STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

INDEPENDENCE PLACE
Facility Name

0037994
I.D. Number

1705 SOUTH PARK AVENUE, HERRIN, ILLINOIS 62948
Address

Reviewed By

SEPTEMBER 27, 2005
Date of Survey

4TH RN FOLLOW-UP TO DECEMBER 18, 2004
Type of Survey

Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

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Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the requirements of this section.

The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:

Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.

Direct care personnel shall be trained in, but are not limited to, the following:

Basic skills required to meet the health needs and problems of the residents.

All legend medications maintained in the facility shall be on individual prescription or from the licensed prescriber's personal office supply, and shall be labeled as set forth in Section 350. 1440. A licensed prescriber who supplies medication from his or her personal office supply shall comply with Sections 33 and 54.5 of the Medical Practice Act of 1987 [225 ILCS 60/33 and 54.5]; or Section 51 of the Illinois Dental Practice Act [225 ILCS 25/51]; or the Podiatric Medical Practice Act of 1987 [225 ILCS 100]; or Section 15.1 of the Illinois Optometric

INDEPENDENCE PLACE | 0037994
Facility Name | I.D. Number

350.670a)
350.1210b)
350.1410c)d)2)
350.1420d)
350.3240a)
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Practice Act of 1987 [225 ILCS 80/15.1]; or Section 15-20 of the Nursing and Advanced Practice Nursing Act [225 ILCS 65/15-20]; or Section 7.5 of the Physician Assistant Practice Act of 1987 [225 ILCS 95/7.5].

All medications administered shall be recorded as set forth in Section 350.1620. Medications shall not be recorded as having been administered prior to their actual administration to the resident.

All medications administered shall be properly recorded as set forth in Section 350.1620(g).

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)

These regulations were not met as evidenced by the following:

1) The facility has failed to maintain a system that assures that medications are administered as physician ordered and that medications are available at the facility to be administered to the individual(s) as physician ordered for seven of 14 individuals of the facility (R2, R3, R6, R8, R11, R13 and R14), including three of these individuals (R2, R3 and R8) whose 6 A.M. medications (R2's Cardizem and Singular, R3's K-Tab and R8's Carbidopa/Levodopa and Detrol) were not available to be given on 09/02/05 due to these medications being presumably stolen from the medication cart. This had the potential to impact all 14 individuals of the facility who receive medications and or treatments as ordered by the physician.

Per review of the facility's Medication Policy regarding medication administration, the policy identifies, “All medications will be given only upon the written order of a physician. All orders are prescribed by the physician and at the designated time…”

The facility has failed to assure that medications were administered as physician-ordered on 8/20/05.

Per review of the facility’s Medication Error Reports on 09/14/05, documentation identified that 13 individuals of the facility did not receive their 6:00 A.M. medications on time, as physician-ordered. During the Entrance Communication with E1 (QMRP) at 4:20 P.M., E1 stated that R1 had been sent to the Emergency Room on 08/20/05.

Per review of the facility’s Incident Report dated 08/20/05, documentation identified that R1 was, “…experiencing a seizure at this time. Her speech was slurred. Ind (individual) got up went to the kitchen, was shaking… I waited a few min. (minutes) called the nurse. Nurse said take her to -------- (name) hospital.”

INDEPENDENCE PLACE | 0037994
Facility Name | I.D. Number

350.670a)
350.1210b)
350.1230d)2)
350.1410c)d)
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Review of the Emergency Room report dated 08/20/05 identified that R1 was seen for "…eval (evaluation) of possible post seizure activity. Caregiver states she normally shakes, but this was like she shakes when she has a seizure - She got up et (and) walked to the kitchen et (and) she was still shaking… "Per further review of the Emergency Room report, R1 was discharged on 08/20/05 with a final diagnosis of "tremor".

Per interview with E3 (Medical Needs Coordinator) on 09/16/05 at 1:53 P.M., E3 confirmed that R1 had gone to the Emergency Room on 08/20/05. E3 also confirmed that R1 had missed her Keppra 500 mg. and Mirapex .25 mg medication on 08/20/05 at the 6:00 A.M. medication pass. Review of R1's file identified that R1 was seen by Z1 (Medical Director), on 04/29/05 for a medical consultation. Documentation for the reason for the consultation identified, "R1 had what appeared to be a seizure on 04/27/05 around 6:15 or 6:30 P.M. Her appearance is very pale today. Tremors…" Orders were received for Mirapex .25 mg BID (twice daily) and for a Depakote level.

Per review of the Drug Side Effects Report provided by the facility's pharmacist, documentation identified the medication Mirapex .25 mg table is in the class of central nervous system agents.

