STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G003	A. BUILDING _____ B. WING _____	C 02/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONEVILLE HUMAN DEVELOPMENT CENTER	87 REED ROAD, HWY 116 SOUTH BOONEVILLE, AR 72927

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS Complaint 14201 was unsubstantaited.	W 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A predetermined full survey was conducted 10/5/09 - 10/14/09.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that a clean, safe environment was provided for the clients, as evidenced by failure to maintain furniture, walls, doors, equipment and fixtures in good repair, failure to maintain floors and storage areas in clean condition, failure to replace worn, frayed bath towels and failure to store hazardous chemicals in a secure area. The failed practice had the potential to affect all 146 clients who resided in the facility, as documented on the Intermediate Care Facility for Persons with Mental Retardation Survey Report dated 10/14/09. The findings are: 1. On 10/14/09 beginning at 12:00 p.m., the following observations were made in the Harbison	W 104		

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W 104	Continued From page 1 House: a. The front lip of the kitchen counter by the Orange Aide Station had the Formica worn through. Because the Formica was not intact, this countertop could not be properly sanitized. b. Toilet room door frames were rusted with the paint coming off throughout the facility. c. The shower room closest to Room 217 had broken, missing tiles with sharp edges. d. The windows in Rooms 204, 223, 232 and 132 had no shades or blinds. e. The medicine cabinets in Rooms 213, 215, 228, 232, 126, 125, 121, 128, 106 and 104 had no shelves and one was missing a mirror. f. Rooms 205 and 227 had air conditioner units in need of repair. g. There was no sink in Room 225 that the resident could use after toileting. h. One wall in Room 118 was in need of repair. There were holes in the plaster and a large area of missing paint on one wall. 2. On 10/15/09 at 8:45 a.m., the following observations were made in the Baldwin Building downstairs: a. The floors in the kitchen area and dayroom were covered with dust and dirt and a solid build-up of old wax and dirt. b. In the personal care closet in the dayroom,	W 104		

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W 104	Continued From page 2 there were toothbrushes stored uncovered with other personal care items. c. The dining room floor had dust and dirt and a build-up of old wax with dirt and hair embedded in wax. d. The ice maker had a slimy brown residue in the water reservoir. e. The cook stove had rusted drip pans. f. One of the radiators in the dining room area had a control cover missing and there were sharp edges exposed. Several other radiators had the control doors missing throughout the clients' rooms. g. Dining room tables had dried food and rust on the rollers, wheels and crossbars. h. Linen closets had many towels with worn, frayed edges. i. The linen closet across from the Nurses Station had chemicals stored inside and the door was not locked. The chemicals included Cancel Malodorous Counteractant Concentrate, Window cleaner, Furniture polish, Citra slide washable mop treatment, Lime away and TSP Tri Sodium Phosphate for mildew stains. j. The shower rooms and tub rooms had tiles with missing grout lines. The cracks where the grout was missing were covered with a black residue. The ceiling tiles were rusted and the handles and drains had rust and corrosion on all of them. k. The toilet brushes in the client bathrooms were	W 104		

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W 104	Continued From page 3 soiled with urine stains and fecal material and had not been cleaned prior to putting them back into the holders, which also had foul odors present. l. The Housekeepers mopped half of the hall, but did not place caution signs up to warn the clients of the wet floors and prevent potential falls. 3. On 10/14/09 at 8:45 a.m., Resident Care Tech (RCT) #2 stated the clients had chores including housekeeping. The RCT stated the floors needed to be swept and mopped more than once a day but a Housekeeper was only available 3-4 hours per day. When asked if the clients could sweep and mop, the RCT stated, "Yes, but they don't." There were 5 staff members present in the building at this time. 4. On 10/15/09 at 9:20 a.m., the following observations were made in the Baldwin Building upstairs: a. Shower rooms and tub rooms had rust and missing grout lines. A build-up of a black residue was present in the cracks left by the missing grout. b. The tubs, handrails, drains and ceiling tiles were rusted. c. Room 205 had paint peeling on the closet doors and there was rust on several of the door facings. 5. On 10/14/09 at 10:10 a.m., Life Skills Trainer #1 stated the clients did have their own Program Plans which were available for staff to review. She stated the staff members were supposed to review the Individual Program Plans (IPP's) to	W 104		

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W 104	Continued From page 4 know which chores/activities the clients were supposed to do. 6. On 10/13/09 at 1:30 p.m., the following observations were made in the Judge Hill Building: a. In the first bathroom/shower room on the left of the hall, the last shower had hot water running even though the faucet was turned off. b. Room 101 had the second drawer sitting on the third drawer in the built-in chest. The drawers were very difficult to open. The bottom drawer of the 6-drawer chest was very unstable. c. Room 103 had drawers in the built-in chest that were very difficult to open and close. The bedroom door to the hall did not latch and would not stay closed. d. Room 104 had drawers in the built-in chest/closet that were very difficult to open and close. The closet door of the built-in did not latch. e. Room 106 had drawers (the third, fourth and fifth drawers) in the 5-drawer chest which dropped when opened 4 to 6 inches. The drawers in the built-in were difficult to open and close. The closet door on the right of the sink did not have a latch. The bottom 2 drawers in the dresser fell when opened 4-6 inches. f. Room 107 - The right closet door had no latch and the left closet door did not open. g. Room 108 - The bottom screw was gone from the handle of the right closet door. The drawers in the built-in were difficult to open and close.	W 104		

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W 104	Continued From page 5 The left closet door had no latch. The book case with 3 drawers had a top drawer that hung on the second drawer. The third drawer dropped when pulled out 4-6 inches. h. Room 109 - The drawers in the built-in would not open easily or correctly. The second and fourth drawers would not open and the third drawer was hung in the open position. The closet drawers would not latch and the bottom of the left door would drag on the floor. The 5-drawer chest had 3 drawers that were very unsteady and wobbly. i. Room 132 - The top left drawer on the 5-drawer chest was broken and had a rough front with a 1/4-inch piece of wood sticking out. The bottom drawer would not open. The drawers of the built-in were also difficult to open. j. Room 122 - The 3 drawers of the dresser were unstable and fell when opened 4-6 inches. k. Room 130 - The 3 drawers of the dresser were all unstable and fell when opened. The bottom drawer was coming apart, with the bottom of the drawer not attached to the front. The built-in drawers did not work. The bedside table's 2 drawers fell when pulled out 4-6 inches. l. Room 131 - The bottom drawer of the 5-drawer chest would not open and the bottom drawer of the built-in would not open. m. Room 124 - The ceiling had a stained area going across the room 9-10 feet. One area was approximately 18 inches across. The area was brown and there were at least 4 holes where water had broken through and dripped on the	W 104		

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W 104	Continued From page 6 floor. n. Room 125 had a hole in the right back corner of the room. The hole was 3-4 inches across and 1 to 1.5 inches deep with a deeper, smaller hole in the center of the busted area. The built-in had drawers that were not in good repair. o. Room 128 - The dresser's top drawer fell when opened 4-6 inches. The toilet seat did not fit the toilet properly. p. Room 127 - The bottom 2 drawers in the chest fell when opened 4-6 inches. The top drawer fell when opened 4-6 inches. The top drawer in the bedside table fell when pulled out 4-6 inches. 7. On 10/14/09 at 1:00 p.m., the following observations were made in the Hillside Down living unit: a. Most closet doors had locks and the clients had keys. Room 101's closet doors had no latches and would not stay shut. b. The bathroom next to Room 101 - The tub drain was very rusted. The tub has areas where the enamel was worn through, exposing the cast iron. The bathroom next-door also had a rusted out drain. c. Room 113 - The closet doors had no latches and a coat hanger had been placed through the latch connection to keep the doors closed. d. Room 106 - The 6-drawer chest had 5 drawers that would not open. e. The tub at the right end of the hall had a drippy	W 104		

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W 104	Continued From page 7 faucet. The drain was rusted out and the enamel was worn off. The room next to the bathroom had closet doors that would not stay shut due to having no latches. The bedside table had the top drawer sitting on the bottom drawer and the bottom drawer would not open unless both drawers were manipulated.	W 104		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a continuous active treatment program was implemented for 3 (Clients #3, #4 and #14) of 14 (Clients #1 - #14) sampled clients whose Individual Program Plans (IPP's) were reviewed. The findings are: 1. Client #3 had diagnoses of Personality Change due to Unspecified Encephalopathy, Nocturnal Enuresis, Borderline Personality Disorder, Moderate Mental Retardation, Seizure Disorder, History of Torsades de Pointes and Constipation. a. The Individual Program Plan dated 5/4/09 documented the following: 1.) "Client Schedule/free time: ...free time in the	W 249		

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W 249	Continued From page 8 evenings and on weekends. She enjoys watching television, visiting with staff and listening to music. Staff will apprise [Client #3] of what activities (depending on her behavior level for that day) are available and encourage her to participate in those that she likes." 2.) "Clients needs: Behavioral: may require behavioral programming. She will always need psychological monitoring/counseling for symptoms of her psychiatric diagnosis and emotional instability. She may occasionally need some staff supervision for the following behaviors related to psychiatric diagnosis: non-compliance, physical aggression and/or self-injurious behavior." b. On 10/7/09 at 4:00 p.m., the clients in Client #3's living unit were all sitting in the living room. Level 1 clients could come and go as they pleased in the house. The television was on and 2 clients were watching it. Three staff members were sitting together, lined up along the hall wall, watching but separate from the clients. Two of the clients started bickering and 1 staff member told them to stop. Client #3 asked if the Surveyor wanted to see her room. The Supervisor heard her and suggested the Surveyor start with the Level 1 clients first. Client #3 was on Level 3 at this time. While the Surveyor accompanied one of the clients, the other clients remained in the living room with no staff/client interaction. 2. Client #4 had diagnoses of Bipolar Disorder, Obsessive Compulsive Disorder and Mild Mental Retardation. a. The Individual Program Plan dated 5/8/09 documented the following:	W 249		

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W 249	Continued From page 9 1.) "Activity Schedule 6:00 to 10:00 p.m.: Leisure time, evening snack, Oral hygiene, meds [medications]." 2.) "Schedule/free time: ...has a tendency to stay in her room during the evenings, often goes to bed during that time. [Client #4] enjoys a variety of leisure activities, but she is more likely to participate during the weekends than she is during the evening hours. When she goes to bed during the evenings, [Client #4] usually still not get up when staff encourage her, unless there is an activity she particularly enjoys. [Client #4] should have supervised leisure time. Staff should encourage her to participate. [Client #4] is able to make her own decisions about what activities she prefers." 3.) "Medical: Most of [Client #4's] medications may cause drowsiness, dizziness, or other side effects. The side effects from her medications are rather complex, and the client needs assistance in reporting and monitoring those problems." 4.) The client's participation in activities was documented as "asleep or in bed" during 14 of 22 opportunities during August 2009, 8 of 18 opportunities during July 2009, 18 of 24 opportunities during June 2009, 16 of 25 opportunities during May 2009 and 21 of 29 opportunities during April 2009. Sleeping was not addressed as a problem in the Individual Program Plan. b. On 10/14/09 at 2:30 p.m., Qualified Mental Retardation Professional (QMRP) #1 was interviewed about the client's sleeping patterns.	W 249		

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W 249	Continued From page 10 She stated she was unaware of any problems and had not received any information. 3. Client #14 had diagnoses of Mood Disorder due to Encephalopathy, Attention Deficit Hyperactivity Disorder, Profound Mental Retardation, Epilepsy, Hypercholesterolemia, Constipation and Gastritis. a. The Individual Program Plan dated 3/10/09 documented, "Schedule/Free time: ...has free time in the evenings and on weekends... able to make her own choices... uses her leisure time appropriately." There was no documentation regarding problems with the client making repetitive loud noises, other than Training Objective 5d which documented, "By 3/01/10, [Client #14] will refrain from unnecessary social communication for 15 minutes while on task 70% of all trials per month for 3 consecutive months." b. On 10/13/09 from approximately 1:00 p.m. to 1:30 p.m., the client was walking around in the living unit making repetitive loud noises with no staff intervention. c. On 10/13/09 at 4:30 p.m., the client was walking around the entry area making loud noises. Staff appeared not to notice, nor did they intervene.	W 249		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.	W 371		

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W 371	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the Interdisciplinary Team's (IDT) Self-Administration of Medications (SAM) assessments and recommendations were implemented based on the clients' functional abilities for 5 (Clients #1, #2, #9, #10 and #11) of 32 sampled clients who received medications. The findings are: 1. Client #2 had diagnoses of Profound Mental Retardation, Attention Deficit/Hyperactivity Disorder (ADHD), Personality Change due to Unspecified Encephalopathy, Seizure Disorder and Obsessive Compulsive Disorder. a. The Individual Program Plan (IPP) dated 12/9/08 documented, "Team discussion... receives supervision and training assistance for administration of medications... Service objectives: ...medical staff will give information to the client about her medication during med [medication] pass as prescribed and SAMS training." b. On 10/5/09 at 11:30 a.m. during the medication pass, Licensed Practical Nurse (LPN) #1 obtained the client's medication box, unlocked the box, punched medications into a cup and handed the cup to the client. The client swallowed the pills. No SAMS training was provided. 2. Client # 9 had diagnosis of Profound Mental Retardation, Autistic Disorder with OCD features, Recurrent Ear Infections and Scoliosis a. The Individual Program Plan (IPP) dated	W 371		

