STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING 00 B. WING	05/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED 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
W 0000 Bldg. 00	This visit was for a pre-determined full annual recertification and state licensure survey. This visit included the investigations of complaint #IN00376227, complaint #IN00376411 and complaint #IN00377595. Complaint #IN00376227: Substantiated; Federal and State deficiencies related to the allegation(s) are cited at W149 and W157. Complaint #IN00376411: Substantiated; Federal and State deficiencies related to the allegation(s) are cited at W149 and W157. Complaint #IN00377595: Substantiated; Federal and State deficiency related to the allegation(s) is cited at W149. Survey Dates: 5/9/22, 5/10/22, 5/11/22 , 5/12/22 and 5/13/22. Facility Number: 000664 Provider Number: 15G127 AIM Number: 100234310 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/24/22.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 17 incident reports affecting clients A, B, C, D, E and	W 0149	To correct the deficient practice all site staff will be re-trained the	06/13/2022

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

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	F, the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment or violation of an individual's rights to prevent 1) a lack of staff supervision and/or monitoring of clients A, B, C, D, E, and F on 12/31/21 when staff members locked themselves in the medication administration room, 2) a lack of staff supervision and/or monitoring of clients A, B, C, D, E, and F on 2/21/22 when staff slept during the overnight hours, and 3) a pattern of aggression from client A towards clients B and C. Findings include: On 5/9/22 at 3:15 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following, which affected clients A, B, C, D, E and F: 1) BDDS incident report dated 1/2/22 indicated the following which affected clients A, B, C, D, E and F, "It was reported nurse arrived at group home to administer home COVID (COVID-19) test to [client D]. When nurse entered the home, she could not locate staff. Nurse was told by client that staff were probably locked in medication room. Nurse attempted to contact staff by knocking on medication room door and calling their phones with no response. When staff did respond to nurse, they stated they were in the locked medication room due to clients getting sick". Investigation summary dated 1/7/22 indicated, "Introduction: An investigation was initiated when [Nurse], LPN reported she arrived at the group home on 12/31/21 and was unable to locate staff for several minutes. When staff were located,		following, ResCare ANEM policy, Client supervision levels, active treatment, and all clients BSP. Client C. has been released from jail and went to his family home on long term LOA (leave of absence) from the ICF. The QIDP continues to have daily contact with BDDS and the family for alternative placements. Additional monitoring will be achieved through three weekly observations for a period of two months to be completed by the AS/QIDP/PM/AED. Ongoing monitoring will be achieved through monthly site reviews completed by ResCare administration.	

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	they were in the medication room with doors locked and reported it was due to a client being sick ... Factual Findings:.. 6 of 7 clients in the home on 12/31/21 stated [former staff #1] and [former staff #2] were locked in the med (medication) room for long periods of time and only came out after [nurse] arrived and knocked on the door ... [Former staff #1] stated he and [former staff #2] did spend time locked in the med room to quarantine due to [client D] being sick. Conclusion: Substantiated [former staff #1] and [former staff #2] locked themselves in med room to avoid sick client. Investigation Peer Review: ... Term (termination) [former staff #1] and [former staff #2]". On 5/12/22 at 11:49 AM the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the incident of staff locking themselves within the medication administration room away from clients A, B, C, D, E and F reported on 1/2/22. The QIDP stated, "Yeah, [nurse] contacted the Program Manager and Area Supervisor. The staff was suspended pending investigation". The QIDP indicated the investigation had substantiated former staff #1 and former staff #2 had locked themselves within the medication administration room away from the clients and had not provided supports appropriately. The QIDP indicated former staff #1 and former staff #2 had been terminated. The QIDP indicated the Abuse, Neglect, Exploitation, Mistreatment and/or Individual's Right's policy should be implemented at all times. On 5/12/22 at 1:05 PM, the Quality Assurance Coordinator (QAC) was interviewed. The QAC was asked about the incident of staff locking themselves within the medication administration room away from clients A, B, C, D, E and F			

