager was asked if clients #3, #4 and #6's medications should be administered according to the physicians orders without error. The Program Manager stated, "Yes, they should".<br><br>9-3-6(a) | | | |
| W 0369<br><br>Bldg. 00 | 483.460(k)(2)<br>DRUG ADMINISTRATION<br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br>Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1 received his nebulizer breathing treatment according to his physician's orders.<br><br>Findings include:<br><br>Observations were conducted at the group home on 8/22/22 from 3:56 PM to 6:15 PM and on 8/23/22 from 6:15 AM to 9:08 AM. During these observations, client #1 was supported by staff #3 during his evening medication administration on 8/22/22, and by staff #1 during his morning medications administration on 8/23/22. On 8/22/22 at 4:06 PM, staff #3 asked client #1 if he was ready for evening medications and to come to the medication administration room as she began to prepare client #1's medications. At 4:12 PM staff #3 stated, "We still don't have Ipratropium 3 ml (milliliters)". Staff #3 indicated she could not administer client #1's breathing treatment through | W 0369 | **W369:** The facility for drug administration must assure that all drugs, including those that are self-administered are administered without error.<br><br>**Corrective Action:**<br>· All staff trained on medication administration policy. (**Attachment B**)<br>· Area Supervisor trained on weekly medication audits.**(Attachment D)**<br>· Staff received disciplinary actions for failing to administer a prescribed medication. **(Attachment E)**<br>· All staff trained on correct way to document if a medication is not available in the home. **(Attachment B)** | 09/18/2022 |

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| | his nebulizer due to a lack of medication supplies. Client #1 did not receive his breathing treatment by use of a nebulizer.<br><br>On 8/23/22 at 8:15 AM, staff #1 stated, "I had an issue with his nebulizer. It's on here (medication administration record), but I don't have it".<br><br>On 8/23/22 at 8:24 AM, the Team Leader (TL) was interviewed. The TL was asked about client #1's breathing treatment and not having the medication supplies to administer his breathing treatment. The TL stated, "I called [name] to let them know I still needed the nebulizer. It's both the doctor and pharmacy issue. As far as I know, [pharmacy name] is supposed to send it over to [medical store]".<br><br>On 8/23/22 at 11:08 AM, client #1's record was reviewed. The record indicated the following:<br><br>-Physician's orders dated 7/12/22 indicated, "Ipratropium / Sol (solution) Albuter (asthma) ... Use 3 ml (milliliters) (one vial) via nebulizer three times daily ...".<br><br>-Medication Administration Record (MAR) dated 7/1/22 through 7/31/22 indicated, "Ipratropium / Sol (solution) Albuter ... Use 3 ml (one vial) via nebulizer three times daily... 7 AM, 4 PM and 8 PM". Client #1's MAR indicated circles around staff initials for a lack of administering his breathing treatments from July 7/13/22 through 7/31/22 after client #1 had returned from nursing facility placement.<br><br>-Medication Administration Record (MAR) dated 8/1/22 through 8/31/22 indicated, "Ipratropium / Sol (solution) Albuter ... Use 3 ml (one vial) via nebulizer three times daily... 7 AM, 4 PM and 8 | | · Area Supervisor will complete medication audits one time weekly on all medications in the home. **(Attachment D)**<br>· Nurse completes weekly check in the home.**(Attachment C)**<br>· Area Supervisor will complete the new Medication Storage Checklist All staff retrained on medication administration. **(Attachment J)**<br>· Area Supervisor will conduct 2 medication administration observations weekly for no less than 60 days. **(Attachment D)**<br>· Nurse Manager or Designee will complete 1 medication administration observation weekly for no less than 60 days. **(Attachment I)**<br><br>**Monitoring of Corrective Action:**<br>· Area Supervisor will conduct weekly med administration observation and submit to the Program Manager for review and to ensure completion.<br>· Site Supervisor will report any issues with medication administration to the Program Manager and Nurse immediately.<br>· Area Supervisor retrained all staff on medication administration.<br>· Nurse sends completed | |