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W 371	Continued From page 12 1/27/09 documented, "...Team discussion... receives supervision and training assistance for administration of medications. Service objectives: ...medical staff will give information to the client about her medication during med pass as prescribed in SAMS training..." b. On 10/5/09 at 11:20 a.m. during the medication pass, LPN #2 administered the clients medications and made no attempt to provide SAMS training to the client. 3. Client #10 had diagnoses of Severe Mental Retardation, Personality Change due to Unspecified Encephalopathy, Seizure Disorder and Obsessive Compulsive Disorder. a. The Individual Program Plan (IPP) dated 3/10/09 documented the client had a service objective to receive information about her medication during administration. b. On 10/15/09 at 11:20 a.m. during the medication pass, LPN #2 obtained the client's medication box, unlocked it and punched the medications out, obtained water for the client, then handed the medications and water to the client without providing any SAMS training. 4. Client #1 had diagnoses of Severe Mental Retardation, Attention Deficit Hyperactivity Disorder, Seizure Disorder, Diabetes Mellitus and Mood Disorder. a. The client's 4/30/09 staffing documented, "...he met his objective for identifying his Depakote and recommendations were to start to punch it out." This plan became Objective 3C which documented, "By 5/1/10, with no more than	W 371		

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BOONEVILLE HUMAN DEVELOPMENT CENTER	87 REED ROAD, HWY 116 SOUTH BOONEVILLE, AR 72927

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W 371	Continued From page 13 1 verbal prompt, [Client] will punch out his medication Depakote, 90% of all trials for 4 consecutive months." b. On 10/5/09 at 10:20 a.m. during the medication pass, the nurse gave the client his Depakote and did not allow the client to attempt to punch the Depakote out of the pack. 5. Client #11 had diagnoses of Mild Mental Retardation, Personality Change due to Encephalopathy, Personality Disorder and Hypertension. a. The client's 4/6/09 staffing documented, "The team also discussed and modified the Self Administration of Medication (SAM) objective to assist [Client] in maintaining his ability to set up his medication on a weekly basis and self-administering his medication in front of the nurse." This plan became Objective 5 (SAM Training) which documented, "By 4/6/10, [Client] will self administer his medications, Trileptal and Inderal in the presence of a nurse, 100% of all trials for 6 consecutive months." b. On 10/5/09 at 10:31 a.m., during the medication pass, the nurse gave the client his medications and did not allow the client to self-administer the Trileptal and Inderal.	W 371		

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W 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A complaint investigation survey was conducted from 7/15/09 to 7/21/09. Complaint #14676 was substantiated (all or in part) with deficiencies cited at W104, W102 (Condition of Participation) and W368. Complaint #14720 was substantiated (all or in part) with deficiencies cited at W102 (Condition of Participation), W104, W318 (Condition of Participation), W331 and W342. Complaints #14614 and #14689 were unsubstantiated.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Complaint #14676 was substantiated (all or in part) with these findings.	W 102		

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

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W 102	Continued From page 1 Based on record review and interview, the facility failed to meet the requirements of the Condition of Participation for Governing Body and Management, as evidenced by the facility's failure to meet the Condition of Participation (CoP) for Health Care Services (W318). The facility's Governing Body failed to immediately develop and implement comprehensive corrective and proactive plans to correct deficient practices that led to a critical illness for Client #2 and a severe sunburn for Clients #11 and #12. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious injury, harm or death to Client #2, who required an emergent hospitalization after receiving another client's medications from a facility nurse and to Clients #11 and #12, who sustained first or second degree burns which were not promptly identified and treated after staff failed to reapply sunscreen during prolonged sun exposure. The facility was informed of the Immediate Jeopardy conditions regarding medication administration failures on 7/28/09 at 2:40 p.m. and regarding failures to protect clients from prolonged sun exposure and provide immediate treatment for a severe sunburn on 7/20/09 at 4:50 p.m. The findings are: 1. The facility's governing body failed to ensure licensed nursing staff implemented facility policies and procedures to ensure the safe and accurate administration of medications, failed to provide staff education and training to prevent medication errors and failed to supervise/monitor nurses who made medication errors after Client #2 required an emergent hospitalization after receiving the wrong medications and failed to ensure direct care and licensed nursing staff promptly identified	W 102		

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W 102	Continued From page 2 and provided treatment to severe sunburns for Clients #11 and #12 - Refer to W104. 2. The facility's governing body failed to meet the Condition of Participation for Health Care Services, as evidenced by failure to ensure direct care employees were trained on providing ongoing client protection from prolonged sun exposure, failure to provide necessary nursing services for treatment of Client #11's severe sunburn and failure to develop a system to ensure Client #2 received the correct, physician-ordered medications - Refer to W318. 3. The Immediate Jeopardy regarding the facility's medication administration failures was removed on 7/28/09 at 2:40 p.m. when the facility implemented the following Plan of Removal: a. When a medication error reported, the Client will be observed per physician's instruction. Nurse Manager, Team RN, Social Service and Psychology and Superintendent will be notified. b. Nurse (LPN) making the error will be removed immediately from passing medication. Nurse Manager/Designee to initiate investigation with documentation. Nurse Manager/Designee will complete a written report of incident. c. Nurse manger/Designee will be responsible for in-service on giving medication. Nurse will be retrained for a total of eight (8) hours on Policy and Procedures. Written test upon completion of in-service. Nursing committing medication error will be monitored by Nursing Manager/Designee for a total of eight (8) hours on giving medication. d. Nurse (LPN) will complete a medication error	W 102		

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W 102	Continued From page 3 form. e. Nurse (LPN) will be monitored weekly for a period of four (4) weeks with documentation by Nurse Manager/Designee. In-service to specifically include client identification before passing medication, controlling clients at medication passes, and acquiring assistance if needed. f. Nurse Manager/Designee to follow up with counseling session in one (1) month with documentation from Nurse (LPN) on what was learned from incident (medication error). g. Hillside House (A complex) upstairs will have split kitchen door. Medication will be passed behind that door which will separate Clients and Medication Nurse. h. Hillside House (A complex) downstairs will have half door to entrance of dining room. Clients will get their medications at the door. Medications are kept behind door away from Clients. 4. The Immediate Jeopardy regarding failure to provide protection during prolonged sun exposure and failure to provide treatment for a severe sunburn was removed on 7/20/09 at 6:45 p.m. when the facility implemented the following Plan of Removal: a. Pool Hours changed to avoid swimming activities during the hottest periods of the day: From 9:00 a.m. to 11:00 a.m. to 6:30 p.m. - 8:00 p.m. Effective July 2, 2009 b. Sunscreen per physician orders, to be applied every hour while clients are participating in	W 102		

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W 102	Continued From page 4 outdoor activities. Nurse Manager will in-service all Living Area Supervisors on this order. The Director of Residential Services will follow-up weekly throughout summer months with documentation. Effective July 6, 2009. c. In-Service on Procedures of Sunscreen for Summer Activities: All direct care staff will be in-serviced in the appropriate times and situations where sunscreen should be applied to clients exposed skin areas. Training for new hires will be completed during Phase (training classes for new hires) classes. Monthly in-service of all staff will be done until pool closing. The Director of Residential Services will follow-up, evaluate and perform pool checks with results documented; and Quality Assurance [QA] Coordinator will do monthly follow-up. Effective July 21, 2009 d. Application of Sunscreen at Pool: Sunscreen to be applied by Direct Care Staff every hour by the Pool Supervisor and/or designee. Pool supervisors will be in-serviced on procedure of Sunscreen for Summer Activities. Pool Supervisors will do follow-up and monitor on a daily basis with documentation. The Director of Residential Services will do over-all evaluations and follow-up weekly with documentation; and Quality Assurance Coordinator will discuss monthly meeting and follow-up. Effective July 21, 2009. e. In-Service Training: In-service will be conducted on a monthly basis to all employees and will be instituted in Phase classes to all new hires for all reporting of any incidents or injuries. In-service will be monthly for all current employees. The Director of Staff Development, the Director of Residential Services, the Quality	W 102		

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W 102	Continued From page 5 Assurance Coordinator and the Nurse Manager will be responsible collectively for follow-up and evaluation with documentation to be discussed monthly. The Nurse Manager or designee will monitor every 8 hours for 72 hours and document. This will be added to the daily 24 hour report which will be sent to the Nurse Manager for review then forwarded to the Superintendent. The Superintendent is to be notified immediately of any incidents regarding clients. Effective July 21, 2009. f. A mandatory, daily staff meeting will be held in a designated location with the Team Leaders (3), Living area Supervisors and a designated nurse. These meetings will be documented by content and attendance and will be based on a 24 hour period. Daily reports will be forwarded to the Superintendent's attention. Residential Services Director will conduct weekly follow up meetings. Monthly reports will be sent to the QA coordinator for review. Effective date: Memo sent 7/21/09 with first meeting to be conducted the morning of 7/22/09 and subsequently thereafter on a daily basis.	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Complaint #14676 was substantiated (all or in part) with these findings. A. Based on observation, record review and interview, the facility failed to ensure licensed nursing staff implemented facility policies and	W 104		

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procedures to ensure the safe and accurate administration of medications, failed to provide staff education and training to prevent medication errors and failed to supervise/monitor nurses who made medication errors to ensure that counseling was effective to prevent further medication errors for 5 (Clients #2, #7, #8, #9 and #10) of 10 (Clients #1 through #10) sampled clients who received medications. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Client #2, who required an emergent hospitalization after receiving another client's medications. The facility was informed of the Immediate Jeopardy condition on 7/28/09 at 2:40 p.m. The findings are:

1. A Medication Incident Report dated 2/3/09 documented a medication error in which Client #6's medications were mistakenly administered to a non-sampled client by Licensed Practical Nurse (LPN) #2. LPN #2's statement documented, "Gave [non-sampled client] meds that were [Client #6's] meds. I thought she said her name was [Client #6] but her speech is impaired..." The Counseling Note at the bottom of the report was signed by Registered Nurse (RN) #3 and documented, "Use more caution when administering meds making sure the right patient gets the right medication @ [at] the right time."

2. A Medication Incident Report dated 2/24/09 documented medication errors involving 2 clients (Clients #7 and #8). LPN #1's statement documented, "Before I was ready to start med pass, two clients [Clients #7 and #8] rushed up to med table at the same time + [and] grabbed meds out of the box + swallowed them while LST's [Life Skills Trainers] were controlling the

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rest of client population..." The Counseling Note at the bottom of this report was dated 2/25/09, signed by RN #1 and documented, "Discussed what could have been done differently. Instructed to always have meds kept away from where clients can reach them, even if med pass has not begun."

3. The facility's March 2009, "Medication and Administration and Documentation Inservice," provided by the DON on 7/16/09, documented, "Prior to the administration of each client's medications, the nurse will consult the MAR [Medication Administration Record] and the picture of the client to ensure that the client is receiving the proper medications. In the areas where there is no med room, the MAR must be taken to the area and used to identify the client and the medications..."

4. A Medication Incident Report dated 3/4/09 documented another medication error made by LPN #1. LPN #1's statement documented, "LPN reached in and handed client [Client #9] wrong med cup." The Counseling Note dated 3/5/09 and signed by RN #2 documented, "Discussed Nurse's responsibility to maintain control of med pass; the client's right to receive the correct meds, and way to prevent med error in the future. Slow down and maintain control."