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	reported on 1/2/22. The QAC stated, "I was a part of the investigation of the staff locking themselves in the med (medication) room". The QAC indicated the investigation process substantiated former staff #1 and former staff #2 had locked themselves within the medication administration room for the purpose of being away from sick clients. The QAC indicated former staff #1 and #2 had been terminated. The QAC indicated the Abuse, Neglect, Exploitation, Mistreatment and/or Individual's Right's policy should be implemented at all times. 2) BDDS incident report dated 2/22/22 indicated, "A client reported that staff [former staff #3] has slept on the couch multiple times while at work". Investigation summary dated 3/1/22 indicated, "Scope of Investigation: Determine if [former staff #3] sleeps while on the clock leaving clients unsupervised ...Factual Findings: ... A review of the timecard for [former staff #3] for January 1 - February 1, 2022, indicates he worked 20 days in addition to 3rd shift on 2/16, 17 and 18. Review of other staff timecards indicates there was no other staff working with [former staff #3] on 2/16, 17, or 18. Three witnesses (client A, client B and client F) stated they saw [former staff #3] sleeping in the living room in his boxers/underwear. The Residential Manager stated on 2/21 it was reported to him by another DSP (direct support professional) that [former staff #3] answered the door at the group home in his underwear ... Conclusion: It is substantiated [former staff #3] was sleeping while on the clock, leaving clients unsupervised". On 5/12/22 at 11:49 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the 2/22/22 incident of			

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	staff sleeping during the overnight hours. The QIDP indicated the investigation process had substantiated with a conclusion that former staff #3 had slept while working during the overnight hours alone. The QIDP indicated former staff #3 was terminated. The QIDP indicated the Abuse, Neglect, Exploitation, Mistreatment and/or Individual's Right's policy should be implemented at all times. On 5/12/22 at 1:05 PM, the Quality Assurance Coordinator (QAC) was interviewed. The QAC was asked about the 2/22/22 incident of staff sleeping during the overnight hours. The QAC indicated client interviews indicated former staff #3 would sleep while working alone during the overnight hours. The QAC was asked if client interviews confirmed former staff #3 slept during his work shift while working alone. The QAC stated, "Right". The QAC indicated former staff #3 had been terminated. The QAC indicated the Abuse, Neglect, Exploitation, Mistreatment and/or Individual's Right's policy should be implemented at all times. 3) BDDS incident report dated 1/10/22 indicated, "It was reported [client A] became agitated when [client C] made a comment to housemate. [Client C] then called [client A] an inappropriate name and [client A] began yelling at [client C]. [Client A] then hit [client C] in the face causing [client C's] glasses to break. [Client C] sustained two ½ inch red marks on the bridge of his nose and one ½ inch red mark under his right eye from glasses". Investigation summary dated 1/10/22 indicated, "Briefly describe the incident. [Client C] was in the kitchen area and was making remarks about another client. [Client A] overheard [client C] call this client a name. [Client A] became quickly upset			

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	and began screaming at [client C]. [Client C] responded by calling [client A] a 'd*******'. [Client C] went down the hallway toward his room. [Client A] followed him, staff screaming and cursing. [Client A] threatened [client C]. [Client C] responded with a threat. [Client A] then hit [client C] in the face (breaking his glasses). Staff were finally able to get clients separated and they both continued to curse at each other. Staff contacted nurse and [client C] was evaluated ... Recommendations: QIDP spent time with both clients reviewing the situation and discussing alternative ways, at each point, they could have made better choices. QIDP reviewed the Client Bill of Rights with both clients and reviewed the grievance training. Clients will be monitored when in the same area". -BDDS incident report dated 2/7/22 indicated, "It was reported [client B] was watching TV (television) when [client A] told him his TV time was up in 30 minutes. [Client B] told [client A] to just watch the TV and [client A] became agitated. [Client A] then hit [client B] in the stomach then grabbed [client B's] neck and pushed [client B] to the floor. [Client B] yelled for staff and staff went to check on him. [Client A] then hit a closet door putting a hole in the door. [Client A] then calmed. Nurse evaluated [client B] and found no injuries. No injuries were reported. Plan to resolve: Staff will continue to follow plans in place". Investigation summary dated 2/8/22 indicated, "Briefly describe the incident: [Client A] went into living room and told [client B] that his TV time was up. [Client B] was upset, due (sic) having been watching a movie, and yelled at [client A] 'just watch the d*** TV'. [Client A] was not pleased with [client B] comment and became agitated and punched [client B] in the stomach.			