Per telephone interview with Z2 on 09/16/05 at 2:23 P.M., Z2 (Pharmacist), stated that the half life for the Mirapex medication was eight hours for a healthy young adult and about 12 hours for an older adult individual. Z2 stated, "A missed dose of the Mirapex would result in a worsening of conditions of Parkinsonian like symptoms such as shaking and tremors." During this interview, Z2 confirmed that a missed dose of Mirapex could have been a contributing factor in R1's increased symptoms of shaking and tremors.

Per telephone interview with Z1 on 09/21/05 at 2:16 P.M., Z1 stated, "I do not think that R1's missed morning medications resulted in her going to the Emergency Room. However, whether or not R1 was hospitalized or not, the medications are to be given at the time prescribed." During this interview, Z1 confirmed that he was not immediately informed of the medication errors that occurred on 08/20/05.

Review of the Medication Error Reports dated 08/20/05, documentation identified, "…6 A.M. meds were not given out until after 8 A.M….no authorized staff on duty…Administrative error and no one (was) scheduled." The Medication Error Reports were signed by the facility's prior registered nurse consultant.

INDEPENDENCE PLACE | 0037994
Facility Name | I.D. Number

350.670a)
350.1210b)
350.1230d)2)
350.1410c)d)
350.1420d)
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Additional examples are available for R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12 and R13 regarding the facility's failure to assure that medications were administered as physician ordered on 08/20/05. Per review of the Physician's Orders Sheet and per review of the Medication Error Report, the following individual's medications were given two hours late due to the fact that there was no authorized staff on duty to pass the prescribed medication(s) at 6 A.M. Examples for 08/20/05 include:

R1 who functions at a severe level of mental retardation and has diagnosis of Seizure Disorder, Anemia, Tardive Dyskinesia, Pica, Amenorrhea and Aggressive Behaviors. Per review of the Physician's Orders sheet and per review of the Medication Error Report, R1 did not receive her Sprintect 6's 0.25 – 0.035 tablet for regular Menstrual Cycle (ordered one time daily). Ferrous Sulfate F/C 325 (65) mg tablet for Anemia (ordered twice daily), Keppra F/C 500 mg tablet (ordered twice daily), Mirapex 0.25 mg tablet (ordered twice daily) and Carbidopa/Levodopa 25 - 100 mg tablet (ordered three times daily);

R2 who functions at a profound level of mental retardation and has diagnosis of Prenatal Infectious Cytomegalic, Inclusion Disease, Bronchitis, COPD (Chronic Obstructive Pulmonary Disease), Blindness, HTN (Hypertension), Excess Ear Wax, Asthma, Constipation and Hearing Impairment. Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R2 did not receive his Cardizem CD 180 mg Capsule SR 24H for HTN (ordered once a day), Singulair 10 mg tablet (ordered once a day), Stress tab with Iron tablet (ordered once a day), Enulose 10 mg/15 ml (ordered twice a day), Debrox 6.5% Ear Drops (ordered twice a day), Metoprolol Tartrate 25 mg tablet (ordered twice a day), Theophylline Anhydrous 300 mg tablet SR 12 H for COPD (ordered twice a day), Trileptal 150 mg table for Seizures (ordered twice a day), Albuterol Sulfate 25's U-D 0.83 mg/1 ml Solution (1) AMP per Hand Held Nebulizer (ordered three times a day) nor his Neurontin 300 mg (ordered three times a day);

R3 who functions at a mild level of mental retardation and has diagnosis of Down's Syndrome, Hepatitis B Carrier, Bilateral Plantar Eversion, CHF (Congestive Heart Failure), Hypothyroidism, Venous Stasis, and PVD (Peripheral Vascular Disease). Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R3 did not receive his K-Tab 10 meq tablet SA (2 tablets) (ordered one time a day), Levothyroxine Sodium 88 mcg tablet (ordered one time a day), Zestril 20 mg tablet for CHF (ordered one time a day), Ferrous Sulfate F/C 325 (65) mg tablet (ordered twice daily), Oyst Cal D 500-200 tablet (ordered twice daily), Demadex 100 mg (1/2) tablet (50 mg) and Demadex 10 mg tablet (ordered twice daily);

INDEPENDENCE PLACE | 0037994
Facility Name | I.D. Number

350.670a)
350.1210b)
350.1230d)2)
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R4 who functions at a severe level of mental retardation and has diagnosis of Wax Impaction, Eczema, Agitation, Anger, Aggression, Intermittent Explosive Behavior, Impulse Control Disorder, Psychosis NOS, and OCD (Obsessive Compulsive Disorder). Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R4 did not receive his Vitamin E Soft Gel W/DL – Alpha 400 Unit capsule for Eczema (ordered one time a day) nor his Risperdal 1 mg table for Agitation/Aggression (ordered twice daily);