5. A Medication Incident Report dated 3/16/09 documented a medication error was made by LPN #3. LPN #3's statement documented, "I misread client's [Client #10's] last name and gave her the wrong meds in error." The Counseling Note dated 3/17/09 and signed by RN #2 documented, "Be more observant at med pass. State client's name before giving meds. Take

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W 104	Continued From page 8 your time during med pass, be in control of your med pass." 6. Client #2 had a diagnosis of Profound Mental Retardation. a. The May 2009 Physician Orders sheet documented the client's routine medications included Fortical nasal spray, Divalproex Sodium, Fluoxetine, Seroquel, Zetia, Calcium Carbonate with Vitamin D and Gemfibrozil. b. A Medication Incident Report dated 5/8/09 at 7:00 p.m. documented another medication error by LPN #1. LPN #1's statement documented, "I was passing meds, pouring drinks and trying to control the population. I thought I had it all under control. I handed [Client #2] [Client #7's] meds and knew immediately what I had done, but [Client #2] wouldn't give them back and he took them." 1.) Nurses Notes dated 5/8/09 at 6:00 p.m. documented, "Client took another clients meds." The Incident Report of the same date documented LPN #1 gave the client the wrong medications and, "Notified [Physician #1], orders received to keep client in observation till 2200 [10:00 p.m.], at 2000 [8:00 p.m.] vital signs [decreased] dropping ... called [Physician #1] ... orders to send client to [Hospital #1] Emergency Room for A/E [assessment and evaluation]. At 2100 [9:00 p.m.] [Physician #2] at ER [Emergency Room] report patient will stay in ER for 2 hours and then go to Hospital for observation with tentative release in a.m. [morning]." 2) A Counseling Note dated 5/9/09 documented Registered Nurse (RN) #1 met with LPN #1, "...to	W 104		

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discuss the medication error she made the night before and the serious effects the error is having on the client, [LPN #1] informed me she had turned in her resignation effective immediately... and [LPN #1] stated having to pass medications was making her too nervous... Effective this date, 05/09/09 [LPN #1] is no longer a [facility] employee." There was no documentation of further observations of medication pass or additional training for other nurses who passed medications in the facility.

c. Nurses Notes dated 5/9/09 at 1:20 a.m. documented, "[Hospital #1] called to get client's last sodium. Called sodium 132 to ER Nurse. They are shipping him to [Hospital #2] due to B/P [blood pressure] still low & [and] pulse ox [blood oxygen saturation] [decreased]..."

d. The History and Physical dated 5/9/09 at 5:53 a.m. from Hospital #2 documented, "This is a transfer from [Hospital #1] for hypoxia, hypertension, and clozapine overdose. Chief Complaint: Altered mental Status. History of present Illness: [Client #2] is a resident of [facility] for Mentally Retarded people who was found to be in an altered mental status around 8 p.m. It happened that the patient was given another patient's medications by mistake... Clozapine... 750 mg [milligrams] at 7 p.m. also Depakote ER [extended release]... 1,000 mg. at 7 p.m... The patient was lethargic, unresponsive, hypotensive in 70 to 80 systolic, and hypoxic in the 80's pulse oximetry saturation so he was sent to [Hospital #1]... He was found to be hypotensive, given 500 cc [cubic centimeter] bolus of fluids, was hypoxic, given Lasix and started on dopamine drip titrated up to 20 microgram per kilogram per hour and that hardly brought his blood pressure to 90's

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W 104	Continued From page 10 systolic... In the emergency room, he gave 300 cc of urine over 3 hours. [Physician at Hospital #1] then called [Physician at Hospital #2] to transfer the patient to a higher level of care. When the patient arrived to [Hospital #2], he was still unarouseable, was moaning, but not responding to verbal stimuli and hardly responding to painful stimuli. His blood pressure was in the 80's over 40's... [Physician at Hospital #2] called [facility] for complete medical records to be faxed to the ICU [Intensive Care Unit]. Family were notified and are on their way... Physical Examination: ...Pupils are narrow, 2 millimeters, equal and nonreactive... The patient is lethargic, responsive only to central painful stimuli, moaning... Assessment and Plan: ...Drug overdose, clozapine overdose and Depakote overdose. Poison Control Center was called and this case discussed with them in detail. No antidote for either [drug]. Side effects of clozapine may include hypotension and hypoxia. We have to watch for agranulocytosis [failure of the bone marrow to produce sufficient white blood cells - may increase risk of infection] once to twice a week after this dose and also watch for LFT's [liver function tests]..." Based on the documentation from Hospital #2, Client #2, who had not previously received Clozapine as a routine medication, was administered 750 mg of Clozapine in error. The manufacturer's prescribing information for Clozaril documented, "Because of a significant risk of agranulocytosis, a potentially life threatening adverse event, Clozapine should be reserved for use in severely ill Schizophrenic patients who fail to show an acceptable response to adequate courses of standard antipsychotic drug treatment... Seizures have been associated with the use of Clozapine... It is recommended that	W 104		

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treatment with Clozaril begin with one-half of a 25 mg tablet once or twice daily. Subsequent dosage increments should be made no more than once or twice weekly, in increments not to exceed 100 mg. Cautious titration and a divided dosage schedule are necessary to minimize the risks of hypotension, seizure, and sedation."
e. The Discharge Summary dated 5/22/09 from Hospital #2 documented, "Diagnosis: Accidental Overdose of clozapine, subsequent sepsis and acute renal failure, lactic acidosis. [Client #2] also has Iron-deficiency anemia with a reactive thrombocytosis, also aspiration pneumonia, respiratory failure, general azotemia ... Hospital course: [Client #2] was admitted after having acute mental status changes, hypotension, basically shock related to clozapine and Depakote overdose. [Client #2] had resultant metabolic acidosis, he required intravenous bicarb [bicarbonate] and fluid resuscitation, he required pressor support and intubation for his respiratory failure... he was seen by nephrology for renal failure, eventually he was able to be extubated, he had swallow study for aspiration pneumonia and had developed adult respiratory distress syndrome ..."

f. A facility Case Note dated 6/1/09 documented the client was discharged from the hospital and readmitted to the facility on 5/22/09 at 2:30 p.m. and resumed his previous activity schedule 5/28/09.

7. On 7/15/09 at 10:48 a.m., the DON stated she had planned to terminate LPN #1, but the LPN had already turned in her resignation. She also stated she had written a new policy and it included disciplinary action and possible termination for medication errors. She stated she

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was aware of 3 medication errors since the new policy and procedure was introduced.

The Policy and Procedure provided by the Director of Nursing (DON) on 7/16/09 documented, "...Prior to administration of each client's medications, the nurse will consult the MAR [Medication Administration Record] and the picture of the client to ensure that the client is receiving the proper medications... The NSUM [Nursing Services Unit Manager] or designee will do random spot checks of the med pass to ensure this process is being followed... Medication Error Procedure... the nurse has 7 days to complete a report outlining the error... what the consequences should be if it occurs again... All medication errors will incur disciplinary action up to and including termination."

8. A Medication Incident Report dated 6/28/09 at 7:00 a.m. documented Client #13 and another client crowded the medication area during LPN #4's medication pass and, "...possibly got meds mixed up."

9. On 7/15/09 at 10:48 a.m., the DON stated, "We counsel and retrain each nurse after a medication error." When asked what was done after LPN #1's errors on 2/24/09, 3/4/09 and 5/8/09, the DON stated the counseling is written on the bottom of the Medication Incident Report. The DON stated the facility did not have any disciplinary action for medication errors until May 2009, but did do random medication pass observations and retraining. The DON stated there was a problem in the Hillside living unit and they had to, "figure out what to do." The DON stated she had not observed medication passes after the first 2 medication errors were made in

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W 104	Continued From page 13 the Hillside living unit. The DON was asked for documentation of the random medication pass observations and and retraining. When asked if she had observed any of the nurses during medication pass and had them demonstrate their ability to accurately and safely pass medications to the clients, the DON stated she had done medication pass observations from across the room when the nurses were not aware she was observing. She stated an inservice was provided to the nurses in March 2009. When asked for documentation of any retraining provided to the LPN's who had made medication errors in the past 4 months, the DON was unable to provide the requested documentation 10. On 7/16/09 at 10:35 a.m., LPN #2, who was involved in the 2/3/09 medication error involving Client #6's medications being administered to a non-sampled client, was asked if any RN or Supervisor had observed her during medication pass. She stated she had not seen any RN/Supervisor doing any spot checks and had never been asked to demonstrate a medication pass after making the medication error on 2/3/09. She also stated the last inservice she had attended regarding medication pass was held in October or November of 2008. She stated, "We talk a little in every meeting about meds, the last time about a new med room and disciplinary action." She stated she had never had any disciplinary action taken against her. She also stated, "There is only one place there is confusion and has caused some nurses problems. You have to pass meds in the dining room and you have to have staff to help control. You can't do it alone. They need a med room." 11. On 7/16/09 at 12:50 p.m., LPN #4, who was	W 104		

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W 104	Continued From page 14 involved in the possible medication error on 6/28/09 involving Client #13 and a non-sampled client, stated she made the medication error on 6/28/09, but was not sure the affected client actually took the medications. When asked if the RN's had observed her or done any spot checks during her medication passes since that error, the LPN stated, "The RN's have come by and said 'Hi', but I didn't have any spot checks or med pass with an RN." The LPN stated it had been 2 years since anyone observed her doing a medication pass. She stated the facility had a department meeting in June 2009, but not a specific inservice regarding medication passes or medication errors. She stated she had never had disciplinary action for a medication error. The LPN also stated there was a problem in the Hillside Up living unit, "...there is no place to keep the client's back. You have to use tables in the dining room and you have to have help to keep them [the clients] back." 12. The Immediate Jeopardy was removed on 7/28/09 at 4:35 p.m. when the facility implemented the following Plan of Removal: 1.) When a medication error reported, the Client will be observed per physician's instruction. Nurse Manager, Team RN, Social Service and Psychology and Superintendent will be notified. 2.) Nurse (LPN) making the error will be removed immediately from passing medication. Nurse Manager/Designee to initiate investigation with documentation. Nurse Manager/Designee will complete a written report of incident. 3.) Nurse manger/Designee will be responsible for in-service on giving medication. Nurse will be	W 104		

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W 104	Continued From page 15 retrained for a total of eight (8) hours on Policy and Procedures. Written test upon completion of in-service. Nursing committing medication error will be monitored by Nursing Manager/Designee for a total of eight (8) hours on giving medication. 4.) Nurse (LPN) will complete a medication error form. 5.) Nurse (LPN) will be monitored weekly for a period of four (4) weeks with documentation by Nurse Manager/Designee. In-service to specifically include client identification before passing medication, controlling clients at medication passes, and acquiring assistance if needed. 6.) Nurse Manager/Designee to follow up with counseling session in one (1) month with documentation from Nurse (LPN) on what was learned from incident (medication error). 7.) Hillside House (A complex) upstairs will have split kitchen door. Medication will be passed behind that door which will separate Clients and Medication Nurse. 8.) Hillside House (A complex) downstairs will have half door to entrance of dining room. Clients will get their medications at the door. Medications are kept behind door away from Clients. B. Based on record review and interview, the facility failed to ensure direct care employees were trained on providing ongoing client protection from prolonged sun exposure for 2 (Clients #11 and #12) of 2 sampled clients who were sunburned. The failed practice resulted in Immediate Jeopardy, which caused or could have	W 104		

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caused serious harm or injury to Clients #11 and #12 and had the potential to affect 2 other clients who were utilizing the facility pool when Clients #11 and #12 were sunburned, as documented on the facility's investigation documentation dated 7/2/09 - 7/8/09. The facility was informed of the Immediate Jeopardy condition on 7/20/09 at 4:50 p.m. The findings are:

1. On 7/21/09 at 1:00 p.m., the facility policy titled, "Sunscreen for Summer Activities" was provided by the facility Superintendent. The policy documented, "...To Outline the appropriate times and situations where sunscreen should be applied to the client's exposed skin... Procedure - Sunscreen should be used during all summertime outdoor activities... Sunscreen is to be applied in the living area by the direct care staff and also by whomever is caring for that client during the outdoor activity... if they will be out more than 30 minutes... Suncreen is to be waterproof... Sunscreen is available kept in stock... Sunscreen needs to be reapplied every hour while they are participating in outdoor activities." This policy was signed by the staff physician on 7/6/09.

2. Client #11 had a diagnosis of Mental Retardation with Profound Adaptive Behaviors.

a. A Report of Incident dated 7/2/09 documented, "[Client #11] ... was at pool 06/28/09 + [and] received a sunburn (severe). Nurses notified on 7/1/09 @ [at] 1345 [1:45 p.m.] ... Client has red arms, back + shoulders. Areas on shoulders are very red [with] skin coming off. Silvadene cream applied + Motrin given already ..." AccuWeather.com documented the weather on 6/28/09 was clear and 94 degrees Fahrenheit (F.).

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b. The facility's Adult Maltreatment Investigation dated 7/2/09 through 7/8/09 and signed by the facility's Program Director documented the following:

1.) "A Medical Department Report of Incident signed by [Registered Nurse (RN) #4], and dated 7/2/09 referred to the initial nursing evaluation of sunburn to [Client #11] on 7-1-09 at 1615 [4:15 p.m.]. The report stated that [client] 'was at pool 06-28-09 and received a sunburn (severe). Nurses notified on 7-1-09 at 1345 [1:45 p.m.].' A Marks Card ... was signed by [Licensed Practical Nurse (LPN) #5], and dated 7-1-09. The report stated an injury of known cause was blister to the shoulders and described as, 'sunburn over upper arms and chest, back and lower back' and caused by 'overexposure to sun' for which treatment was ordered ..."

