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	14G111	A. BUILDING ____ B. WING ____	C 10/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON MANOR LIVING CENTER-DD	**111 EAST ILLINOIS STREET NEW BADEN, IL 62265**

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W 370	Continued From page 15 E4 noted that "E6 (LPN) presented the medications for all four clients scheduled to go on the 10/02/08 over night trip. E6 had packed medication cards with a copy of the MAR (Medication Administration Record) in a plastic tub and each client's medications had a rubber band in place to separate each clients medications". E4 stated she was a certified direct service provider and was not trained in medication administration. "I did not know what to look for in regards to the medications and was not trained on the medications". E4 stated she administered medications for R2, R3, R4, and R5 in the AM of 10/03/08 but could not recall what medications where administered. In addition, she stated she administered medications in the PM of 10/02/08 but could not recall what medications and to whom they were administered. According to the Illinois Department of Human Services Rule 116, it states that direct-care staff can be trained and authorized to administer medications in homes no larger that 16 resident occupancy. There are no other allowances made in the State for unlicensed staff to administer medication. According to an undated facility roster, 50 individuals (R1-R50) live in the home.	W 370		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210b) 350.1230d)	W9999		

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W9999	Continued From page 16 350.1410a) 350.1420a) 350.1430a) 350.1430c) Section 350.1210 Health Services 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: b) 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. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. Section 350.1410 Medication Policies and Procedures a) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning and disposing of drugs and medications. These	W9999		

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	14G111	A. BUILDING ______ B. WING ______	C 10/28/2008

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W9999	Continued From page 17	W9999		

Continued From page 17

policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

Section 350.1420 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber.

Section 350.1430 Administration of Medication

a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements.

c) Medications prescribed for one resident shall not be administered to another resident.

These REGULATIONS are not met as evidenced by:

Based on record review and interviews, the facility failed to ensure that appropriate monitoring systems are in place so that the general policies and operating directions are reviewed for compliance with state and federal regulations and are safely implemented.

1. While on an outing, direct-care staff administered medications in error to R3 resulting in hospitalization with the potential to affect all individuals in the facility (R's 1-50).
.
2) The facility failed to ensure all drugs

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	14G111	A. BUILDING ______ B. WING ______	C 10/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON MANOR LIVING CENTER-DD	111 EAST ILLINOIS STREET NEW BADEN, IL 62265

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W9999	Continued From page 18	W9999		

Continued From page 18

administered on outings are in compliance with physician orders for 1 of 4 clients (R3) in the sample.

3) The facility failed to ensure staff members demonstrate and implement first aid procedures obtained through direct service provider training for 1 of 4 clients (R3) in the sample.

4) The facility failed to ensure staff members on facility outings have access to emergency personnel and working communicative devices to ensure client safety during outings away from the facility for 1 of 4 clients (R3) in the sample.

Findings include:

The facility Roster (undated) documents that there are 50 Residents of the home (R1-R50). When interviewed on 10/09/08 at 3:05PM, E1 stated that all 50 individuals in the home go on outings. E1 continued, medications were administered by direct care staff prior to 10/7/08 when a new policy was written. There is no allowance within State law for homes with population of over 16 individuals to have direct-care staff administer medications.

R3 is a 67 year old male with a diagnosis of mild Mental Retardation, Cerebral Palsy, seizure disorder, anemia, and hypothyroidism according to his face sheet (no date) in his client record.

The facility report "Investigation of medication error made on 10/03/08" sent on 10/09/08 to the IDPH (Illinois Department of Public Health) states R3 was hospitalized due to a medication error during an outing on 10/3/08.

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W9999	Continued From page 19 The facility investigation notes that E4 (direct service provider) and E5 (direct service provider) "escorted four residents to a cabin at Carlye Lake for an overnight outing (on 10/03/08). E4 was given the four residents' (R2, R3, R4, & R35) medication by E6 (Licensed Practical Nurse) prior to departure. The Social Service Designee (E7) drove them to the camp site. E7 stated in her statement that she did ask E4 if her cell phone got a signal, and she reported that E4 told her "yes." E4 reported that E7 asked her about her phone, and at that time she had a couple of bars. E4 reported that the signal on her cell phone came in and out during their time at the camp ground. E4 and E5 did not have a vehicle at the camp ground because E5 does not have a valid drivers license, and E4 does not own a vehicle and is not covered under the agency's insurance because of her age. According to E4's statement, on 10/03/08, at approximately 6:30AM, she made repeated calls to the facility to report that she had given R3 another resident's medications and then his medications. E4 explained that she popped out the pills into cups and then was giving medications to one person at a time. E4 stated that she realized she had accidentally given R3 another resident's medications. E4 repeatedly attempted to call the facility, but her cell phone did not to get a strong signal. E4 said she could get the phone to ring at the facility. However before she could push an extension and exit the greeting menu, her cell phone would drop the call. E4 stated that she attempted to text E6 (LPN) @	W9999		