R5 who functions at a mild level of mental retardation and has diagnosis of Spina Bifida, Bladder Spasms, PUD (Peptic Ulcer Disease), DVT (Deep Vein Thrombosis), Vaginitis, and Paraplegia. Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R5 did not receive her Detrol LA 4 mg capsule (ordered one time daily), Emgel Topical 2% Gel for Acne (ordered one time daily), Multivitamin tablet (ordered one time daily), Macrobid 100 mg capsule for Bladder Spasms (ordered one time daily), Triaz 6% Gel (ordered one time daily), Calcium Carb, with Vitamin D 600-200 tablet (ordered twice daily), Docusate Sodium 100 mg capsule for Constipation (ordered twice daily), Vitamin C 500 mg tablet (ordered twice daily), Zinc Sulfate 220 mg capsule (2 capsules) (ordered twice daily), Motrin 800 mg (ordered three times daily) and Methenamine Mandelate 500 mg tablet for Bladder Spasms (ordered four times daily);

R6 who functions at a profound level of mental retardation and has diagnosis of Function Constipation, Control Disorder, Perianal Dermatitis, Seizure Disorder and PUD (Peptic Ulcer Disease). Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R6 did not receive his Flomax 0.4 mg capsule (ordered once a day), Prilosec OTC 20 mg tablet (ordered once a day), Baclofen 10 mg tablet (ordered twice a day), Tegretol 200 mg tablet for Seizure Control (ordered twice a day), Oyst Cal D 500-200 tablet (ordered twice a day), Senokot 8.6 mg tablet (two tablets) for Constipation (ordered twice a day), Enulose 10 GM/15 ml syrup 30 mg for Constipation (ordered three times a day) and Neurontin 400 mg capsule for Seizure Disorder (ordered three times a day);

R7 who functions at a mild level of mental retardation and has diagnosis of Depressive Disorder, Reflux, Estrogen Deficiency, Personality Disorder, Functional Constipation, Psychosis, Breast Cancer, Right Mastectomy and Meningioma (L) Cerebellum. Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R7 did not receive her Metamucil powder one tablespoon in eight ounces of water for Constipation (ordered once daily), Lexapro F/C 10 mg tablet (ordered once daily), Prilosec OTC 20 mg tablet for GERD (ordered once daily), Tamoxifen Citrate 30.4 mg, 20 mg tablet (ordered once daily), Risperdal 0.5 mg tablet (ordered twice daily), Zelnorm U-D 6X10 Tab 6 mg tablet (ordered twice daily), Motrin 600 mg tablet for Bursitis of the knee (ordered three times daily) and Oyst Cal D 500-200 tablet for Calcium Replacement (ordered three times daily);

INDEPENDENCE PLACE
Facility Name

0037994
I.D. Number

350.670a)
350.1210b)
350.1230d)2)
350.1410c)d)
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R8 who functions at a profound level of mental retardation and has diagnosis of Tardive Dyskinesia, COPD (Chronic Obstructive Pulmonary Disease), Hypercholesterolemia, GERD (Gastro Esophogeal Reflux Disease), Anxiety, PUD (Peptic Ulcer Disease), Colitis, Rectal Prolapse and History of Cardio Megaly. Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R8 did not receive her Aspirin 81 mg tablet DR for Hypercholesterinemia (ordered once a day), Questran 4 Gm Powder for Hypercholesterinemia (ordered once a day), Detrol LA 4 mg capsule SR 24H (ordered once a day), Toprol XL F/C 25 mg tablet SR 24H 0.5 tablet (12.5 mg) for COPD (ordered once a day), Relefan 500 mg tablet (ordered twice a day), Reminyl F/C 4 mg tablet for Dementia (ordered twice a day), Albuterol Sulfate 25'S U-D 0.83 mg/1 ml solution (1) Amp per Nebulizer (ordered three times a day), Sinemet 25-200 mg tablet for Parkinson (ordered three times a day), Oyst Cal D 500-200 tablet for Osteoporosis (ordered three times a day) and Risperdal 0.25 mg tablet (ordered three times a Day);

R9 who functions at a mild level of mental retardation and has diagnosis of Chronic Seborrheic Dermatitis, Functional Constipation, history of Seizure Disorder, Estrogen Deficiency, Hypothyroidism, Osteoporosis with Kyphosis, Hypercholesterolemia, Insomnia, Hysterectomy, Positive Mantoux and DJD (Degenerative Joint Disorder). Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R9 did not receive her Hydrochlorothiazide 25 mg tablet ½ tablet for Hypertension (ordered once a day), Synthroid 125 mcg tablet (ordered once a day), Claritin 10 mg tablet (ordered once a day), Multivitamin for Vitamin Replacement (ordered once a day) and Caltrate 600 W/D 600-200 for Osteoporosis (ordered twice a day);