2.) "[Resident Care Assistant (RCA) #2] is a direct care worker ... and was on duty at the pool on 6-28-09 between the hours of 1300 [1:00 p.m.] and 1600 [4:00 p.m.]. She stated that one of her clients asked to go swimming. She then applied sunscreen to him and took him to the pool. She did not reapply sunscreen to that client during his swimming period. She stated she called back to the living unit and asked if any other clients wished to go swimming. The LST [Life Skills Trainer] at the aide station then sent three other clients to the pool, one of whom was [Client #11]. [RCA #2] stated that it was her first time to supervise clients at the pool. She stated that since she had applied sunscreen to the client she escorted to the pool, she did not think of applying it to the other three who were sent out after she and her client went to the pool. She said she did

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not notice anyone with a sunburn at the pool. She also said, 'it didn't cross my mind' that the LST at the aid station 'hadn't applied sunscreen till that next day when the clients were burned.' It must be noted that RCA #2 was not in a location to see whether sunscreen had been applied to the other three clients."

3.) "[RCA #3] is a direct care worker ... and was on duty at the pool on 6/28/09 at approximately 1300 [1:00 p.m.] and stayed just a short while. He was designated as one of three 'qualified swimmers' on duty in the pool. He stated that he saw [Client #11] wearing a tee shirt. He also stated that [the LST in his assigned living unit], had previously instructed staff to apply sunscreen to clients prior to outdoor recreational activities. [RCA #3] stated that he became aware that [Client #11] had gotten a sunburn the next day, 6-29-09."

4.) "[Lifeguard #1] is a temporary summer worker and was on duty on 6-28-09. His function was that of a pool lifeguard. [Lifeguard] #1 stated that he did not recall any incident happening on 6-28-09 at the pool, but was told later that some clients had gotten sunburned. He stated that his supervisor told him it was not his responsibility to apply sunscreen to clients. He said he was told the clients were to have sunscreen applied before coming to the pool area... He stated he did not see sunscreen reapplied to clients while at the pool, although he was not specifically watching for such activity..."

5.) "[Resident Care Technician (RCT) #2] is a direct care worker... and was on duty at the pool on 6-28-09 from approximately 1300 to 1600... He stated he knew about the need for the use of

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sunscreen for outdoor activities, such as swimming. He also stated that he thought sunscreen was applied to clients before they left the living area."

6.) [RCA #1] is a direct care worker... and was on duty on 6-28-09. She stated that some time after 1300, she received a call to send other clients out to swim. She said she sent out three other clients, including [Client #11]. She stated that before she sent them outside, she applied sunscreen to them and had them put on tee shirts. She did not accompany the clients to the pool because she was the only one on duty at her aide station. She stated that she was aware of the need to apply sunscreen before the clients left the living area. She also stated that she knew, 'the rules that when you are out at the pool that every hour you are to put sunblock on them.' When the clients returned, she [RCA #1] noticed [Client #11] was in some discomfort. She said she checked him and 'he was burned but not bad.' She stated that because it was near the end of her shift, she did not complete a Marks Card for [Client #11] or report to the nurse."

7.) "[RCT #3] is a direct care worker... and was on duty on 6-28-09. She stated that she helped monitor clients in the pool from about 1315 [1:15 p.m.] to 1600. Of the three clients she was monitoring, she stated that she applied sunscreen to one client and supervised while the other two applied their own sunscreen in the living unit before going to the pool area. She stated that to her knowledge sunscreen application at the pool 'has always been that the person in charge of the pool, usually a recreation worker, is in charge of applying sunscreen to clients.' She stated that she did not reapply sunscreen to anyone and did

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not see anyone reapply sunscreen to anyone. She stated that she did not know who was specifically responsible for reapplying sunscreen. It should be noted that both Recreation workers had been on extended leave and neither were on duty on 6-28-09."

8.) "Synopsis: On 6/28/09, between the hours of 1:00 p.m. and 4:00 p.m., [facility] client, [Client #11] received a sunburn, which developed into blisters, while participating in swimming activities at the [facility] pool... The investigation process revealed that there was some confusion regarding specific staff responsibility in assuring that [Client #11] had sunscreen applied at intervals which would reduce the likelihood of him being sunburned if exposed to the sun for a prolonged period of time... Interviews and written statements indicated that he [Client #11] did indeed receive sunscreen prior to leaving his living area. However, after looking at the included information, there was no clear procedure as to who was responsible to see that after each hour of exposure sunscreen was reapplied..."

c. The facility's Adult Maltreatment Investigation dated 7/2/09 through 7/8/09 also included a statement signed by the facility's Chief Psychologist, which documented, "...Most staff appear to be generally aware of the need for clients to receive sunscreen application prior to outdoor leisure activities, such as swimming... Most staff appear to be generally unsure about whose responsibility it was to reapply sunscreen at pool."

d. A typed statement dated 7/8/09 and signed by the DON documented, "On 7/2/09 [Client #11] was brought over to Sick Call for his sunburn to

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be rechecked. At that time I noted his shoulders to have large areas where the skin was stiff and brown... On 7/3/09 [Client #11] was sent to [hospital] due to having large scabbed areas where his sunburn was. Pictures were taken. The pictures of his sunburn on this day were much worse than when I saw the original sunburn due to the client's habit of picking and scratching at sores..."

e. On 7/20/09 at 4:10 p.m., RCA #1, who stated she worked with the client on 6/28/09 through 7/2/09, was interviewed by the Surveyor. She stated she saw the sunburn on the client on 6/28/09, but, " ...it wasn't that bad." She stated she did not report it to anyone. When asked if she had been trained regarding the application of sunscreen to clients during sun exposure, she stated she had not, but, "I know I always put sunscreen on the clients before going out in the sun. We recently had an inservice on using sunscreen." She also stated, "We help [Client #11] change clothing; he has to be helped."

f. On 7/20/09 at 4:15 p.m., RCA #2, who stated she worked on 6/28/09 and 6/29/09, was interviewed by the Surveyor. She stated she was told that Client #11's sunburn was, "not that bad" and she did not report it to anyone. She stated she had not had any training for use of sunscreen and, she, " ...heard there was an in-service, but I was off that day." She stated she did not see anyone reapply sunscreen to the clients on 6/28/09 and she did not know you were supposed to reapply it every hour.

3. Client #12 had a diagnosis of Profound Mental Retardation.

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a. The Incident Report dated 6/29/09 at 8:00 a.m. documented, "...Place of Incident [Facility] Outdoor Therapeutic Pool...Type of Incident sunburn with blistering to shoulders... Note: Date and Time of Incident as listed above is date/time sunburn was discovered by staff... Marks Card completed by LST [RCA #2] documents that on 6/29/09 at 6:30 p.m. that staff discovered [Client #12] to have a sunburn on his shoulders, chest and back.' Marks Card indicates [Client #12] had been swimming on 6/28/09... Marks Card completed by [LPN #6] documents that on 6/29/09 at 6:30 p.m. that [Client #12's] 'shoulders are blistered. Back and arms are very red. Top of head is lighter red.' ...Nurses Notes completed by [LPN #7], examining LPN, (6/29/09 at 6:45 p.m.), states, 'Client presents to Medical with sunburn covering all of upper torso. Blisters across shoulders. Sent to [hospital] night clinic per orders of [Staff Physician].' Medical Report of Incident describes sunburn as 'Sunburn from waist to top of head, front and back of arms. Blisters on shoulders.'..."

b. The facility's Adult Maltreatment Investigation dated 7/2/09 - 7/8/09 documented the following:

1.) "Interview with [RCA #2]... was on duty at the pool on 6/28/09 between the hours of [1:00 p.m. and 4:00 p.m.]. She stated that one of her clients asked to go swimming. She then applied sunscreen to him and took him to the pool. She did not reapply sunscreen to that client during his swimming period. She stated she called back to the living unit and asked if any other clients wished to go swimming. The LST at the aide station then sent three other clients to the pool, one of whom was [Client #12]... She stated that since she had applied sunscreen to the client she

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W 104	Continued From page 23 escorted to the pool, she did not think of applying it to the other three who were sent out..." 2.) Interview with [RCA #1]... She stated that sometime after [1:00 p.m.] she received a call to send other clients out to swim. She said she sent out three other clients, including [Client #12]. She stated that before she sent them outside, she applied sunscreen to them and had them put on tee shirts. She did not accompany the clients to the pool because she was the only one on duty at her aide station... When the clients returned she noticed [Client #12] was in some discomfort. In her written report, she said he, 'was holding up the shoulders of his shirt saying hot.' During the interview, she said the word [Client #12] used was, 'burned.' She stated that because it was near the end of her shift, she did not complete a Marks Card for [Client #12] or report to the nurse." 4. The Immediate Jeopardy was removed on 7/20/09 at 6:45 p.m. when the facility implemented the following Plan of Removal: a. Pool Hours changed to avoid swimming activities during the hottest periods of the day: From 9:00 a.m. to 11:00 a.m. to 6:30 p.m. - 8:00 p.m. Effective July 2, 2009 b. Sunscreen per physician orders, to be applied every hour while clients are participating in outdoor activities. Nurse Manager will in-service all Living Area Supervisors on this order. The Director of Residential Services will follow-up weekly throughout summer months with documentation. Effective July 6, 2009. c. In-Service on Procedures of Sunscreen for	W 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G003	A. BUILDING _____ B. WING _____	C 07/28/2009

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W 104	Continued From page 24 Summer Activities: All direct care staff will be in-serviced in the appropriate times and situations where sunscreen should be applied to clients exposed skin areas. Training for new hires will be completed during Phase (training classes for new hires) classes. Monthly in-service of all staff will be done until pool closing. The Director of Residential Services will follow-up, evaluate and perform pool checks with results documented; and Quality Assurance [QA] Coordinator will do monthly follow-up. Effective July 21, 2009 d. Application of Sunscreen at Pool: Sunscreen to be applied by Direct Care Staff every hour by the Pool Supervisor and/or designee. Pool supervisors will be in-serviced on procedure of Sunscreen for Summer Activities. Pool Supervisors will do follow-up and monitor on a daily basis with documentation. The Director of Residential Services will do over-all evaluations and follow-up weekly with documentation; and Quality Assurance Coordinator will discuss monthly meeting and follow-up. Effective July 21, 2009. e. In-Service Training: In-service will be conducted on a monthly basis to all employees and will be instituted in Phase classes to all new hires for all reporting of any incidents or injuries. In-service will be monthly for all current employees. The Director of Staff Development, the Director of Residential Services, the Quality Assurance Coordinator and the Nurse Manager will be responsible collectively for follow-up and evaluation with documentation to be discussed monthly. The Nurse Manager or designee will monitor every 8 hours for 72 hours and document. This will be added to the daily 24 hour report which will be sent to the Nurse Manager for	W 104		

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W 104	Continued From page 25 review then forwarded to the Superintendent. The Superintendent is to be notified immediately of any incidents regarding clients. Effective July 21, 2009. f. A mandatory, daily staff meeting will be held in a designated location with the Team Leaders (3), Living area Supervisors and a designated nurse. These meetings will be documented by content and attendance and will be based on a 24 hour period. Daily reports will be forwarded to the Superintendent's attention. Residential Services Director will conduct weekly follow up meetings. Monthly reports will be sent to the QA coordinator for review. Effective date: Memo sent 7/21/09 with first meeting to be conducted the morning of 7/22/09 and subsequently thereafter on a daily basis.	W 104		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Complaint #14720 was substantiated (all or in part) with these findings. Based on record review and interview, the facility failed to meet the requirements of the Condition of Participation for Health Care Services, as evidenced by the facility's failure to ensure direct care employees were trained on providing ongoing client protection from prolonged sun exposure for 2 (Clients #11 and #12) of 2 sampled clients who were sunburned and failure to ensure a system was developed and implemented to ensure accurate and safe	W 318		

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W 318	Continued From page 26 medication administration in accordance with the physician order for Client #2. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Client #2, who required an emergent hospitalization after receiving another client's medications and to Clients #11 and #12, who sustained first or second degree burns which were not promptly identified and treated after staff failed to reapply sunscreen during prolonged sun exposure. The facility was informed of the Immediate Jeopardy condition regarding the medication administration failures on 7/28/09 at 2:40 p.m. and regarding the failure to protect clients from prolonged sun exposure and provide immediate treatment for a severe sunburn on 7/20/09 at 4:50 p.m. The findings are: 1. The facility failed to meet the Standard of Nursing Services (W331) as evidenced by failure to ensure clients received adequate monitoring, evaluation, preventative services and prompt treatment for 2 (Clients #11 and #12) of 2 sampled clients who were sunburned after direct care staff failed to provide ongoing protection from prolonged sun exposure. Clients #11 and #12 had first or second degree burns which were not promptly identified, monitored and treated and did not receive services indicated to prevent a severe sunburn while at the swimming pool. The facility also failed to ensure new onset pain was promptly evaluated and treated by the nursing staff for Client #4, who complained of left side pain for a period of approximately 3 weeks before diagnostic services determined the presence of multiple rib fractures. The failed practices resulted in Immediate Jeopardy to Clients #11, #12 and #2 - Refer to W331.	W 318		