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	14G111	A. BUILDING ____ B. WING ____	C 10/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 20 (approximately) 6:45AM, but E4's cell phone indicated it would send later when the signal was stronger. E4 stated she made many attempts to call someone--too many to count. At approximately 7:15AM, E4 documented that she tried to call E6 (LPN) but was unable to leave a message. E4 called the facility and got through to the nurse E8 (Registered Nurse) at 8:55AM. E4 stated that she told the nurse (E8) that R3 got another resident's medication and his medication. The connection was not clear. It was cutting in and out, but E8 was able to decipher that E4 gave R3 the wrong medications. E8 (RN) then spoke with her supervisor E3 (Director of Nursing) at approximately 9:30AM. E3 called E1 (RSD) to see if she had any idea of what happened. According to the investigation report, E1 and E7 left the facility at approximately 8:00AM (on 10/03/08) in two separate vehicles to go to Carlye Lake and pick up the staff and residents who had gone camping. When E1 and E7 arrived, E4 and E5 informed them that R3 had gotten another resident's medication. E1 assessed R3 and tried to get him to speak to E1, but he was unable. E1 and E7 loaded everyone in the van and headed back to the facility. E1 realized she missed a call from the facility at 9:36AM. E1 called E3 and gave a description of R3's condition. E3 suggested that the vehicle with R3 go to the hospital. Once at the emergency room, E1 asked E4 to tell the nurse at the ER what happened. E4 stated that she gave R3 another client's medication and	W9999		

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W9999	Continued From page 21	W9999		

his medication. The ER immediately contacted poison control to determine if any medications could have dangerous side effects if combined.

When E1 left the emergency room, the physician said that R3 would be observed for at least the next six hours and he would probably be admitted for observation. The physician stated that his major concern was R3's blood pressure. He had received a double dose of synthroid which has lowered his blood pressure. Before E1 left the hospital, staff had given R3 an Albuterol treatment.

R3's regular morning medications are as follows: alendronate SOD 70mg (sub for fosamax 70mg), levothyroxine 100mg (sub for synthroid 100mg), famotidine 20mg, ferrous sulfate 325mg, folic acid 1mg, furosemide 20mg, hydralazine 12.5mg, multivitamin tablet, plavix 75mg, depakote 250mg, gabapentin 600mg, oysco 500D tablet (sub for os-cal 500 + D 200IU), klor-con M20 tablet (sub for potassium CL 20 MEQ tablet SA), and lamictal 200mg, saline nasal spray 45ml.

The other person's (R4) regular morning medications that were also given to R3 are as follows: Asprin chewable 81mg, gemfibrozil 600mg (sub for lopid), levothyroxine 75mg (sub for synthroid 75mg), prevacid 15mg, sertraline HCL 150mg (sub for zoloft 150mg), lamictal 100mg, clozapine 100mg.

The Report continues: there was not a specific procedure in place that both the DSP staff and nursing staff had been trained to follow. Our agency does not have a medication pass class, and we do not have direct support staff who have been trained in medication pass. At this time all

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	14G111	A. BUILDING ____ B. WING ____	C 10/28/2008

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W9999	Continued From page 22 outings surrounding a medication time must be approved by the Residential Service Director, the Director of Nursing, or the Assistant Director of Nursing. A new policy and procedure is being implemented and staff are currently being trained on it. R3 was admitted to the intensive care unit for observations. On 10/04/08 R3 was using a retreat breathing machine and was receiving dopamine for his blood pressure. The hospital staff stated R3 was improving and more alert. On 10/05/08 R3 was moved to a standard room and placed on a c-pap machine for his breathing. He is no longer receiving dopamine for his blood pressure and is alert and responsive to hospital staff and family. Findings of Investigation: E4 and E5 both received a corrective action, to coach them on being aware of emergencies and how to respond appropriately. All staff were re-trained on the new policy of outings and medication administration. E6 received a corrective action and coaching regarding safeguarding medications and the new policy on medication administration. The new policy on medication administration was revised that states that all medications whether inside the building, on outings, or appointments will be administered by a nurse. It is our finding that had the procedures outlined in our new policy been employed then the individual in question may have gotten medical attention sooner. We also found it was necessary to re-train staff and revise our policies surrounding outings, medication administration, communication and emergency situations to	W9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON MANOR LIVING CENTER-DD	**111 EAST ILLINOIS STREET NEW BADEN, IL 62265**