R10 who functions at a mild level of mental retardation and has diagnosis of Down's Syndrome Hepatitis B Carrier, Hypothyroidism, Chronic Eczema, Onychomycosis, functional Constipation, DJD (Degenerative Joint Disorder), Scoliosis, Alzheimer and Bilateral Cataract Removal. Per review of the Physician's Orders sheet and per review of the Medication Error Report, R10 did not receive his Synthroid 100 mcg tablet for Hypothyroidism (ordered once a day), Multi-Vitamin tablet for Vitamin Deficiency (ordered once a day), Namenda F/C 10 mg tablet (ordered two times a day), Oyst Cal D 500-200 tablet to reduce Bone Loss (ordered two times a day);

R11 who functions at a moderate level of mental retardation and has diagnosis of HTN (Hypertension), Bi-Polar Manic Depressive, Psychosis with Bi-Polar Schizophrenia, Chronic Conjunctivitis, Functional Constipation, Paranoid Schizophrenia and Cataracts. Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R11 did not Receive his Docusate Sodium 100 mg capsule for Constipation (ordered once a day), Hydrochlorothiazide 50 mg tablet for Chronic HTN (ordered once a day), Levothyroxine

INDEPENDENCE PLACE — Facility Name
0037994 — I.D. Number

350.670a)
350.1210b)
350.1230d)2)
350.1410c)d)
350.1420e)
350.3240a)
(Cont.)

Sodium 125 mcg tablet (ordered once a day), and Micro-K 20 (two) capsules for Diuretic Therapy (ordered twice a day);

R12 who functions at a mild level of mental retardation and has diagnosis of Hallucinations. Impulsive Behavior, Major Depressive Disorder, Impulse Control Disorder and Incontinence. Per review of the Physician's Orders Sheet and per review of the Medication Error Report, R12 did not receive her Risperdal 0.5 mg tablet for Hallucinations and Zoloft 100 mg tablet ½ Tablet for Depression (both medications ordered for once a day); and

R13 who functions at a moderate level of mental retardation and has diagnosis of Chronic Conjunctivitis, DJD (Degenerative Joint Disorder), Chronic Anxiety, Chronic Dermatitis, Anemia, GERD (Gastro Esophogeal Reflux Disease), and Thrombocytopenia. Per review of the Physician's Orders sheet and per review of the Medication Error Report, R13 did not receive his Detrol LA 4 mg capsule SR 24H (ordered once a day), Prilosec OTC 20 mg tablet DR for GERD (ordered once a day), Uroxatral 10 mg tablet SR 24H (ordered once a day), Metamucil Orange SF Smooth Packet in 8 ounces of water for Constipation (ordered two times A day and AKWA Tears 1.4% drops (three drops (into affected eyes (ordered three times a Day).

Per interview with E1 (QMRP) on 09/16/05 at 8:20 A.M., E1 confirmed that the 6:00 A.M. medications were given two hours late due to fact that there were no authorized staff available to pass the individuals medications until 8:00 A.M. on 08/20/05.

b) After staff gave the individuals their 6 A.M. medication(s) two hours late on 08/20/05, staff omitted to pass the 4:00 P.M. medications for nine of nine individuals (R1, R2, R3, R5, R6, R7, R8, R9 and R10) who receive medications at 4:00 P.M.

Per review of the Medication Error Reports dated 08/20/05, documentation identified that the, "… 4 P.M. meds were not given out at all…Staff did not start med pass…"

Per review of the Medication Error Reports and per review of the Physician's Orders Sheets for R1, R2, R3, R5, R6, R7, R8, R9 and R10, the following medications were ordered, but were not administered by staff:

R1 did not receive her Ferrous Sulfate F/C 325 (65) mg tablet for Anemia (ordered twice Daily), Keppra F/C 500 mg tablet (ordered twice daily), Mirapex 0.25 mg tablet (ordered twice Daily) and Carbidopa/Levodopa 25-100 mg tablet (ordered three times daily);

INDEPENDENCE PLACE | 0037994
Facility Name | I.D. Number

350.670a)
350.1210b)
350.1230d)2)
350.1410c)d)
350.1420d)
350.3240a)
(Cont.)