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W 318	Continued From page 27 2. The facility failed to ensure direct care employees were trained on providing ongoing client protection from prolonged sun exposure for Clients #11 and #12, who sustained first or second degree burns when direct care staff failed to reapply sunscreen during prolonged sun exposure at the facility swimming pool. The failed practices resulted in Immediate Jeopardy to Clients #11 and #12 - Refer to W342. 3. The facility failed to ensure a system was developed and implemented to ensure accurate and safe medication administration in accordance with the physician order for Client #2. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Client #2, who required an emergent hospitalization after receiving another client's medications - Refer to W368. 4. The Immediate Jeopardy regarding the facility's medication administration failures was removed on 7/28/09 at 2:40 p.m. when the facility implemented the following Plan of Removal: a. When a medication error reported, the Client will be observed per physician's instruction. Nurse Manager, Team RN, Social Service and Psychology and Superintendent will be notified. b. Nurse (LPN) making the error will be removed immediately from passing medication. Nurse Manager/Designee to initiate investigation with documentation. Nurse Manager/Designee will complete a written report of incident. c. Nurse manger/Designee will be responsible for in-service on giving medication. Nurse will be retrained for a total of eight (8) hours on Policy	W 318		

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W 318	Continued From page 28 and Procedures. Written test upon completion of in-service. Nursing committing medication error will be monitored by Nursing Manager/Designee for a total of eight (8) hours on giving medication. d. Nurse (LPN) will complete a medication error form. e. Nurse (LPN) will be monitored weekly for a period of four (4) weeks with documentation by Nurse Manager/Designee. In-service to specifically include client identification before passing medication, controlling clients at medication passes, and acquiring assistance if needed. f. Nurse Manager/Designee to follow up with counseling session in one (1) month with documentation from Nurse (LPN) on what was learned from incident (medication error). g. Hillside House (A complex) upstairs will have split kitchen door. Medication will be passed behind that door which will separate Clients and Medication Nurse. h. Hillside House (A complex) downstairs will have half door to entrance of dining room. Clients will get their medications at the door. Medications are kept behind door away from Clients. 5. The Immediate Jeopardy regarding failure to provide protection during prolonged sun exposure and failure to provide treatment for a severe sunburn was removed on 7/20/09 at 6:45 p.m. when the facility implemented the following Plan of Removal: a. Pool Hours changed to avoid swimming	W 318		

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W 318	Continued From page 29 activities during the hottest periods of the day: From 9:00 a.m. to 11:00 a.m. to 6:30 p.m. - 8:00 p.m. Effective July 2, 2009 b. Sunscreen per physician orders, to be applied every hour while clients are participating in outdoor activities. Nurse Manager will in-service all Living Area Supervisors on this order. The Director of Residential Services will follow-up weekly throughout summer months with documentation. Effective July 6, 2009. c. In-Service on Procedures of Sunscreen for Summer Activities: All direct care staff will be in-serviced in the appropriate times and situations where sunscreen should be applied to clients exposed skin areas. Training for new hires will be completed during Phase (training classes for new hires) classes. Monthly in-service of all staff will be done until pool closing. The Director of Residential Services will follow-up, evaluate and perform pool checks with results documented; and Quality Assurance [QA] Coordinator will do monthly follow-up. Effective July 21, 2009 d. Application of Sunscreen at Pool: Sunscreen to be applied by Direct Care Staff every hour by the Pool Supervisor and/or designee. Pool supervisors will be in-serviced on procedure of Sunscreen for Summer Activities. Pool Supervisors will do follow-up and monitor on a daily basis with documentation. The Director of Residential Services will do over-all evaluations and follow-up weekly with documentation; and Quality Assurance Coordinator will discuss monthly meeting and follow-up. Effective July 21, 2009. e. In-Service Training: In-service will be	W 318		

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W 318	Continued From page 30 conducted on a monthly basis to all employees and will be instituted in Phase classes to all new hires for all reporting of any incidents or injuries. In-service will be monthly for all current employees. The Director of Staff Development, the Director of Residential Services, the Quality Assurance Coordinator and the Nurse Manager will be responsible collectively for follow-up and evaluation with documentation to be discussed monthly. The Nurse Manager or designee will monitor every 8 hours for 72 hours and document. This will be added to the daily 24 hour report which will be sent to the Nurse Manager for review then forwarded to the Superintendent. The Superintendent is to be notified immediately of any incidents regarding clients. Effective July 21, 2009. f. A mandatory, daily staff meeting will be held in a designated location with the Team Leaders (3), Living area Supervisors and a designated nurse. These meetings will be documented by content and attendance and will be based on a 24 hour period. Daily reports will be forwarded to the Superintendent's attention. Residential Services Director will conduct weekly follow up meetings. Monthly reports will be sent to the QA coordinator for review. Effective date: Memo sent 7/21/09 with first meeting to be conducted the morning of 7/22/09 and subsequently thereafter on a daily basis.	W 318		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Complaint #14720 was substantiated (all or in	W 331		

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W 331	Continued From page 31 part) with these findings. A. Based on record review and interview, the facility failed to ensure nursing staff identified and provided prompt treatment for 2 (Clients #11 and #12) of 2 sampled clients who sustained sunburns in the facility pool. The failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm or injury to Clients #11 and #12 and had the potential to affect 2 other clients who were utilizing the facility pool when Client's #11 and #12 were sunburned, as documented on the facility's investigation documentation dated 7/2/09 - 7/8/09. The facility was informed of the Immediate Jeopardy condition on 7/20/09 at 4:50 p.m. The findings are: 1. Client #11 had a diagnosis of Mental Retardation with Profound Adaptive Behaviors. a. A Report of Incident dated 7/2/09 documented, "[Client #11] ... was at pool 06/28/09 + [and] received a sunburn (severe). Nurses notified on 7/1/09 @ [at] 1345 [1:45 p.m.] ... Client has red arms, back + shoulders. Areas on shoulders are very red [with] skin coming off. Silvadene cream applied + Motrin given already ..." b. The facility's Adult Maltreatment Investigation dated 7/2/09 through 7/8/09 and signed by the facility's Program Director documented the following: 1.) "[RCA #3] is a direct care worker... and was on duty at the pool on 6/28/09 at approximately 1300 [1:00 p.m.] and stayed just a short while... [RCA #3] stated that he became aware that [Client #11] had gotten a sunburn the next day,	W 331		

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W 331	Continued From page 32 6-29-09. " 2.) "A Medical Department Report of Incident signed by [Registered Nurse (RN) #4], and dated 7/2/09 referred to the initial nursing evaluation of sunburn to [Client #11] on 7-1-09 at 1615 [4:15 p.m.]... Nurses notified on 7-1-09 at 1345 [1:45 p.m.].' A Marks Card... was signed by [Licensed Practical Nurse (LPN) #5], and dated 7-1-09. The report stated an injury of known cause was blister to the shoulders and described as, 'sunburn over upper arms and chest, back and lower back' and caused by 'overexposure to sun' for which treatment was ordered..." [This was a period of 3 days after the client was sunburned and a period of 2 days after RCA #3 became aware of the sunburn]. 3.) [RCA #1] is a direct care worker... and was on duty on 6-28-09. She stated that some time after 1300, she received a call to send other clients out to swim. She said she sent out three other clients, including [Client #11]... When the clients returned, she [RCA #1] noticed [Client #11] was in some discomfort. She said she checked him and 'he was burned but not bad.' She stated that because it was near the end of her shift, she did not complete a Marks Card for [Client #11] or report to the nurse." 4.) "Synopsis: On 6/28/09, between the hours of 1:00 p.m. and 4:00 p.m., [facility] client, [Client #11] received a sunburn, which developed into blisters, while participating in swimming activities at the [facility] pool..." c. A typed statement dated 7/8/09 and signed by the DON documented, "On 7/2/09 [Client #11] was brought over to Sick Call for his sunburn to	W 331		

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be rechecked. At that time I noted his shoulders to have large areas where the skin was stiff and brown... On 7/3/09 [Client #11] was sent to [hospital] due to having large scabbed areas where his sunburn was. Pictures were taken. The pictures of his sunburn on this day were much worse than when I saw the original sunburn due to the client's habit of picking and scratching at sores..."

d. On 7/20/09 at 4:10 p.m., RCA #1, who stated she worked with the client on 6/28/09 through 7/2/09, was interviewed by the Surveyor. She stated she saw the sunburn on the client on 6/28/09, but, "...it wasn't that bad." She stated she did not report it to anyone.

e. On 7/20/09 at 4:15 p.m., RCA #2, who stated she worked on 6/28/09 and 6/29/09, was interviewed by the Surveyor. She stated she was told that Client #11's sunburn was, "not that bad" and she did not report it to anyone.

2. Client #12 had a diagnosis of Profound Mental Retardation.

a. The Incident Report dated 6/29/09 at 8:00 a.m. documented, "...Place of Incident [Facility] Outdoor Therapeutic Pool...Type of Incident sunburn with blistering to shoulders... Note: Date and Time of Incident as listed above is date/time sunburn was discovered by staff... Marks Card completed by LST [RCA #2] documents that on 6/29/09 at 6:30 p.m. that staff discovered [Client #12] to have a sunburn on his shoulders, chest and back.' Marks Card indicates [Client #12] had been swimming on 6/28/09... Marks Card completed by [LPN #6] documents that on 6/29/09 at 6:30 p.m. that [Client #12's] 'shoulders

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are blistered. Back and arms are very red. Top of head is lighter red.' ...Nurses Notes completed by [LPN #7], examining LPN, (6/29/09 at 6:45 p.m.), states, 'Client presents to Medical with sunburn covering all of upper torso. Blisters across shoulders. Sent to [hospital] night clinic per orders of [Staff Physician].' Medical Report of Incident describes sunburn as 'Sunburn from waist to top of head, front and back of arms. Blisters on shoulders.'..."

b. The facility's Adult Maltreatment Investigation dated 7/2/09 - 7/8/09 documented the following:

1.) "Interview with [RCA #2]... was on duty at the pool on 6/28/09 between the hours of [1:00 p.m. and 4:00 p.m.]. She stated that one of her clients asked to go swimming. She then applied sunscreen to him and took him to the pool. She did not reapply sunscreen to that client during his swimming period. She stated she called back to the living unit and asked if any other clients wished to go swimming. The LST at the aide station then sent three other clients to the pool, one of whom was [Client #12]... She stated that since she had applied sunscreen to the client she escorted to the pool, she did not think of applying it to the other three who were sent out..."

2.) Interview with [RCA #1]... She stated that sometime after [1:00 p.m.] she received a call to send other clients out to swim. She said she sent out three other clients, including [Client #12]. She stated that before she sent them outside, she applied sunscreen to them and had them put on tee shirts. She did not accompany the clients to the pool because she was the only one on duty at her aide station... When the clients returned she noticed [Client #12] was in some discomfort. In

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her written report, she said he, 'was holding up the shoulders of his shirt saying hot.' During the interview, she said the word [Client #12] used was, 'burned.' She stated that because it was near the end of her shift, she did not complete a Marks Card for [Client #12] or report to the nurse."

3. The Immediate Jeopardy was removed on 7/20/09 at 6:45 p.m. when the facility implemented the following Plan of Removal:

1.) Pool Hours changed to avoid swimming activities during the hottest periods of the day: From 9:00 a.m. to 11:00 a.m. to 6:30 p.m. - 8:00 p.m. Effective July 2, 2009

2.) Sunscreen per physician orders, to be applied every hour while clients are participating in outdoor activities. Nurse Manager will in-service all Living Area Supervisors on this order. The Director of Residential Services will follow-up weekly throughout summer months with documentation. Effective July 6, 2009.

3.) In-Service on Procedures of Sunscreen for Summer Activities: All direct care staff will be in-serviced in the appropriate times and situations where sunscreen should be applied to clients exposed skin areas. Training for new hires will be completed during Phase (training classes for new hires) classes. Monthly in-service of all staff will be done until pool closing. The Director of Residential Services will follow-up, evaluate and perform pool checks with results documented; and Quality Assurance [QA] Coordinator will do monthly follow-up. Effective July 21, 2009

4.) Application of Sunscreen at Pool: Sunscreen

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W 331	Continued From page 36 to be applied by Direct Care Staff every hour by the Pool Supervisor and/or designee. Pool supervisors will be in-serviced on procedure of Sunscreen for Summer Activities. Pool Supervisors will do follow-up and monitor on a daily basis with documentation. The Director of Residential Services will do over-all evaluations and follow-up weekly with documentation; and Quality Assurance Coordinator will discuss monthly meeting and follow-up. Effective July 21, 2009. 5.) In-Service Training: In-service will be conducted on a monthly basis to all employees and will be instituted in Phase classes to all new hires for all reporting of any incidents or injuries. In-service will be monthly for all current employees. The Director of Staff Development, the Director of Residential Services, the Quality Assurance Coordinator and the Nurse Manager will be responsible collectively for follow-up and evaluation with documentation to be discussed monthly. The Nurse Manager or designee will monitor every 8 hours for 72 hours and document. This will be added to the daily 24 hour report which will be sent to the Nurse Manager for review then forwarded to the Superintendent. The Superintendent is to be notified immediately of any incidents regarding clients. Effective July 21, 2009. 6.) A mandatory, daily staff meeting will be held in a designated location with the Team Leaders (3), Living area Supervisors and a designated nurse. These meetings will be documented by content and attendance and will be based on a 24 hour period. Daily reports will be forwarded to the Superintendent's attention. Residential Services Director will conduct weekly follow up meetings.	W 331		

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Monthly reports will be sent to the QA coordinator for review. Effective date: Memo sent 7/21/09 with first meeting to be conducted the morning of 7/22/09 and subsequently thereafter on a daily basis.