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W9999	Continued From page 23 ensure that an incident like this does not occur again. Review of E4's personnel file (3/36/08) disclosed that E4 received a "violation report" on 10/09/08 for the incident occurring on 10/03/08. The type of violation noted "basic health and safety." In the "supervisor remarks-this supervisor reviewed with E4 the emergency procedures she was taught in hab class such as: recognizes emergencies, takes appropriate emergency actions when faced with an emergency, when to call for emergency medical assistance and ensuring a residents safety." E4 remarked on the report "I feel we did our best to take the appropriate manor in dealing with the situation. I agree that mistakes were made, but I also feel that we should have been trained more thoroughly on this situation." E4's personnel file noted that E4 completed her habilitation training on 6/26/08 with competency remarks in the areas of basic health and safety; first aid and CPR; human interaction and communication and abuse and neglect. E4's file also outlined training on policies for medication administration on outings and procedures on outings signed by E4 on 10/07/08. Review of E5's personnel file (2/27/08) disclosed that E5 received a "violation report" on 10/09/08 for the incident occurring on 10/03/08. The type of violation noted "basic health and safety." In the "supervisor remarks-this supervisor reviewed with E5 the emergency procedures he was taught in hab class such as: recognizes emergencies, takes appropriate emergency actions when faced with an emergency, when to call for emergency	W9999		

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	14G111	A. BUILDING ______ B. WING ______	C 10/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 24 medical assistance and ensuring a residents safety." E5's personnel file noted that E5 completed his habilitation training on 5/5/08 with competency remarks in the areas of basic health and safety; first aid and CPR; human interaction and communication and abuse and neglect. E5's file also outlined training on new policies for medication administration on outings and procedures on outings signed by E5 on 10/07/08. Review of facility policy on abuse and neglect (04/05) states "Neglect-the failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a residents physical or mental condition shall include any allegation where the alleged failure causing injury or deterioration in ongoing or repetitious; or a resident required medical treatment as a result of the alleged failure; or the failure is alleged to have caused a noticeable negative impact on a resident's health, behavior or activities for more than 24 hours." There is no evidence that the facility investigation considered neglect in the process of determining the events of 10/3/08. E4, on 10/09/08 @2:35PM, stated she was the staff member responsible for the 10/03/08 AM medication pass. E4 confirmed the facility medication error investigation of 10/03/08. E4 stated this was the first overnight outing with clients in which she had participated, and was assigned the medication pass for 10/02/08 (PM) & 10/03/08 (AM). E4 stated she received a write up from E1 in relation to failing to provide timely	W9999		

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	14G111	A. BUILDING ____ B. WING ____	C 10/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON MANOR LIVING CENTER-DD	111 EAST ILLINOIS STREET NEW BADEN, IL 62265

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W9999	Continued From page 25 medical care. E4 noted that "E6 presented the medications for all four clients scheduled to go on the 10/02/08 over night trip. E6 had packed medication cards with a copy of the MAR(Medication Administration Record) in a plastic tub and each client's medications had a rubber band in place to separate each client's medications." E4 stated that R3 "would not wake up for nothing" after the medications for R3 and R4 were consumed by R3 on 10/03/08. E4 also stated that she and E5 attempted several times to wake R3 and monitored his pulse and respirations. E4 noted that "R3's pulse appeared weak" during monitoring while making numerous attempts to call the facility. E4 stated that she did not record any vitals or time frames related to monitoring R3's health status. E4 stated she administered R3's medication with the knowledge that R3 had already received R4's medications. E4 stated "I knew he had a seizure condition and I wanted to make sure that he got his seizure meds and didn't have a seizure." E4 stated she is a certified direct service provider and had received training in first aid, CPR, emergency training, and abuse and neglect. E4 stated that she did not call 911 on her cell phone. E4 reported, "I did not know what to look for in regards to the medications and was not trained on the medications." E1, on 10/09/08 at 3:05PM, stated she conducted the 10/03/08 investigation of medication errors for R3. E3 confirmed the findings of the	W9999		

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	14G111	A. BUILDING ______ B. WING ______	C 10/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON MANOR LIVING CENTER-DD	**111 EAST ILLINOIS STREET NEW BADEN, IL 62265**

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W9999	Continued From page 26 investigation "had the procedures outlined in our new policies been employed then, R3 may have gotten medical attention sooner. E4 and E5 were re-trained and revisions to our policies surrounding outings, medication administration, communication and emergency situations to ensure that an incident like this does not occur again." (A)	W9999		