R2 did not receive his Enulose 10 gm/15 ml (ordered twice a day), Debrox 6.5% Ear Drops (ordered twice a day), Metoprolol Tartrate 25 mg tablet (ordered twice a day), Theophylline Anhydrous 300 mg tablet SR 12 H for COPD (ordered twice a day), Trileptal 150 mg table for Seizures (ordered twice a day), Albuterol Sulfate 25's U-D 0.83 mg/1 ml Solution (1) AMP per Hand Held Neubulizer (ordered three times a day) nor his Neurontin 300 mg (ordered three Times a day);

R3 did not receive his Ferrous Sulfate F/C 325 (65) mg tablet (ordered twice daily), Oyst Cal D 500-200 tablet (ordered twice daily), Demadex 100 mg (1/2) tablet (50 mg) and Demadex 10 mg tablet (ordered twice daily), nor his Motrin 400 mg tablet (ordered three times daily);

R5 did not receive her Calcium Carb, with Vitamin D 600-200 tablet (ordered twice daily), Docusate Sodium 100 mg capsule for Constipation (ordered twice daily), Vitamin C 500 mg tablet (ordered twice daily), Zinc Sulfate 220 mg capsule (2 capsules) (ordered twice daily), Motrin 800 mg (ordered three times daily) and Methenamine Mandelate 500 mg tablet for Bladder Spasms (ordered four times daily) and Coumadin 5 mg tablet, nor Coumadin 1 mg tablet ½ (0.5 mg) ordered one time a day at 4 P.M.);

R6 did not receive his Baclofen 10 mg tablet (ordered twice a day), Tegretol 200 mg tablet for Seizure Control (ordered twice a day), Oyst Cal D 500-200 tablet (ordered twice a day), Senokot 8.6 mg tablet (two tablets) for Constipation (ordered twice a day), Enulose 10 GM/15 ml syrup 30 ml for Constipation (ordered three times a day) and Neurontin 400 mg capsule for Seizure Disorder (ordered three times a day);

R7 did not receive her Risperdal 0.5 mg tablet (ordered twice daily), Zelnorm U-D 6X10 Tab 6 mg tablet (ordered twice daily), Motrin 600 mg tablet for Bursitis of the knee (ordered three times daily) and Oyst Cal D 500-200 tablet for Calcium Replacement (ordered three times Daily);

R8 did not receive her Relefan 500 mg tablet (ordered twice a day), Reminyl F/C 4 mg tablet for Dementia (ordered twice a day), Albuterol Sulfate 25'S U-D 0.83 mg/1 ml solution (1) Amp per Nebulizer (ordered three times a day), Sinemet 25-200 mg tablet for Parkinson (ordered three times a day), Oyst Cal D 500-200 tablet for Osteoporosis (ordered three times a day) and Risperdal 0.25 mg tablet (ordered three times a day);

R9 did not receive her Caltrate 600 W/D 600-200 for Osteoporotis (ordered twice a day); and

INDEPENDENCE PLACE | 0037994
Facility Name | I.D. Number

350.670a)
350.1210b)
350.1230d)2)
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350.1420d)
350.3240a)
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R10 did not receive his Docusate Sodium 100 mg capsule for Constipation (ordered one time daily in the evening), Namenda F/C 10 mg tablet (ordered two times a day), Oyst Cal D 500-200 tablet to reduce Bone Loss (ordered two times a day) and Synalar 0.01% Solution to both ears (ordered once a day at 4 P.M.).

2) Based on interview, file review and per review of the facility's policies and procedures regarding medication, nursing services has failed to provide necessary training for direct care staff to ensure that they are competently trained to pass medications and has failed to promptly re-train direct care staff when medication errors have occurred, having the potential to impact 14 of 14 individuals of the facility (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13 and R14) who presently receive medications and treatments as ordered by the physician.

Per review of the Medication Administration Records and per review of the Medication Error Reports, repeated medication errors have occurred and the facility has allowed staff to continue passing medications without evidence of immediate re-training.

a) Per review of the Medication Administration Records and per review of the Medication Error Reports, for the month of August, 2005, the facility has had 14 documented days of medication errors which included the dates of 08/05, 08/09, 08/10, 08/11, 08/12, 08/13, 08/18, 08/20, 08/25, 08/26, 08/27, 08/28, 08/29 and 08/31/05 where medications were either omitted, late, not administered and or not available. Review of the Medication Error Reports for 08/05/05 and 08/20/05 did not identify facility staff had immediately notified the physician of the medication errors. No Medication Error Reports were noted for the dates of 08/09, 08/10, 08/11, 08/12, 08/13, 08/18, 08/25, 08/26, 08/27, 08/29 and or 08/31/05 as identified per the Medication Administration Records for these dates of error.

Per continued review, on 08/20/05 medications were given two hours late for 13 of 13 individuals (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12 and R13) who were to receive their prescribed medication(s) at the 6 A.M. medication pass. These 13 individuals did not receive their medications as ordered because the facility failed to schedule qualified staff to administer the 6:00 A.M. medications.