B. Based on record review and interview, the facility failed to ensure new onset pain was promptly evaluated and treated by the nursing staff for 1 (Client #4) of 1 sampled client with new onset pain complaints in the past 3 months. The client complained of left side pain for a period of approximately 3 weeks before diagnostic services determined the presence of multiple rib fractures. The findings are:

Client #4 had a diagnosis of Moderate Mental Retardation.

a. A Report of Incident dated 4/18/09 at 4:00 p.m. documented an altercation occurred involving Client #4 and Client #1, in which Client #1 was hit by a chair. No further physical altercations were documented for Client #4 between 4/18/09 and 5/6/09.

b. Nurses Notes dated 5/6/09 at 8:40 a.m. documented, "C/O [complained of L [left] waist pain, area soft, no c/o pain during palpation... No red areas or swelling - Gave 400 mg [milligrams] Ibuprofen... Marks Card done... 940 [9:40 a.m.] no further c/o - med helped." There was no documentation the physician was consulted regarding the new complaint of pain or of further nursing assessments/evaluations to determine the cause of the pain.

c. Nurses Notes dated 5/17/09 at 3:45 p.m. documented the client complained of, "...pain on

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the left side above hip area. Was hit in the side by another client. [No] marks were found. [No] swelling or redness noted. Marks Card, Notifications, Pictures and Reports made." The Report of Incident dated 5/17/09 at 3:45 p.m. documented, "c/o pain to left side above hip because another client in his area [Client #1] hit him with a boot..."

d. A Report of Incident dated 5/18/09 at 2:10 a.m. documented the client again complained of left side pain and, "...states another client [Client #1] pushed him down. Fresh bruise to left hip and bruise to left rib cage (older)." The Nurses Note for this incident was dated 5/18/09 at 2:20 a.m. and documented, "c/o L side pain. 3 in [3-inch] bruise found on ribs under his arm. This mark is starting to fade. 1 1/2 in [One and one-half inch] fresh bruise found on L hip area. Client states he was pushed down by [Client #1]. Client given ii [two] APAP [acetaminophen] 325 mg for discomfort..." There was no documentation of further evaluation of the injuries until 5/20/09.

e. Nurses Notes dated 5/20/09 at 3:00 a.m. documented, "Complaints of L side rib pain - Medicated with Ibuprofen tab 2 [2 tablets] - Ambulates very slow." A physician order dated 5/20/09 at 1:00 p.m. documented, "Motrin 400 mg three times a day for 3 days."

f. Nurses Notes dated 5/20/09 at 7:15 a.m. documented, "...complaint of rib pain... Tylenol 325 mg." The next documentation in the Nurses Notes was dated 5/28/09.

g. A Behavior Report dated 5/27/09 at 6:00 a.m. documented, "[Client #4] has continually

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complained about his side for roughly 2 weeks and continued to complain today. I think it may be more than a psychosomatic and recommend he be checked out by Nursing."

h. A physician order dated 5/27/09 at 1:30 p.m. documented, "Motrin 400 mg three times a day for 3 days."

i. Nurses Notes dated 5/28/09 at 7:05 a.m. documented the client complained of falling and, "...unable to understand when the client fell due to garbled speech... slight discoloration noted to upper mid back, left side and upper left hip. No treatment needed at this time... Has been started this a.m. [morning] - Motrin 400 for pain three times a day for 3 days due to complaints of pain this week."

j. A Medical Imaging Consultation Report dated 5/29/09 documented, "History: Left sided chest wall pain. Chest for rib detail with emphasis on the left rib cage: There are no previous studies available for comparison... There is a moderate pleural effusion in the left lung base with some focal atelectatic or infiltrative change in the left infrahilar region. There are displaced fractures of the left fifth, sixth and seventh ribs in the mid axillary line... Additionally, there is thought to be a small pneumothorax estimated at 10% or less in the left apical region..."

k. A physician order dated 6/4/09 documented, "...Concern - pneumothorax, left side... Tylenol three times a day for 5 days."

l. A Computed Tomography (CT) Report dated 6/5/09 documented, "CT Chest with contrast... Reason: left side and chest pain... abnormal x-ray

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W 331	Continued From page 40 (05/29/09)... Findings: no definite pneumothorax... comminuted fractures of the lateral aspect of the left sixth, seventh, eighth and ninth ribs. Healing change of a medical posterior left tenth rib fracture. Some of these rib fractures laterally are more acute in appearance. Could also be subacute within a few weeks old..." m. On 7/21/09 at 9:50 a.m., the Director of Nursing (DON) was asked about the altercation between Clients #1 and #4 on 5/17/09 which involved Client #1 hitting Client #4 with a boot. When asked why it took so long to get Client #4 to the hospital, the DON stated the physician had checked the client several times and after the client failed to improve, the physician ordered the transfer to the hospital. n. On 7/21/09 at 12:50 p.m., the DON and Administrator were asked how Client #4 sustained the rib fractures. Both stated they did not know. When asked why the client's injuries were not evaluated when he continued to complain of pain, the DON and Administrator both stated they did not know why there was no follow-up and the Administrator stated, "People don't pay attention."	W 331		
W 342	483.460(c)(5)(iii) 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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.	W 342		

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W 342	Continued From page 41 This STANDARD is not met as evidenced by: Complaint #14720 was substantiated (all or in part) with these findings. Based on record review and interview, the facility failed to ensure direct care employees were trained on providing ongoing client protection from prolonged sun exposure for 2 (Clients #11 and #12) of 2 sampled clients who were sunburned. The failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm or injury to Clients #11 and #12 and had the potential to affect 2 other clients who were utilizing the facility pool when Client's #11 and #12 were sunburned, as documented on the facility's investigation documentation dated 7/1/09. The facility was informed of the Immediate Jeopardy condition on 7/20/09 at 4:50 p.m. The findings are: 1. On 7/21/09 at 1:00 p.m., policy titled, "Sunscreen for Summer Activities" was provided by the facility Superintendent. The policy documented, "...To Outline the appropriate times and situations where sunscreen should be applied to the client's exposed skin... Procedure - Sunscreen should be used during all summertime outdoor activities... Sunscreen is to be applied in the living area by the direct care staff and also by whomever is caring for that client during the outdoor activity... if they will be out more than 30 minutes... Suncreen is to be waterproof... Sunscreen is available kept in stock... Sunscreen needs to be reapplied every hour while they are participating in outdoor activities." This policy was signed by the staff physician on 7/6/09. 2. Client #11 had a diagnosis of Mental Retardation with Profound Adaptive Behaviors.	W 342		

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W 342	Continued From page 42 a. A Report of Incident dated 7/2/09 documented, "[Client #11] ... was at pool 06/28/09 + [and] received a sunburn (severe). Nurses notified on 7/1/09 @ [at] 1345 [1:45 p.m.] ... Client has red arms, back + shoulders. Areas on shoulders are very red [with] skin coming off. Silvadene cream applied + Motrin given already ..." AccuWeather.com documented the weather on 6/28/09 was clear and 94 degrees Fahrenheit (F.). b. The facility's Adult Maltreatment Investigation dated 7/2/09 through 7/8/09 and signed by the facility's Program Director documented the following: 1.) "A Medical Department Report of Incident signed by [Registered Nurse (RN) #4], and dated 7/2/09 referred to the initial nursing evaluation of sunburn to [Client #11] on 7-1-09 at 1615 [4:15 p.m.]. The report stated that [client] 'was at pool 06-28-09 and received a sunburn (severe). Nurses notified on 7-1-09 at 1345 [1:45 p.m.].' A Marks Card ... was signed by [Licensed Practical Nurse (LPN) #5], and dated 7-1-09. The report stated an injury of known cause was blister to the shoulders and described as, 'sunburn over upper arms and chest, back and lower back' and caused by 'overexposure to sun' for which treatment was ordered ..." 2.) "[Resident Care Assistant (RCA) #2] is a direct care worker ... and was on duty at the pool on 6-28-09 between the hours of 1300 [1:00 p.m.] and 1600 [4:00 p.m.]. She stated that one of her clients asked to go swimming. She then applied sunscreen to him and took him to the pool. She did not reapply sunscreen to that client during his	W 342		

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swimming period. She stated she called back to the living unit and asked if any other clients wished to go swimming. The LST [Life Skills Trainer] at the aide station then sent three other clients to the pool, one of whom was [Client #11]. [RCA #2] stated that it was her first time to supervise clients at the pool. She stated that since she had applied sunscreen to the client she escorted to the pool, she did not think of applying it to the other three who were sent out after she and her client went to the pool. She said she did not notice anyone with a sunburn at the pool. She also said, 'it didn't cross my mind' that the LST at the aid station 'hadn't applied sunscreen till that next day when the clients were burned.' It must be noted that RCA #2 was not in a location to see whether sunscreen had been applied to the other three clients."

3.) "[RCA #3] is a direct care worker ... and was on duty at the pool on 6/28/09 at approximately 1300 [1:00 p.m.] and stayed just a short while. He was designated as one of three 'qualified swimmers' on duty in the pool. He stated that he saw [Client #11] wearing a tee shirt. He also stated that [the LST in his assigned living unit], had previously instructed staff to apply sunscreen to clients prior to outdoor recreational activities. [RCA #3] stated that he became aware that [Client #11] had gotten a sunburn the next day, 6-29-09.

4.) [Lifeguard #1] is a temporary summer worker and was on duty on 6-28-09. His function was that of a pool lifeguard. [Lifeguard] #1 stated that he did not recall any incident happening on 6-28-09 at the pool, but was told later that some clients had gotten sunburned. He stated that his supervisor told him it was not his responsibility to

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W 342	Continued From page 44 apply sunscreen to clients. He said he was told the clients were to have sunscreen applied before coming to the pool area ... He stated he did not see sunscreen reapplied to clients while at the pool, although he was not specifically watching for such activity ..." 5.) [Resident Care Technician (RCT) #2] is a direct care worker ... and was on duty at the pool on 6-28-09 from approximately 1300 to 1600 ... He stated he knew about the need for the use of sunscreen for outdoor activities, such as swimming. He also stated that he thought sunscreen was applied to clients before they left the living area." 6.) [RCA #1] is a direct care worker ... and was on duty on 6-28-09. She stated that some time after 1300, she received a call to send other clients out to swim. She said she sent out three other clients, including [Client #11]. She stated that before she sent them outside, she applied sunscreen to them and had them put on tee shirts. She did not accompany the clients to the pool because she was the only one on duty at her aide station. She stated that she was aware of the need to apply sunscreen before the clients left the living area. She also stated that she knew, 'the rules that when you are out at the pool that every hour you are to put sunblock on them.' When the clients returned, she [RCA #1] noticed [Client #11] was in some discomfort. She said she checked him and 'he was burned but not bad.' She stated that because it was near the end of her shift, she did not complete a Marks Card for [Client #11] or report to the nurse." 7.) "[RCT #3] is a direct care worker... and was on duty on 6-28-09. She stated that she helped	W 342		

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W 342	Continued From page 45 monitor clients in the pool from about 1315 [1:15 p.m.] to 1600. Of the three clients she was monitoring, she stated that she applied sunscreen to one client and supervised while the other two applied their own sunscreen in the living unit before going to the pool area. She stated that to her knowledge sunscreen application at the pool 'has always been that the person in charge of the pool, usually a recreation worker, is in charge of applying sunscreen to clients.' She stated that she did not reapply sunscreen to anyone and did not see anyone reapply sunscreen to anyone. She stated that she did not know who was specifically responsible for reapplying sunscreen. It should be noted that both Recreation workers had been on extended leave and neither were on duty on 6-28-09." 8.) "Synopsis: On 6/28/09, between the hours of 1:00 p.m. and 4:00 p.m., [facility] client, [Client #11] received a sunburn, which developed into blisters, while participating in swimming activities at the [facility] pool... The investigation process revealed that there was some confusion regarding specific staff responsibility in assuring that [Client #11] had sunscreen applied at intervals which would reduce the likelihood of him being sunburned if exposed to the sun for a prolonged period of time... Interviews and written statements indicated that he [Client #11] did indeed receive sunscreen prior to leaving his living area. However, after looking at the included information, there was no clear procedure as to who was responsible to see that after each hour of exposure sunscreen was reapplied..." c. The facility's Adult Maltreatment Investigation dated 7/2/09 through 7/8/09 also included a statement signed by the facility's Chief	W 342		