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	[Client A] then proceeded to grab [client B] by the throat and threw him to the ground. When staff came running to the living room, [client A] ran toward the dining room. In the process he stopped and punched a hole in the door of the utility closet. [Client A] then sat down in the dining room and began to cry. Staff came to check him and he stated, 'I am sorry'. [Client A] went upstairs and [client B] remained in the living room. Nurse was called and [client B] was evaluated. Nurse determined that no further medical treatment was needed ... 6. Do any changes need to be made to prevent future occurrences? More consistent monitoring of [client A] when he begins to demand things from others ... Recommendations: QIDP (Qualified Intellectual Disabilities Professional) has requested that there be two staff on duty from 7 AM until midnight to help ensure the safety of all clients. RM (Residential Manager) and Area Supervisor have staggered staff to have two staff in the home until bedtime". -BDDS incident report dated 4/12/22 indicated, "It was reported [client A] became agitated when he did not receive a spend down check. [Client A] pulled a light from the wall and threw a chair at a window causing the window to break. A short time later [client A] was complaining about the menu for dinner. [Client A] began to yell at [client B] then pushed [client B] against the wall and attempted to choke [client B]. Staff initiated one-man YSIS (You're Safe I'm Safe) with [client A] for 5 seconds to separate the men. Staff called the police for assistance. Officer arrived and spoke with [client A]. Officer suggested to [client A] that he go to the hospital for a med (medical) review and [client A] refused. [Client A] then attempted to hit the police officer and was handcuffed. [Client A] continued to resist the			

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	officer and was placed under arrest for Resisting Law Enforcement and Battery Against a Public Safety Official. [Client B] stated he wanted to press charges against [client A] and gave a statement to police. There were no injuries reported to either man. Plan to Resolve: Maintenance was called and arrived to secure the broken window. [Client A] is being held on a $15,000 bond. [Client A] has an initial hearing on 3/18/22. ResCare will follow all legal directives". Investigation summary dated 4/12/22 indicated, "Description of incident: Client (client A) had a behavior of physical aggression in the early afternoon. Client had de-escalated and calmed. At 5:20 PM, client began to complain about the menu or any alternatives offered. Client feels like he is being put on a diet that he does not want to be on. Nurse explained to client that it is a heart healthy menu for everyone in the home. Client continued to escalate and started yelling at another client (client B). The other client attempted to ignore client (client A) and client (client A) pushed the other client (client B) into the wall and put his hands on other client's (client B's) throat. Staff intervened and performed YSIS on client (client A) and separated the two clients. The other client (client B) did not have any injuries. Client (client A) then went into the living room and other client (client B) assisted staff with cooking in the kitchen. Client continued to make verbal threats to other client (client B) and to staff from the living room. Client was provided planned ignoring until client (client A) began to threaten all clients and staff. 911 was called. When the officer arrived, client (client A) was provided support and offered to be taken to the hospital for evaluation and possible medication. Client refused and became verbally aggressive toward the police. Client declined to go to the hospital and			

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	continued to verbally threaten police and others in the home. Police then attempted to place client under arrest. Client began to physically fight the police and they had to call for backup. Client fought with police all the way to the police car and out in the front yard. Client was handcuffed and taken to jail ... 2. What triggered the individual's behavior? Client (client A) had been agitated over not having been given a 450 dollar check earlier in the day. QIDP had never talked to client about a check. Area Supervisor had been in the home earlier and had asked two other clients what they wanted to spend their spend downs on. Client wanted money too. Client had also been agitated for several days as nurse was working to ensure staff were following the heart healthy overall menu for the home. It has more healthy snack options and healthier entrée options. Client (client A) has been stealing snacks and taking them to his room and was upset due to the snacks not being chips (baked instead of regular), cookies or cream pies. 3. How did staff intervene to address the behavior? Were all behavior strategies followed appropriately and do the current behavior strategies address the above behavior? What does the BSP (Behavior Support Plan) say about calling the police? Staff worked from 4:30 PM to 5:20 PM to verbally calm client (client A) and encourage him to be positive. Staff redirected client (client A) by playing music to take his mind off of his thoughts. Staff utilized planned ignoring when client (client A) was attempting to escalate himself. BSP states that verbal de-escalation is to be used, that YSIS is to be used, then and only then should police be called in order to ensure the safety of the client and others in the home ...			