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| | PM". Client #1's MAR indicated circles around staff initials for a lack of administering his breathing treatments from 8/1/22 through 8/23/22.<br><br>On 8/23/22 at 1:23 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about the lack of medication supplies to complete client #1's breathing treatment according to his physician orders and if it was considered a medication administration error. The QIDPD stated, "We don't have the meds (medication supplies) ...". The QIDPD was asked if this was a medication error. The QIDPD stated, "Yes". The QIDPD indicated medications should be administered according to the physicians orders without error.<br><br>On 8/23/22 at 1:37 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the lack of medication supplies to complete client #1's breathing treatment according to his physician orders and if it was considered a medication administration error. The QIDP indicated client #1 not receiving his nebulizer breathing treatment according to physician orders was a medication error. The QIDP indicated medication should be administered according to client #1's physician orders without error and stated, "Yes. It's errors according to our policy".<br><br>On 8/25/22 at 10:50 AM, the Nurse was interviewed. The Nurse was asked about client #1's missed breathing treatments. The Nurse stated, "I called the home, I think it was Tuesday (8/23/22) and asked if they did not have the medication or the machine. I was reassured he did have the medication. I brought the machine here when he was admitted". The Nurse reviewed the medication administration room and at 11:04 AM | | medication observations to Nurse Manager.<br><br>**Completion Date: 9/18/22** | |

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| | stated, "There is (sic) 3 boxes of it (medication) ... The medication is here, and I brought the machine here ... There is a new machine here". The Nurse was asked if the machine was just delivered. The Nurse stated, "Yes, not the medication, but the machine, yes". The Nurse indicated all medical supplies were currently available to complete client #1's breathing treatments.<br><br>On 8/25/22 at 12:59 PM, the Program Manager was interviewed. The Program Manager was asked about client #1's missed breathing treatment and if those treatments should have been administered according the physicians orders without error. The Program Manager stated, "Yes, they should".<br><br>9-3-6(a) | | | |
| W 0455<br><br>Bldg. 00 | 483.470(l)(1)<br>INFECTION CONTROL<br>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.<br>Based on observation, record review and interview for 1 of 3 sampled clients (#2), and 1 additional client (#7), the facility failed to ensure infection control practices were implemented when clients #2 and #7 were not provided plates to place their toast on during their morning meal.<br><br>Findings include:<br><br>An observation was conducted on 8/23/22 from 6:15 AM to 9:08 AM. At 6:27 AM, clients #2 and #7 joined their peers at the dining room table for their morning meal which consisted of oatmeal, yogurt, toast with coffee and juice to drink. Clients #2 and #7 had 2 bowls for their oatmeal and yogurt. At 6:47 AM, both clients #2 and #7 were seated at opposite ends of the table and | W 0455 | **W455:** The facility must provide a sanitary environment to avoid sources and transmission of infections.<br><br>**Corrective Action:**<br><br>· All staff trained on mealtime plans and procedures, ensuring the surfaces are cleaned prior to meals, all food is served on plates or in bowls. (**Attachment B**)<br>· Area Supervisor will complete mealtime observations 2 times weekly for no less than 30 days to ensure infection control practices are implemented. | 09/18/2022 |