After staff gave the individuals their prescribed 6 A.M. medication(s) two hours late on 08/20/05, the facility failed to assure that all medications were administered as physician ordered for the 4:00 P.M. medications which were omitted by staff for nine of nine individuals (R1, R2, R3, R5, R6, R7, R8, R9 and R10).

Per interview with E1 (QMRP) on 09/16/05 at 8:20 A.M., E1 stated that E6 and E8 (direct care staff) were on duty at the time the 4:00 P.M. medication pass was scheduled on 08/20/05.

INDEPENDENCE PLACE | 0037994
Facility Name | I.D. Number

350.670a)
350.1210b)
350.1230d)2)
350.1410c)d)
350.1420d)
350.3240a)
(Cont.)

E1 also stated that E7 (direct care staff) had worked from 8:00 A.M. to 4:00 P.M. and had left the facility without giving medications. E1 stated that E7 was removed from passing medications (due to prior medication errors). During this interview, E1 confirmed that E6 and E8 were certified to pass medications. E1 did not provide the surveyor with any additional documentation during the survey dates that would identify why E6 or E8 did not pass the individuals' 4:00 P.M. medications after E7 left the facility. No documentation was provided to the surveyor that would identify that the facility had immediately retrained staff in regards to the omitted 4:00 P.M. medication for 08/20/05.

Ten days after the 08/20/05 medication errors, facility staff were in-serviced on 08/30/05 by nursing staff regarding medication passes. Review of the signature page identified that only six staff (E2, E8, E9, E10, E11 and E12) and the QMRP attended the in-service. Review of the facility's staffing report for the month of August, 2005, identified that the facility currently has thirteen direct care staff on the schedule.

Per continued review, documentation identifies that after staff were in-serviced on 08/30/05, medication errors continued.

b) Per review of the Medication Administration Records and per review of the Medication Error Reports, for the month of September, 2005, the facility has had nine documented medication errors within the first sixteen days of the month on 09/02, 09/03, 09/04, 09/05, 09/06, 09/11, 09/12, 09/15 and 09/16.

Examples include:
Per review of the Physician's Orders sheet R6 functions at a profound level of mental retardation and has diagnosis of Functional Constipation, Control Disorder, Peri-anal Dermatitis, Seizure Disorder and PUD (Peptic Ulcer Disease). On 09/03/05, R6 received his four 4:00 P.M. medications of Baclofen 10 mg tablet, Tegretol 200 mg tablet for Seizure Control, Oyst Cal D 500-200 tablet, and Senokot 8.6 mg tablet (two tablets) at 12 midnight on 09/04/05. E6 was the staff that administered the medications at the wrong time. Additionally, R6 did not receive his Enulose 10 Gm/15 ml syrup 30 ml and Neurontin 400 mg capsule at 4:00 P.M. on 09/03/05 as physician-ordered.

Per telephone interview with E4 (Registered Nurse Consultant) on 09/20/05 at 4:40 P.M., E4 stated that E6 had called him "after" he had given R6 his missed medications at 12 A.M. (were scheduled for 4:00 P.M.).

Per file review, no documentation was identified that the physician had been contacted and that orders were received to give R6 his medications of Baclofen 10 mg tablet, Tegretol 200 mg tablet for Seizure Control, Oyst Cal D 500-200 tablet, and Senokot 8.6 mg table (two tablets) at 12 midnight). Additionally, per review, no documentation was noted that E6 had been

350.670a)
350.1210b)
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350.3240a)
(Cont.)

immediately retrained regarding his medication errors made on 09/03/05.

On 09/16/05, the surveyor was presented with a memo from the facility that identified, "…E6 will undergo retraining and perform one medication pass with another DSP (Direct Service Person) supervising after undergoing retraining…" (Confirmed per interview with E1 that the memo was written the morning of 09/16/05 by E4.)

Per telephone interview with E4 (Registered Nurse Consultant) on 09/20/05 at 4:40 P.M., E4 confirmed that E6 would not be retrained until 09/29/05.

Review of the Medication Administration Record for September, 2005, documentation identifies that E6 continues to pass medications without evidence of immediate retraining. Documentation identified that E6 has passed medications on 09/05, 09/07, 09/08, 09/12, 09/13, and 09/15/05 during the 9:00 P.M. medication pass for these dates.

Per telephone interview with E4 (Registered Nursing Consultant) on 09/20/05 at 4:40 P.M., E4 confirmed that he was aware of the facility's medication error problems and that staff training was needed. E4 also confirmed that he was not certified as a Nurse Trainer. E4 stated, "I am scheduled to attend the training for certification (Nurse Trainer) on 10/13/05. A training in-service will be scheduled for staff on 09/29/05 regarding medication errors. Due to a conflict in scheduling, E9 (Prior Registered Nurse Consultant) will not be able to do the med retraining staff until 09/29/05."