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	7. Was the client arrested? Are they still in jail? Client was arrested and he remains in jail and will have initial hearing on 4/16/22. 8. Do any changes need to be made to prevent future occurrences? QIDP contacted BDDS placement office and a request was made for change of placement. Client level of behaviors is not appropriate for this placement ... Conclusion: Client was arrested and taken to jail. Recommendations: QIDP will continue to advocate on behalf of client (client A) to have a change of placement. QIDP has provided documentation to BDDS to support request". On 5/12/22 at 11:49 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the incident history of client A's aggression towards clients B and C. The QIDP indicated client A did have a pattern of aggression toward clients B and C. The QIDP indicated more appropriate placement options for client A were being pursued through client A's BDDS Service Coordinator and had been initiated prior to client A's arrest on 4/11/22. The QIDP was asked about forms of abuse such as hitting, pushing, and putting hands around client B's throat. The QIDP indicated the implementation of the Abuse, Neglect, Exploitation, Mistreatment and/or Individual's Right's policy should be implemented at all times. On 5/11/22 at 12:29 PM, a review of the 7/10/19 Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights (ANE) policy was conducted. The ANE policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals ... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of			

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	an Individual's rights". This federal tag relates to complaint #IN00376227. This federal tag relates to complaint #IN00376411. This federal tag relates to complaint #IN00377595. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 17 incident reports affecting clients A, B, C, D, E and F, the facility failed to implement corrective measures to monitor and prevent the reoccurrence of 1) a lack of staff supervision and/or monitoring of clients A, B, C, D, E, and F on 12/31/21 when staff members locked themselves in the medication administration room and 2) a lack of staff supervision and/or monitoring of clients A, B, C, D, E, and F on 2/21/22 when staff slept during the overnight hours. Findings include: On 5/9/22 at 3:15 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following, which affected clients A, B, C, D, E and F: 1) BDDS incident report dated 1/2/22 indicated the following which affected clients A, B, C, D, E and F, "It was reported nurse arrived at group home to administer home COVID (COVID-19) test to [client D]. When nurse entered the home, she could not	W 0157	To correct the deficient practice all investigation recommendations will be reviewed by a Peer Review Committee and approved by the ED. The committee members will ensure recommendation of additional monitoring is implemented when warranted. To ensure no others were affected, the QA department will review incidents for the past 6 months to ensure appropriate recommendations were implemented. Ongoing monitoring will be achieved through quarterly Quality and safety committee meetings with review for all patterns of incidents and appropriate follow up.	06/13/2022

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	locate staff. Nurse was told by client that staff were probably locked in medication room. Nurse attempted to contact staff by knocking on medication room door and calling their phones with no response. When staff did respond to nurse, they stated they were in the locked medication room due to clients getting sick". Investigation summary dated 1/7/22 indicated, "Introduction: An investigation was initiated when [Nurse], LPN reported she arrived at the group home on 12/31/21 and was unable to locate staff for several minutes. When staff were located, they were in the medication room with doors locked and reported it was due to a client being sick ... Factual Findings:.. 6 of 7 clients in the home on 12/31/21 stated [former staff #1] and [former staff #2] were locked in the med (medication) room for long periods of time and only came out after [nurse] arrived and knocked on the door ... [Former staff #1] stated he and [former staff #2] did spend time locked in the med room to quarantine due to [client D] being sick. Conclusion: Substantiated [former staff #1] and [former staff #2] locked themselves in med room to avoid sick client. Investigation Peer Review: ... Term (termination) [former staff #1] and [former staff #2]". On 5/12/22 at 11:49 AM the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the incident of staff locking themselves within the medication administration room away from clients A, B, C, D, E and F reported on 1/2/22. The QIDP stated, "Yeah, [nurse] contacted the Program Manager and Area Supervisor. The staff was suspended pending investigation". The QIDP indicated the investigation had substantiated former staff #1 and former staff #2 had locked themselves within			

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	the medication administration room away from the clients and had not provided supports appropriately. The QIDP indicated former staff #1 and former staff #2 had been terminated. The QIDP was asked if additional monitoring to ensure staff neglect for supports and services would not reoccur had been an outcome from the investigation process. The QIDP indicated the investigation process would generate recommendations in the form of assignments such as additional monitoring. The QIDP indicated she had not been instructed to provide additional oversight and was not aware of this type of instruction to other team members. The QIDP indicated further follow-up with the Quality Assurance Department would be needed to identify additional corrective measures other than her knowledge of staff being retrained on the Abuse, Neglect, and Exploitation policy. On 5/12/22 at 1:05 PM, the Quality Assurance Coordinator (QAC) was interviewed. The QAC was asked about the incident of staff locking themselves within the medication administration room away from clients A, B, C, D, E and F reported on 1/2/22. The QAC stated, "I was a part of the investigation of the staff locking themselves in the med (medication) room". The QAC indicated the investigation process substantiated former staff #1 and former staff #2 had locked themselves within the medication administration room for the purpose of being away from sick clients. The QAC indicated former staff #1 and #2 had been terminated. The QAC was asked if additional monitoring to ensure staff neglect for supports and services would not reoccur had been an outcome from the investigation process. The QAC stated, "My understanding is [QIDP] was in the home about every day and at different times. She never found			