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| | were eating their toast. Clients #2 and #7 were not provided small plates and would take a bite and then lay their toast down on the surface of the dining room table. Client #7 picked his toast up and finished eating it. At 6:49 AM, client #7 stood and took his two bowls to the kitchen sink. Client #2 continued to eat his toast and lay it back down on the surface of the dining room table between bites. At 6:50 AM, client #2 picked his toast up with his left hand and took a bite. Client #2 then laid his toast back down on the surface of the table. At 6:51 AM, client #2 picked his toast back up with his left hand and took another bite and laid it back down on the surface of the table. Client #2 used his right hand to put his two empty bowls together from where he finished eating his oatmeal and yogurt. Client #2 then picked the remaining piece of toast up from the table surface and continued to eat it until finished.<br><br>On 8/23/22 at 7:02 AM, the Team Leader (TL) was interviewed. The TL was asked if the home had enough plates for serving the morning meal. The TL nodded her head yes and opened a kitchen cabinet to show there was enough plates for everyone. The TL was asked if she had noticed clients #2 and #7 did not have small plates to lay their toast down on and used the surface of the dining room table. The TL shook her head no and stated, "That's my fault. I did not notice that. I should have set more". The TL was asked about a lack of infection control practice when clients #2 and #7 had to lay their piece of toast down on the surface of the dining room table. The TL nodded her head yes.<br><br>On 8/23/22 at 12:17 PM, client #2's record was reviewed. The review indicated the following:<br><br>-Individual Support Plan (ISP) dated 2/4/22 | | **(Attachment D)**<br>· Rescare Management will complete mealtime observations 2 times weekly for no less than 30 days to ensure infection control practices are implemented. **(Attachment K)**<br><br>**Monitoring of Corrective Action:**<br>· The Area Supervisor and Site Supervisor will send completed observations to the Program Manager for monitoring and to ensure completion.<br>· Rescare Management observations will be sent to the Program Manager for review and to ensure completion.<br><br>**Completion Date: 9/18/22** | |

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indicated, "Priority Objectives: Mealtime safety ... Methodology: Staff will supervise mealtimes ...".

On 8/24/22 at 3:34 PM, a focused review of client #7's record was conducted. The review indicated the following:

-Individual Support Plan (ISP) dated 8/6/22 indicated, "Who is [client #7]: ... Needs verbal assistance to complete all ADLs (adult living skills) ... Priority Objectives: ... Mealtime safety ... Goal #4: Mealtime Safety ... Methodology: Staff will supervise meals ...".

On 8/23/22 at 1:23 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about clients #2 and #7 placing their toast on the dining room table and implementation of infection control practices. The QIDPD stated, "Should have been on a napkin or a plate". The QIDPD was asked if clients #2 and #7 act of putting their toast on the surface of the dining room table was a lack of infection control. The QIDPD nodded her head yes.

On 8/23/22 at 1:37 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about clients #2 and #7 placing their toast on the dining room table and implementation of infection control practices. The QIDP stated, "Yes, it's an infection control issue". The QIDP indicated clients #2 and #7 should have used a plate to be able to place their toast down between bites.

On 8/25/22 at 10:50 AM, the Nurse was interviewed. The Nurse was asked about clients #2 and #7 placing their toast on the dining room table and implementation of infection control

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| | practices. The Nurse stated, "Exactly, I've not witnessed anything like that". The Nurse indicated she usually observed either the lunch or supper mealtimes and had not witnessed infection control issues such as clients #2 and #7 placing toast onto the surface of the table and then consuming it. The Nurse was asked if this practice would be a lack of infection control. The Nurse stated, "Absolutely".<br><br>On 8/25/22 at 12:59 PM, the Program Manager was interviewed. The Program Manager was asked about infection control practices when clients #2 and #7 did not have small plates and placed their toast down on the dining room tabletop surface. The Program Manager stated, "We should have ensured they had a paper towel or plate to put it on".<br><br>9-3-7(a) | | | |
| W 9999<br><br>Bldg. 00 | State Findings<br><br>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:<br><br>460 IAC 9-3-1(b) Governing Body<br><br>(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: 16. A medication error or medical treatment error as follows: a. Wrong medication given; b. Wrong dosage given; c. Missed medication - not given; d. Medication given | W 9999 | **W 9999:**<br>Governing Body:<br><br>**Corrective action:**<br>· Quality Assurance Manager inserviced that all medications errors are to be reported within 24 hours to BDDS. (**Attachment L)**<br>· All staff trained to report medication errors immediately as a BDDS report is to be completed within 24 hours of the error.<br>**(Attachment B)**<br>**Monitoring of Corrective Action**:<br>·All incident reports are reviewed | 09/18/2022 |