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W 342	Continued From page 46 Psychologist, which documented, "...Most staff appear to be generally aware of the need for clients to receive sunscreen application prior to outdoor leisure activities, such as swimming... Most staff appear to be generally unsure about whose responsibility it was to reapply sunscreen at pool." d. A typed statement dated 7/8/09 and signed by the DON documented, "On 7/2/09 [Client #11] was brought over to Sick Call for his sunburn to be rechecked. At that time I noted his shoulders to have large areas where the skin was stiff and brown... On 7/3/09 [Client #11] was sent to [hospital] due to having large scabbed areas where his sunburn was. Pictures were taken. The pictures of his sunburn on this day were much worse than when I saw the original sunburn due to the client's habit of picking and scratching at sores..." e. On 7/20/09 at 4:10 p.m., RCA #1, who stated she worked with the client on 6/28/09 through 7/2/09, was interviewed by the Surveyor. She stated she saw the sunburn on the client on 6/28/09, but, " ...it wasn't that bad." She stated she did not report it to anyone. When asked if she had been trained regarding the application of sunscreen to clients during sun exposure, she stated she had not, but, "I know I always put sunscreen on the clients before going out in the sun. We recently had an inservice on using sunscreen." She also stated, "We help [Client #11] change clothing; he has to be helped." f. On 7/20/09 at 4:15 p.m., RCA #2, who stated she worked on 6/28/09 and 6/29/09, was interviewed by the Surveyor. She stated she was told that Client #11's sunburn was, "not that bad"	W 342		

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and she did not report it to anyone. She stated she had not had any training for use of sunscreen and, she, " ...heard there was an in-service, but I was off that day." She stated she did not see anyone reapply sunscreen to the clients on 6/28/09 and she did not know you were supposed to reapply it every hour.

3. Client #12 had a diagnosis of Profound Mental Retardation.

a. The Incident Report dated 6/29/09 at 8:00 a.m. documented, "...Place of Incident [Facility] Outdoor Therapeutic Pool...Type of Incident sunburn with blistering to shoulders... Note: Date and Time of Incident as listed above is date/time sunburn was discovered by staff... Marks Card completed by LST [RCA #2] documents that on 6/29/09 at 6:30 p.m. that staff discovered [Client #12] to have a sunburn on his shoulders, chest and back.' Marks Card indicates [Client #12] had been swimming on 6/28/09... Marks Card completed by [LPN #6] documents that on 6/29/09 at 6:30 p.m. that [Client #12's] 'shoulders are blistered. Back and arms are very red. Top of head is lighter red.' ...Nurses Notes completed by [LPN #7], examining LPN, (6/29/09 at 6:45 p.m.), states, 'Client presents to Medical with sunburn covering all of upper torso. Blisters across shoulders. Sent to [hospital] night clinic per orders of [Staff Physician].' Medical Report of Incident describes sunburn as 'Sunburn from waist to top of head, front and back of arms. Blisters on shoulders.'..."

b. The facility's Adult Maltreatment Investigation dated 7/2/09 - 7/8/09 documented the following:

1.) "Interview with [RCA #2]... was on duty at the

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W 342	Continued From page 48 pool on 6/28/09 between the hours of [1:00 p.m. and 4:00 p.m.]. She stated that one of her clients asked to go swimming. She then applied sunscreen to him and took him to the pool. She did not reapply sunscreen to that client during his swimming period. She stated she called back to the living unit and asked if any other clients wished to go swimming. The LST at the aide station then sent three other clients to the pool, one of whom was [Client #12]... She stated that since she had applied sunscreen to the client she escorted to the pool, she did not think of applying it to the other three who were sent out..." 2.) Interview with [RCA #1]... She stated that sometime after [1:00 p.m.] she received a call to send other clients out to swim. She said she sent out three other clients, including [Client #12]. She stated that before she sent them outside, she applied sunscreen to them and had them put on tee shirts. She did not accompany the clients to the pool because she was the only one on duty at her aide station... When the clients returned she noticed [Client #12] was in some discomfort. In her written report, she said he, 'was holding up the shoulders of his shirt saying hot.' During the interview, she said the word [Client #12] used was, 'burned.' She stated that because it was near the end of her shift, she did not complete a Marks Card for [Client #12] or report to the nurse." 4. The Immediate Jeopardy was removed on 7/20/09 at 6:45 p.m. when the facility implemented the following Plan of Removal: a. Pool Hours changed to avoid swimming activities during the hottest periods of the day: From 9:00 a.m. to 11:00 a.m. to 6:30 p.m. - 8:00	W 342		

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W 342	Continued From page 49 p.m. Effective July 2, 2009 b. Sunscreen per physician orders, to be applied every hour while clients are participating in outdoor activities. Nurse Manager will in-service all Living Area Supervisors on this order. The Director of Residential Services will follow-up weekly throughout summer months with documentation. Effective July 6, 2009. c. In-Service on Procedures of Sunscreen for Summer Activities: All direct care staff will be in-serviced in the appropriate times and situations where sunscreen should be applied to clients exposed skin areas. Training for new hires will be completed during Phase (training classes for new hires) classes. Monthly in-service of all staff will be done until pool closing. The Director of Residential Services will follow-up, evaluate and perform pool checks with results documented; and Quality Assurance [QA] Coordinator will do monthly follow-up. Effective July 21, 2009 d. Application of Sunscreen at Pool: Sunscreen to be applied by Direct Care Staff every hour by the Pool Supervisor and/or designee. Pool supervisors will be in-serviced on procedure of Sunscreen for Summer Activities. Pool Supervisors will do follow-up and monitor on a daily basis with documentation. The Director of Residential Services will do over-all evaluations and follow-up weekly with documentation; and Quality Assurance Coordinator will discuss monthly meeting and follow-up. Effective July 21, 2009. e. In-Service Training: In-service will be conducted on a monthly basis to all employees and will be instituted in Phase classes to all new	W 342		

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W 342	Continued From page 50 hires for all reporting of any incidents or injuries. In-service will be monthly for all current employees. The Director of Staff Development, the Director of Residential Services, the Quality Assurance Coordinator and the Nurse Manager will be responsible collectively for follow-up and evaluation with documentation to be discussed monthly. The Nurse Manager or designee will monitor every 8 hours for 72 hours and document. This will be added to the daily 24 hour report which will be sent to the Nurse Manager for review then forwarded to the Superintendent. The Superintendent is to be notified immediately of any incidents regarding clients. Effective July 21, 2009. f. A mandatory, daily staff meeting will be held in a designated location with the Team Leaders (3), Living area Supervisors and a designated nurse. These meetings will be documented by content and attendance and will be based on a 24 hour period. Daily reports will be forwarded to the Superintendent's attention. Residential Services Director will conduct weekly follow up meetings. Monthly reports will be sent to the QA coordinator for review. Effective date: Memo sent 7/21/09 with first meeting to be conducted the morning of 7/22/09 and subsequently thereafter on a daily basis.	W 342		
W 368	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. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a system	W 368		

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was developed and implemented to ensure accurate and safe medication administration in accordance with the physician order for 5 (Clients #2, #7, #8, #9 and #10) of 10 (Clients #1 through #10) sampled clients who received medications. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Client #2, who required an emergent hospitalization after receiving another client's medications. The facility was informed of the Immediate Jeopardy condition on 7/28/09 at 2:40 p.m. The findings are:

1. A Medication Incident Report dated 2/3/09 documented a medication error in which Client #6's medications were mistakenly administered to a non-sampled client by Licensed Practical Nurse (LPN) #2. LPN #2's statement documented, "Gave [non-sampled client] meds that were [Client #6's] meds. I thought she said her name was [Client #6] but her speech is impaired..." The Counseling Note at the bottom of the report was signed by Registered Nurse (RN) #3 and documented, "Use more caution when administering meds making sure the right patient gets the right medication @ [at] the right time."

2. A Medication Incident Report dated 2/24/09 documented medication errors involving 2 clients (Clients #7 and #8). LPN #1's statement documented, "Before I was ready to start med pass, two clients [Clients #7 and #8] rushed up to med table at the same time + [and] grabbed meds out of the box + swallowed them while LST's [Life Skills Trainers] were controlling the rest of client population..." The Counseling Note at the bottom of this report was dated 2/25/09, signed by RN #1 and documented, "Discussed

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W 368	Continued From page 52 what could have been done differently. Instructed to always have meds kept away from where clients can reach them, even if med pass has not begun." 3. The facility's March 2009, "Medication and Administration and Documentation Inservice," provided by the DON on 7/16/09, documented, "Prior to the administration of each client's medications, the nurse will consult the MAR [Medication Administration Record] and the picture of the client to ensure that the client is receiving the proper medications. In the areas where there is no med room, the MAR must be taken to the area and used to identify the client and the medications..." 4. A Medication Incident Report dated 3/4/09 documented another medication error made by LPN #1. LPN #1's statement documented, "LPN reached in and handed client [Client #9] wrong med cup." The Counseling Note dated 3/5/09 and signed by RN #2 documented, "Discussed Nurse's responsibility to maintain control of med pass; the client's right to receive the correct meds, and way to prevent med error in the future. Slow down and maintain control." 5. A Medication Incident Report dated 3/16/09 documented a medication error was made by LPN #3. LPN #3's statement documented, "I misread client's [Client #10's] last name and gave her the wrong meds in error." The Counseling Note dated 3/17/09 and signed by RN #2 documented, "Be more observant at med pass. State client's name before giving meds. Take your time during med pass, be in control of your med pass."	W 368		

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W 368	Continued From page 53 6. Client #2 had a diagnosis of Profound Mental Retardation. a. The May 2009 Physician Orders sheet documented the client's routine medications included Fortical nasal spray, Divalproex Sodium, Fluoxetine, Seroquel, Zetia, Calcium Carbonate with Vitamin D and Gemfibrozil. b. A Medication Incident Report dated 5/8/09 at 7:00 p.m. documented another medication error by LPN #1. LPN #1's statement documented, "I was passing meds, pouring drinks and trying to control the population. I thought I had it all under control. I handed [Client #2] [Client #7's] meds and knew immediately what I had done, but [Client #2] wouldn't give them back and he took them." 1.) Nurses Notes dated 5/8/09 at 6:00 p.m. documented, "Client took another clients meds." The Incident Report of the same date documented LPN #1 gave the client the wrong medications and, "Notified [Physician #1], orders received to keep client in observation till 2200 [10:00 p.m.], at 2000 [8:00 p.m.] vital signs [decreased] dropping... called [Physician #1]... orders to send client to [Hospital #1] Emergency Room for A/E [assessment and evaluation]. At 2100 [9:00 p.m.] [Physician #2] at ER [Emergency Room] report patient will stay in ER for 2 hours and then go to Hospital for observation with tentative release in a.m. [morning]." 2) A Counseling Note dated 5/9/09 documented Registered Nurse (RN) #1 met with LPN #1, "...to discuss the medication error she made the night before and the serious effects the error is having on the client, [LPN #1] informed me she had	W 368		

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turned in her resignation effective immediately... and [LPN #1] stated having to pass medications was making her too nervous... Effective this date, 05/09/09 [LPN #1] is no longer a [facility] employee." There was no documentation of further observations of medication pass or additional training for other nurses who passed medications in the facility.

c. Nurses Notes dated 5/9/09 at 1:20 a.m. documented, "[Hospital #1] called to get client's last sodium. Called sodium 132 to ER Nurse. They are shipping him to [Hospital #2] due to B/P [blood pressure] still low & [and] pulse ox [blood oxygen saturation] [decreased]..."

d. The History and Physical dated 5/9/09 at 5:53 a.m. from Hospital #2 documented, "This is a transfer from [Hospital #1] for hypoxia, hypertension, and clozapine overdose. Chief Complaint: Altered mental Status. History of present Illness: [Client #2] is a resident of [facility] for Mentally Retarded people who was found to be in an altered mental status around 8 p.m. It happened that the patient was given another patient's medications by mistake... Clozapine... 750 mg [milligrams] at 7 p.m. also Depakote ER [extended release]... 1,000 mg. at 7 p.m... The patient was lethargic, unresponsive, hypotensive in 70 to 80 systolic, and hypoxic in the 80's pulse oximetry saturation so he was sent to [Hospital #1]... He was found to be hypotensive, given 500 cc [cubic centimeter] bolus of fluids, was hypoxic, given Lasix and started on dopamine drip titrated up to 20 microgram per kilogram per hour and that hardly brought his blood pressure to 90's systolic... In the emergency room, he gave 300 cc of urine over 3 hours. [Physician at Hospital #1] then called [Physician at Hospital #2] to transfer