3) Based on observation, interview, file review and per review of the facility's policy and procedures, the facility failed to immediately notify the physician of medication errors that have occurred for 14 of 14 individuals of the facility (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13 and R14) who presently receive medications and or treatments as ordered by the physician.

Per review of the facility's Medication Policy, documentation identifies that, "…In the event of a medication error, authorized staff will immediately report the error to the registered professional nurse, physician, physician assistant, or physician ordering medication to receive direction on any action to be taken…"

Per review of the facility's Medication Administration Records and per review of the Nurse's Medication Notes Reports (contained with the MARs) for the months of August and September 2005, per review of the Physician's Order Sheets and per review of the facility's Medication Error Reports, the following errors have occurred:

INDEPENDENCE PLACE | 0037994
Facility Name | I.D. Number

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350.1210b)
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a) Medications were given two hours late for 13 of 13 individuals (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12 and R13) who were to received their prescribed medication(s) at 6:00 A.M. because the facility failed to schedule qualified staff to administer the 6:00 A.M. medications;

b) 4:00 P.M., medications were omitted by staff for nine of nine individuals (R1, R2, R3, R5, R6, R7, R8, R9 and R10 who are to receive their medications at 4:00 P.M.; and

c) Medications were not available to be administered as physician ordered for seven of 14 individuals of the facility (R2, R3, R6, R8, R11, R13 and R14) which included:

R2 did not receive his Cardizem CD 180 mg capsule for Hypertension and Singulair 10 mg during the 6:00 A.M. medication pass on 09/02/05 because the medications were presumably stolen, on 09/04/05 Enulose 10 gm/15 ml and Albuterol Sulfate 25's U-D 0.83 mg/1 ml Solution were not given because the medication was not available at the 4:00 P.M. medication pass, on 09/11/05 Metoprotol Tartrate 25 mg tablet not give because the medication was not refilled and was not available at the 6:00 A.M. medication pass, and on 09/12/05 when R2's Metoprolol Tartrate 25 mg tablet not given because the medication was not refilled and was not available at the 6:00 A.M. medication pass.

R3 did not receive his Levothyroxine Sodium 88 mcg tablet because the medication was not available on 08/18/05, K-Tab 10 meq tablet SA (2 tablets) not available to be given on 09/02/05 at 6 A.M. due to the medication being presumably stolen from the medication cart, and R3 received Zoloft 100 mg tablet which was given at 4 P.M., but is physician ordered for bedtime.

R6 received his 4 P.M. medication of Baclofen 10 mg tablet, Tegretol 200 mg tablet for seizure control, Oyst Cal D 500-200 tablet, Senokot 8.6 mg tablet (two tablets) at 12 midnight for 09/03/05 and had his Enulose 10 GM/15 ml syrup 30 ml and Neurontin 400 mg capsule omitted at 4 P.M. on 09/03/05, and R6's Enulose 10 GM/15 ml syrup 30 ml medication was not available to be given on 09/05 at 9 P.M., nor at 6 A.M. on 09/06/05.

R8 did not receive her Detrol LA 4 mg capsule SR 24H and her Sinemet 25-200 mg tablet on 09/02/05 at 6 A.M. due to these medications being presumably stolen off the medication cart, and her noon medications of Sinemet 25-200 mg tablet, Oyst Cal D 500-200 tablet, Risperdal 0.25 mg tablet, and Albuterol Sulfate 25's U-D 0.83 mg/1 ml Solution were omitted on 08/05/05.

INDEPENDENCE PLACE | 0037994
Facility Name | I.D. Number

350.670a)
350.1210b)
350.1230d)2)
350.1410c)d)
350.1420d)
350.3240a)
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R11 did not receive his Milk of Magnesia 30 ml at bedtime on 08/25, 08/26, 08/27, 08/28, and 08/29/05 because the medication was not available and who did not receive his Debrox 6.5% ear drops on 08/09, 08/10, 08/11, 08/12 and 08/13/05 because no applicator was sent by the pharmacist.

R13 did not receive his Metamucil Orange SF Smooth Packet in 8 ounces of water at 9 P.M. because the medication was not available; and

R14 did not receive his Senior Topix Emollix Lotion after his shower on 08/25, 08/26, 08/27 and 08/31/05 because his physician-ordered lotion was not available.

Per review of the facility's Medication Error reports, no documentation was noted that would identify that the physician had been immediately notified of the medication errors.

Review of the facility's Medication Policy does not identify how the physician will be immediately notified at the time of a medication error.