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	15G127	A. BUILDING 00 B. WING	05/13/2022

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	that issue (staff neglect)". The QAC was asked if interviews from the investigation process indicated former staff #1 and former staff #2 would lock themselves within the medication administration prior to the reported incident on 1/2/22. The QAC indicated the client interviews had found a history of former staff #1 and former staff #2 would lock themselves within the medication administration room. The QAC was asked if the QIDP's normal day to day routine had not found former staff #1 and former staff #2 had been locking themselves within the medication administration room prior, how would it prevent future reoccurrence of neglect. The QAC stated, I see what you're saying". The QAC was asked about corrective measures to included additional monitoring. The QAC stated, "No, it doesn't". The QAC was asked if additional monitoring should have occurred. The QAC stated, "Looking back on it, yeah". 2) BDDS incident report dated 2/22/22 indicated, "A client reported that staff [former staff #3] has slept on the couch multiple times while at work". Investigation summary dated 3/1/22 indicated, "Scope of Investigation: Determine if [former staff #3] sleeps while on the clock leaving clients unsupervised ...Factual Findings: ... A review of the timecard for [former staff #3] for January 1 - February 1, 2022, indicates he worked 20 days in addition to 3rd shift on 2/16, 17 and 18. Review of other staff timecards indicates there was no other staff working with [former staff #3] on 2/16, 17, or 18. Three witnesses (client A, client B and client F) stated they saw [former staff #3] sleeping in the living room in his boxers/underwear. The Residential Manager stated on 2/21 it was reported to him by another DSP (direct support professional) that [former staff #3] answered the			

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	door at the group home in his underwear ... Conclusion: It is substantiated [former staff #3] was sleeping while on the clock, leaving clients unsupervised". On 5/12/22 at 11:49 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the 2/22/22 incident of staff sleeping during the overnight hours. The QIDP indicated the investigation process had substantiated with a conclusion that former staff #3 had slept while working during the overnight hours alone. The QIDP indicated former staff #3 was terminated. The QIDP was asked if additional monitoring to ensure staff neglect for supports and services would not reoccur had been an outcome from the investigation process. The QIDP indicated the investigation process would generate recommendations in the form of assignments such as additional monitoring. The QIDP indicated she had not been instructed to provide additional oversight and was not aware of this type of instruction to other team members. The QIDP indicated further follow-up with the Quality Assurance Department would be needed to identify additional corrective measures other than her knowledge of staff being retrained on the Abuse, Neglect, and Exploitation policy. On 5/12/22 at 1:05 PM, the Quality Assurance Coordinator (QAC) was interviewed. The QAC was asked about the 2/22/22 incident of staff sleeping during the overnight hours. The QAC indicated client interviews indicated former staff #3 would sleep while working alone during the overnight hours. The QAC was asked if client interviews confirmed former staff #3 slept during his work shift while working alone. The QAC stated, "Right". The QAC indicated former staff #3 had been terminated. The QAC was asked			

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	about the lack of additional monitoring after the investigation process was completed into former staff #3's sleeping multiple times during the overnight hours. The QAC indicated the investigation process did not include additional monitoring and stated, "I agree with you". This federal tag relates to complaint #IN00376227. This federal tag relates to complaint #IN00376411. 9-3-2(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review and interview for 1 additional client (E), the facility failed to ensure client E received his Azithromycin antibiotic medication according to his physician orders without error. Findings include: An observation was conducted on 5/10/22 from 6:42 AM through 9:35 AM. The observation indicated the following: -At 7:13 AM, the Area Supervisor washed his hands in preparation of administering client E's morning medication. -At 7:14 AM, the Area Supervisor unlocked the medication cabinet, pulled out a basket with medicines from the cabinet, and began reviewing the prescription labels to an electronic medication record (MAR) for client E.	W 0368	To correct the deficient practice all site staff will be re-trained appropriate medication administration procedures as well as medication audit procedures. Additional monitoring will be achieved through site staff completing daily medication supply audits and the nurse reviewing weekly for discrepancies. As well as once weekly medication pass observations to be completed by the AS/QIDP/Nurse/PM. To ensure no others were affected, the site nurse will review the current physicians' orders for all medication supplies. Ongoing monitoring will be achieved through site staff completing weekly medication supply audits as well as the nurse reviewing the	06/13/2022