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W 368	Continued From page 55 the patient to a higher level of care. When the patient arrived to [Hospital #2], he was still unarouseable, was moaning, but not responding to verbal stimuli and hardly responding to painful stimuli. His blood pressure was in the 80's over 40's... [Physician at Hospital #2] called [facility] for complete medical records to be faxed to the ICU [Intensive Care Unit]. Family were notified and are on their way... Physical Examination: ...Pupils are narrow, 2 millimeters, equal and nonreactive... The patient is lethargic, responsive only to central painful stimuli, moaning... Assessment and Plan: ...Drug overdose, clozapine overdose and Depakote overdose. Poison Control Center was called and this case discussed with them in detail. No antidote for either [drug]. Side effects of clozapine may include hypotension and hypoxia. We have to watch for agranulocytosis [failure of the bone marrow to produce sufficient white blood cells - may increase risk of infection] once to twice a week after this dose and also watch for LFT's [liver function tests]..." Based on the documentation from Hospital #2, Client #2, who had not previously received Clozapine as a routine medication, was administered 750 mg of Clozapine in error. The manufacturer's prescribing information for Clozaril documented, "Because of a significant risk of agranulocytosis, a potentially life threatening adverse event, Clozapine should be reserved for use in severely ill Schizophrenic patients who fail to show an acceptable response to adequate courses of standard antipsychotic drug treatment... Seizures have been associated with the use of Clozapine... It is recommended that treatment with Clozaril begin with one-half of a 25 mg tablet once or twice daily. Subsequent dosage increments should be made no more than once or	W 368		

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twice weekly, in increments not to exceed 100 mg. Cautious titration and a divided dosage schedule are necessary to minimize the risks of hypotension, seizure, and sedation."
e. The Discharge Summary dated 5/22/09 from Hospital #2 documented, "Diagnosis: Accidental Overdose of clozapine, subsequent sepsis and acute renal failure, lactic acidosis. [Client #2] also has Iron-deficiency anemia with a reactive thrombocytosis, also aspiration pneumonia, respiratory failure, general azotemia ... Hospital course: [Client #2] was admitted after having acute mental status changes, hypotension, basically shock related to clozapine and Depakote overdose. [Client #2] had resultant metabolic acidosis, he required intravenous bicarb [bicarbonate] and fluid resuscitation, he required pressor support and intubation for his respiratory failure... he was seen by nephrology for renal failure, eventually he was able to be extubated, he had swallow study for aspiration pneumonia and had developed adult respiratory distress syndrome ..."

f. A facility Case Note dated 6/1/09 documented the client was discharged from the hospital and readmitted to the facility on 5/22/09 at 2:30 p.m. and resumed his previous activity schedule 5/28/09.

7. On 7/15/09 at 10:48 a.m., the DON stated she had planned to terminate LPN #1, but the LPN had already turned in her resignation. She also stated she had written a new policy and it included disciplinary action and possible termination for medication errors. She stated she was aware of 3 medication errors since the new policy and procedure was introduced.

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W 368	Continued From page 57 The Policy and Procedure provided by the Director of Nursing (DON) on 7/16/09 documented, "...Prior to administration of each client's medications, the nurse will consult the MAR [Medication Administration Record] and the picture of the client to ensure that the client is receiving the proper medications... The NSUM [Nursing Services Unit Manager] or designee will do random spot checks of the med pass to ensure this process is being followed... Medication Error Procedure... the nurse has 7 days to complete a report outlining the error... what the consequences should be if it occurs again... All medication errors will incur disciplinary action up to and including termination." 8. A Medication Incident Report dated 6/28/09 at 7:00 a.m. documented Client #13 and another client crowded the medication area during LPN #4's medication pass and, "...possibly got meds mixed up." 9. On 7/15/09 at 10:48 a.m., the DON stated, "We counsel and retrain each nurse after a medication error." When asked what was done after LPN #1's errors on 2/24/09, 3/4/09 and 5/8/09, the DON stated the counseling is written on the bottom of the Medication Incident Report. The DON stated the facility did not have any disciplinary action for medication errors until May 2009, but did do random medication pass observations and retraining. The DON stated there was a problem in the Hillside living unit and they had to, "figure out what to do." The DON stated she had not observed medication passes after the first 2 medication errors were made in the Hillside living unit. The DON was asked for documentation of the random medication pass observations and and retraining. When asked if	W 368		

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she had observed any of the nurses during medication pass and had them demonstrate their ability to accurately and safely pass medications to the clients, the DON stated she had done medication pass observations from across the room when the nurses were not aware she was observing. She stated an inservice was provided to the nurses in March 2009. When asked for documentation of any retraining provided to the LPN's who had made medication errors in the past 4 months, the DON was unable to provide the requested documentation

10. On 7/16/09 at 10:35 a.m., LPN #2, who was involved in the 2/3/09 medication error involving Client #6's medications being administered to a non-sampled client, was asked if any RN or Supervisor had observed her during medication pass. She stated she had not seen any RN/Supervisor doing any spot checks and had never been asked to demonstrate a medication pass after making the medication error on 2/3/09. She also stated the last inservice she had attended regarding medication pass was held in October or November of 2008. She stated, "We talk a little in every meeting about meds, the last time about a new med room and disciplinary action." She stated she had never had any disciplinary action taken against her. She also stated, "There is only one place there is confusion and has caused some nurses problems. You have to pass meds in the dining room and you have to have staff to help control. You can't do it alone. They need a med room."

11. On 7/16/09 at 12:50 p.m., LPN #4, who was involved in the possible medication error on 6/28/09 involving Client #13 and a non-sampled client, stated she made the medication error on

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W 368	Continued From page 59 6/28/09, but was not sure the affected client actually took the medications. When asked if the RN's had observed her or done any spot checks during her medication passes since that error, the LPN stated, "The RN's have come by and said 'Hi', but I didn't have any spot checks or med pass with an RN." The LPN stated it had been 2 years since anyone observed her doing a medication pass. She stated the facility had a department meeting in June 2009, but not a specific inservice regarding medication passes or medication errors. She stated she had never had disciplinary action for a medication error. The LPN also stated there was a problem in the Hillside Up living unit, "...there, is no place to keep the client's back. You have to use tables in the dining room and you have to have help to keep them [the clients] back." 12. The Immediate Jeopardy was removed on 7/28/09 at 4:35 p.m. when the facility implemented the following Plan of Removal: 1.) When a medication error reported, the Client will be observed per physician ' s instruction. Nurse Manager, Team RN, Social Service and Psychology and Superintendent will be notified. 2.) Nurse (LPN) making the error will be removed immediately from passing medication. Nurse Manager/Designee to initiate investigation with documentation. Nurse Manager/Designee will complete a written report of incident. 3.) Nurse manger/Designee will be responsible for in-service on giving medication. Nurse will be retrained for a total of eight (8) hours on Policy and Procedures. Written test upon completion of in-service. Nursing committing medication error	W 368		

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W 368	Continued From page 60 will be monitored by Nursing Manager/Designee for a total of eight (8) hours on giving medication. 4.) Nurse (LPN) will complete a medication error form. 5.) Nurse (LPN) will be monitored weekly for a period of four (4) weeks with documentation by Nurse Manager/Designee. In-service to specifically include client identification before passing medication, controlling clients at medication passes, and acquiring assistance if needed. 6.) Nurse Manager/Designee to follow up with counseling session in one (1) month with documentation from Nurse (LPN) on what was learned from incident (medication error). 7.) Hillside House (A complex) upstairs will have split kitchen door. Medication will be passed behind that door which will separate Clients and Medication Nurse. 8.) Hillside House (A complex) downstairs will have half door to entrance of dining room. Clients will get their medications at the door. Medications are kept behind door away from Clients.	W 368		

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	04G003	A. BUILDING 01 B. WING _____	10/20/2009

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K 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The findings on this Statement of Deficiencies demonstrates noncompliance with Title 42, Code of Federal Regulations 483.470(j), life safety from fire. The requirement is not met as evidenced by the facility's failure to meet the National Fire Protection Association code(s) cited.	K 000		
K 032	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the Rock House living unit had at least 2 separate paths of egress from the upstairs living quarters. The failed practice had the potential to affect 8 clients who resided in the affected area, as identified by the Engineer Supervisor on 10/20/09. The findings are:	K 032		

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K 032	Continued From page 1 On 10/20/09 at 10:40 a.m., the Rock House living unit, a wood construction building with no sprinkler coverage, had upstairs living quarters for 8 clients. There were 2 dead-end corridors and only the central stairway was available for evacuation from the second story.	K 032		
K 033	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the non-sprinklered stairwell in the Judge Hill dormitory was protected by smoke detectors. The failed practice had the potential to affect 26 clients who accessed this stairwell, as identified by the Administrator on 10/20/09. The findings are: On 10/20/09 at 11:40 a.m., the stairwell in the Judge Hill dormitory was not protected with smoke detectors and there was no sprinkler coverage.	K 033		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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K 062	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure quarterly testing of the sprinkler system's tamper and flow switches was conducted as required. The failed practice had the potential to affect all 146 clients, as identified by Administrative Staff on 10/20/09. The findings are: On 10/20/09 at 12:50 p.m., the facility was unable to provide documentation of the required quarterly testing of the sprinkler system tamper and flow switches.	K 062		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure a fire truck with mechanical ladder was available to access the second stories of the Rock House, Baldwin Hall and Davidson House and the 5-story Administration Building. The failed practice had the potential to affect all 146 clients, as identified by Administrative Staff on 10/20/09. The findings are: On 10/20/09 at 1:00 p.m., there was not a sufficient fire truck with mechanical ladder available to access the second floors of the Rock House, Baldwin Hall and Davidson House or the 5-story Administration Building. The 1957 GMC	K 130		

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K 130	Continued From page 3 fire truck was not capable of pumping a sufficient amount of water to extinguish a fire unless the truck was connected to a fire hydrant.	K 130		
K 160	NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the elevator room in the Judge Hill dormitory had the required smoke detector and fire extinguisher installed. The failed practice had the potential to affect 26 clients who utilized this area, as identified by Administrative Staff on 10/20/09. The findings are: On 10/20/09 at 11:50 a.m., the elevator room in the Judge Hill dormitory, a 2-story building, did not have a smoke detector or fire extinguisher as required.	K 160		

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{W 000}	INITIAL COMMENTS A revisit survey was conducted from 1/5/10 to 1/6/10. Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.	{W 000}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Rewritten deficiency Based on observation and interview, the facility failed to ensure a clean and safe environment was provided for the clients, as evidenced by failure to maintain equipment, fixtures, ceilings and roofs in good repair. The failed practice had the potential affect all 145 clients, as documented on the Client Living Area sheet provided by the Administrative Office on 1/5/10 at 2:00 p.m. The findings are: 1. On 1/6/10 at 10:00 a.m. in the Judge Hill	{W 104}		

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{W 104}	Continued From page 1 residence, Rooms #124, #122 and #131 had water spots on the ceiling. Aide #2 stated the areas leaked when it rained and the client in Room #124 had to be moved out of his room. She also stated some of the rooms had holes drilled all the way through and had not been closed. On 1/6/10 at 4:15 p.m., the Habilitation Supervisor who was standing in for the Administrator was asked about the ceilings in the Judge Hill residence. He stated the contractors had not returned to make the necessary repairs and he was not sure about their progress. 2. On 1/6/10 at 11:00 a.m., the following observations were made in the Hillside Down living area: a. The tub in Bathroom #1 had worn areas where the enamel was in need of replacement. b. The tub in Bathroom #3 had worn areas where the enamel was in need of replacement and there was a black mold-like substance extending up the grout approximately 1.5 inches in the front corner. c. The tub in Bathroom #4 had worn areas where the enamel was in need of replacement. There was a black mold-like substance at the front of the tub on the caulking. There was rust and a black substance around the drain. 3. On 1/6/10 at 11:15 a.m., the following observations were made in the Hillside Up living area: a. Bathroom #2 had hot water running from the	{W 104}		

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{W 104}	Continued From page 2 faucet in the lavatory. There was an orange stain from the faucet to the drain. The tub had worn areas where the enamel was in need of replacement. There was a black mold-like substance around the front, side and back on the caulking. There was a hand-rail attached to the wall with rusted brackets and chipped paint. There was mold on the grout between the wall tiles extending 7 tiles up from the tub. b. Bathroom #4 had cold water running in the lavatory, leaving a stain under the faucet. The caulking had a 2-inch open space at the back on the right side. The tub had worn areas where the enamel was in need of replacement. There was black mold around the tub on the caulking and on the grout going up 11 tiles from the tub. c. Bathroom #3 had black mold all around the tub on the caulking and on the grout between the wall tiles going up 11 tiles from the tub. 4. On 1/6/10 at 3:00 p.m., the Habilitation Supervisor who was standing in for the Administrator indicated there was no purchase order for the material to re-enamel the tubs.	{W 104}		