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| | wrong route; or e. Medication error that jeopardizes an individual's health and welfare and requires medical attention.<br><br>This state rule was not met as evidenced by:<br><br>Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure incidents involving medication errors were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours.<br><br>Findings include:<br><br>On 8/22/22 at 2:14 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) incident reports was conducted. No BDDS incident reports of client #1 missing breathing treatments due to a lack of Ipratropium 3 ml (asthma) medication were provided for review.<br><br>Observations were conducted at the group home on 8/22/22 from 3:56 PM to 6:15 PM and on 8/23/22 from 6:15 AM to 9:08 AM. During these observations, client #1 was supported by staff #3 during his evening medication administration on 8/22/22, and by staff #1 during his morning medications administration on 8/23/22. On 8/22/22 at 4:06 PM, staff #3 asked client #1 if he was ready for evening medications and to come to the medication administration room as she began to prepare client #1's medications. At 4:12 PM staff #3 stated, "We still don't have Ipratropium 3 ml (milliliters)". Staff #3 indicated she could not administer client #1's breathing treatment through his nebulizer due to a lack of medication supplies. Client #1 did not receive his breathing treatment by use of a nebulizer. | | at quarterly safety meeting to monitor for trends and patterns.<br>·Program Manager & Executive Director will receive a copy of all BDDS reports for thoroughness, timeliness, and complete adherence to state requirements.<br><br>**Completion Date: 9/18/22** | |

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| | On 8/23/22 at 8:15 AM, staff #1 stated, "I had an issue with his nebulizer. It's on here (medication administration record), but I don't have it".<br><br>On 8/23/22 at 11:08 AM, client #1's record was reviewed. The record indicated the following:<br><br>-Physician's orders dated 7/12/22 indicated, "Ipratropium / Sol (solution) (asthma) ... Use 3 ml (milliliters) (one vial) via nebulizer three times daily ...".<br><br>-Medication Administration Record (MAR) dated 7/1/22 through 7/31/22 indicated, "Ipratropium / Sol (solution)... Use 3 ml (one vial) via nebulizer three times daily...7 AM, 4 PM and 8 PM". Client #1's MAR indicated circles around staff initials for a lack of administering his breathing treatments from July 7/13/22 through 7/31/22, once client #1 had returned from his nursing facility placement.<br><br>-Medication Administration Record (MAR) dated 8/1/22 through 8/31/22 indicated, "Ipratropium / Sol (solution)... Use 3 ml (one vial) via nebulizer three times daily... 7 AM, 4 PM and 8 PM". Client #1's MAR indicated circles around staff initials for a lack of administering his breathing treatments from 8/1/22 through 8/23/22.<br><br>On 8/23/22 at 1:23 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about reporting the lack of medication supplies to complete client #1's breathing treatment according to his physician orders and if it was considered a medication administration error. The QIDPD stated, "We don't have the meds (medication supplies)...". The QIDPD was asked if this was a medication error. The QIDPD stated, "Yes". The QIDPD indicated medication errors should be | | | |

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reported to BDDS within 24 hours.

On 8/23/22 at 1:37 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about reporting the lack of medication supplies to complete client #1's breathing treatment according to his physician orders and if it was considered a medication administration error. The QIDP indicated medication should be administered according to client #1's physician orders without error and stated, "Yes. It's errors according to our policy". The QIDP indicated medication errors should be reported to BDDS within 24 hours.

On 8/25/22 at 10:50 AM, the Nurse was interviewed. The Nurse was asked about the reporting to BDDS within 24 hours client #1's July and August 2022 breathing treatment not administered as indicated by staff circling their initials on his MARs. The Nurse stated, "I guess so". The Nurse was asked if client #1's medication administration errors should have been reported to BDDS within 24 hours. The Nurse stated, "That is the policy, yes".

On 8/25/22 at 12:59 PM, the Program Manager was interviewed. The Program Manager was asked about the reporting of client #1's July and August 2022 missed breathing treatments and if those should have been reported to BDDS within 24 hours. The Program Manager stated, "Yes. It should have been reported within 24 hours".

9-3-1(b)