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	-At 7:43 AM, client E completed his breathing treatment and turned off his breathing machine. -At 7:53 AM, the Area Supervisor called the nurse to inform client E's Azithromycin (antibiotic) Tablet 250 mg (milligrams) was not available for administration. The Nurse indicated to the Area Supervisor she was going to come by the home and check it out. Client E then stated, "I took the last one yesterday". -At 8:39 AM, the nurse entered the home. On 5/10/22 at 4:05 PM, a focused review of client E's record was conducted. The review indicated the following: -Physician Orders dated 3/10/22 indicated, "Azithromycin ... Take two (2) tablets (500 mg) on day 1, then take one (1) tablet (250 mg) once daily on days 2 thru (through) 5". On 5/10/22 at 9:01 AM, the nurse was interviewed. The nurse was asked about client E's not having his Azithromycin antibiotic available for administration. The nurse indicated the bubble pack was found and after review determined to be a previous medication error. The nurse stated, "He started 5/6/22 at 7 AM, received 2 tablets. Day 2 through 5 one tablet. Today would have been day 5. It looks like [staff #4] on 5/7/22 give it at 12 AM and then on 5/7/22 at 7 AM she gives it again. It was given twice on 5/7/22 and we did not have it this morning. We've reported, so she'll have to contact me so we can discuss how not to make error in the future. Training will be completed with medication error (form) filled out". The nurse indicated client E should receive his medication according to his physician orders without error.		weekly audit.	

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	9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 additional client (E), the facility failed to ensure client E received his Symbicort Inhaler medication according to his physician orders without error. Findings include: An observation was conducted on 5/10/22 from 6:42 AM through 9:35 AM. The observation indicated the following: -At 7:13 AM, the Area Supervisor washed his hands in preparation of administering client E's morning medication. -At 7:14 AM, the Area Supervisor unlocked the medication cabinet, pulled out a basket with medicines from the cabinet, and began reviewing the prescription labels to an electronic medication record (MAR) for client E. -At 7:35 AM, the Area Supervisor indicated a phone call with the nurse was needed. The Area Supervisor indicated the electronic record had Budesonide (Symbicort / allergy) Inhalation Suppression 0.5 mg (milligrams) / 2 ml (milliliters) on client E's MAR twice. -At 7:36 AM, the Area Supervisor verbally prompted client E to wash his hands. Once finished washing his hands, client E then poured a	W 0369	To correct the deficient practice all site staff will be re-trained appropriate medication administration procedures as well as medication audit procedures. Additional monitoring will be achieved through site staff completing daily medication supply audits and the nurse reviewing weekly for discrepancies. As well as once weekly medication pass observations to be completed by the AS/QIDP/Nurse/PM. To ensure no others were affected, the site nurse will review the current physicians' orders for all medication supplies. Ongoing monitoring will be achieved through site staff completing weekly medication supply audits as well as the nurse reviewing the weekly audit.	06/13/2022

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	vial of Budesonide 0.5 mg and a vial of Perforomist (asthma) 20 mcg (micrograms) into his breathing machine and started his breathing treatment. -At 7:43 AM, client E completed his breathing treatment and turned off his breathing machine. -At 7:47 AM, the Area Supervisor called the nurse to ask about client E's MAR listing Budesonide 0.5 mg twice. -At 8:39 AM, the nurse entered the home. On 5/10/22 at 4:05 PM, a focused review of client E's record was conducted. The review indicated the following: -Physician Orders dated 3/10/22 indicated, "Symbicort ... Inhale two puffs by mouth twice daily". On 5/10/22 at 9:15 AM, the nurse was interviewed. The nurse was asked about client E's MAR having Budesonide (Symbicort) listed twice and the phone conversation with the Area Supervisor. The nurse stated, "I'm going to have to call the doctor". The nurse indicated Symbicort was not listed on the MAR twice, one was for a vial breathing treatment that was received and the other was an inhaler which client E had not received. The nurse followed up this clarification by stating, "He should have received that. I've ordered it". The nurse was asked how long client E had not received the Symbicort Inhaler. The nurse indicated the medication was last ordered on 3/29/22 and would have been a month supply and stated, "I would say that was the April (2022) supply, so the last 10 days". The nurse indicated client E should receive his medication according			

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	to his physician orders without error. 9-3-6(a)			