Per interview with E3 (Medical Needs Coordinator) on 09/16/05 at 1:53 P.M., E3 stated that she had notified the physician of the 08/20/05 medication errors on 08/22/05.

Per telephone interview with E1(QMRP) on 09/23/05 at 2:50 P.M., E1 stated that the facility staff either "calls of faxes" the physician when a medication error occurs.

Per telephone interview with Z1 (Medical Director) on 09/21/05 at 2:16 P.M. stated, "I am not immediately contacted regarding medication errors. That concerns me that they are making many errors…"

4) Based on interview and file review, the facility has failed to assure that medications are stored under proper conditions of security which has resulted in missing medications, with the potential to impact all medications stored in the facility's medication cart, as evidenced by:

a) R1 whose three bubble packs of Depakote 500 mg tablets were discovered missing on 08/28/05 and the facility failed to thoroughly investigate this incident and revise their security

b) R2's, R3's, R4's and R5's medications were discovered missing from the medication cart on 09/02/05 and the facility failed to thoroughly investigate this incident, thereby failing to assure that medications are stored and maintained under proper conditions of security.

measures to prevent further potential loss of medications.

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Per review of the facility's policy and procedures regarding Storage and Disposal of Medication, documentation identified, "...The key to the medication cabinet is the responsibility of the authorized direct care person for overseeing the administration of medication by individuals and is kept in the possession of that staff member at all times on that shift."

Per review of the hand written report that was submitted to the surveyor on 09/16/05 by E1 (QMRP), documentation identified that R1's Depakote 500 mg tablets were discovered missing from the facility on 08/28/05. Review of this documentation identified:

08/15 Depakote was delivered, E8 signed
08/25 Depakote still in Cart E3 and E8 (verified)
08/28 Noticed Depakote missing
08/30 Called Pharmacy - No record of any returned
08/31 Depakote Re-ordered

Per interview with E3 (Medical Needs Coordinator) on 09/16/05 at 10:12 A.M., E3 stated, "R1's Depakote was in the storage drawer which is the third drawer at the bottom of the medication cart. R1 had been in the hospital (returned to the facility on 07/03/05) and didn't need the medication that had been received. When staff noted reorder was needed for R1's Depakote, they went to replace the medication and discovered that the 93 pills of Depakote 500 mg were gone. We searched everywhere and did not find the medication." During this interview, E3 confirmed that the facility assumed that the medication was stolen by staff.

Per telephone interview with E5 (Administrator) on 09/16/05 at 12:35 P.M., E5 stated she had told E3 to start an investigation regarding R1's missing medications.

During the survey dates, no documentation was provided to the surveyor to identify the facility had investigated the theft of R1's Depakote 500 mg medication.

Subsequent interview with E3 at 1:53 P.M., E3 confirmed she did not investigate the theft of the medication. E3 stated, "I only called and notified E5 of the incident." During this interview, E3 confirmed that the local police department had been notified.

Review of the Police Report dated 08/31/05 identified a description of how the offense was committed, "Some UNK (Unknown) suspect stole a total of 93-500 mg pills of Depakote."

Five days after R1's 93 pills of Depakote 500 mg were stolen, the facility discovered on 09/02/05 that four individuals' medications were missing from the medication cart.

INDEPENDENCE PLACE
Facility Name

0037994
I.D. Number

350.670a)
350.1210b)
350.1230d)2)
350.1410c)d)
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Documentation identified:

R8's Detrol LA 4 mg tablet and Carbidopa/Levodopa 25-100 mg medications were missing for the 09/02/05 6 A.M. medication pass.

R2's Diltiazem HCL 180 mg and Singulair 10 mg medications were missing for the 09/02/05 6 A.M. medication pass.

R3's K - Tab 10 meq (two tablets) were missing for the 09/02/05, 6 A.M. medication pass.

R5's entire bubble pack of Butalbital APAP/Caff 325 mg for the 4 P.M. medication pass was missing.

Per interview with E1 (QMRP) and E2 (direct care staff) on 09/16/05 at 12:05 P.M., E1 stated that they had contacted the police and the police would not take the report. During this interview, E1 and E2 confirmed that all staff of the facility have access to the keys to the medication cart. E1 confirmed that no investigation had been conducted by the facility to determine the loss of these medications.

Review of the Police Report dated 09/02/05 identified, "Medication has come up missing again. She (E3) doesn't know whether it was stolen or misplaced. They just made a report on August 31, 2005, of stolen medication. They were advised to do an internal investigation."

During the survey dates, no documentation was provided to the surveyor to identify that the facility had investigated the loss of R1's, R2's, R3's, R5's and R8's missing medications whereby medications are stored and maintained under proper conditions of security.

(A)