STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 05/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODWARD RESOURCE CENTER	1251 334TH STREET WOODWARD, IA 50276

(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 At the time of the investigation of #67753-I, deficiencies were cited at W104 and W368.	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 interviews and record review, the facility's governing body failed to ensure staff consistently followed established protocol to ensure the health and safety of clients. Staff failed to follow established protocol for the administration of a potentially dangerous medication. This affected 1 of 1 client (Client #1) involved in investigation 67753-I. Finding follows: Record review on 5/9/16 revealed a Medication Variance Report, dated 4/26/17 for Client #1. According to the report Client #1 received another client's dose of Clozaril. Further review revealed a Nursing Assessment, dated 4/26/17 at 9:02 a.m., indicated staff brought Client #1 to the medical center for observation. The client was transferred to the hospital for accidental administration and ingestion of Clozaril. The assessment noted Client #1 had taken his/her prescribed medications prior to the ingestion of the Clozaril. According to the assessment Client #1 appeared drowsy and speech seemed more difficult to understand. Staff administered activated charcoal prior to arrival at the med center, as required by policy. At 9:24 a.m. another assessment documented Client #1's transfer to the hospital. Client #1 was transferred	W 104	See attached POC 7/6/17	

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 104	Continued From page 1 onto a gurney and left the medical center for the hospital at 9:30 a.m. Nursing staff completed an assessment at 4:15 p.m. According to the assessment Client #1 returned to medical center from the hospital and appeared a little sleepy, but able to ambulate with standby assist. Client #1's parents were at his/her bedside and requested medications be held until tomorrow. Additional record review revealed a nursing assessment, completed 4/26/17 at 9:00 a.m. The assessment documented Client #1 received another clients medications, which included: Clozaril 150 mg, Inderal mg, Lithium 750 mg, Clorazepate 15 mg; in addition to his/her own medications, which included: Depakote 750 mg, Klonipin 1.5 mg, and Cogentin 1.5 mg. Further record review revealed Woodward Resource Center Nursing Protocol subject Clozapine (Clozaril), revision date 8/16. The purpose of the policy read, "There are individuals at WRC (Woodward Resource Center) receiving clozapine for management of psychotic disorders. Clozapine has serious side effects, and can potentially cause harm-even death. Employees at WRC need to be aware of the potential harm, and the procedure to safely administer this medication. The policy included Special Procedures which required a "helper" to witness the administration of clozapine and document on the helper checklist. Review of the a.m. shift helper checklist revealed Staff B initialed all area of the helper checklist. When interviewed on 5/9/17 at 12:30 p.m. Staff A said she administered medications on 4/26/17 when Client #1 received 100 mg of Clozaril/clozapine. She confirmed Client #1	W 104		

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W 104	Continued From page 2 received another client's Clozaril. She said the morning had been hectic and although the policy/protocol directed that Clozaril be passed first, the client to receive the medication would not get out of bed so she administered other client medications. She confirmed Staff B functioned as the "helper" to witness the administration of Clozaril per protocol. She said Staff B signed the "helper" checklist after she popped the pills and placed them in a medication cup. She said after Client #1 took the Clozaril she contacted the nurse and administered activated charcoal. Once the nurse arrived Client #1 was sent to med center and then on to Mercy hospital. When interviewed on 5/17/17 at 10:45 a.m. Staff B admitted he signed the "helper" checklist before visually identifying the correct person. According to Staff B said he should have completed each step of the protocol before signing they items had been completed. Staff B said he could say whether Client #1 grabbed the medications or Staff A handed the medications to Client #1. When interviewed on 5/9/17 at 1:00 p.m. Staff C (nurse) said Staff A called her to report Client #1 she gave Client #1 another client's Clozaril. Staff C said she asked Staff A why the Clozaril wasn't administered first per protocol and Staff A said the client who should have received the Clozaril would not get out of bed so Staff A administered other medications. Staff A confirmed Staff B should not have signed the "helper" checklist before he ensured the medication aide identified the correct person. She said Staff A told her that Staff B had signed off on the "helper" checklist before Client #1 received the Clozaril.	W 104		

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W 104	Continued From page 3 Review on 5/17/17 of the document titled Woodward Resource Center (WRC) Nursing Protocols, identified nursing protocols which included and in bold letters the following: "Clozapine given to the wrong person may be fatal!" Client #1's diagnosis included bipolar disorder, intermittant explosive disorder, attention deficient hyperactivity disorder and moderate intellectual disabilities. Review on 5/17/17 of WRC Type 1 Incident Investigation report revealed Client #1 received the following medications prescribed for another client on4/26/17, Clozaril 150 mg, Inderal 20 mg, Lithium 750 mg and Clorazepate 15mg. Staff A also administered Client #1's routine medications that included Depakote 750 mg, Klonopin 1.5 mg and Cogentin 1.5 mg. Interviews and record review confirm the "helper" signed off that all steps of the protocol had been completed without actually following and ensuring the steps had been followed. This resulted in Client #1 receiving Clozaril (clozapine) a potentially fatal medication not intended for the client.	W 104		
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 interviews and record review, the facility' failed to ensure clients received medication consistent with physician's orders. This affected 1 of 1 client (Client #1) involved in	W 368		

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W 368	Continued From page 4 investigation 67753-I. Finding follows: Record review on 5/9/16 revealed a Medication Variance Report, dated 4/26/17 for Client #1. According to the report Client #1 received another client's medications. Additional record rview revealed the following: a. A nursing assessment, completed 4/26/17 at 9:00 a.m., documented Client #1 received another clients medications, which included: Clozaril 150 mg, Inderal mg, Lithium 750 mg, Clorazepate 15 mg; in addition to his/her own medications, which included: Depakote 750 mg, Klonipin 1.5 mg, and Cogentin 1.5 mg. b. A nursing assessment, completed 4/26/17 at 9:02 a.m., indicated staff took Client #1 to the med center for observation. The client was transferred to the hospital for accidental administration and ingestion of Clozaril. The assessment noted Client #1 took his/her prescribed medications prior to the ingestion of the other client's medications. According to the assessment Client #1 appeared drowsy and speech seemed more difficult to understand. Staff administered activated charcoal prior to arrival at the med center, as required by policy. At 9:24 a.m. another assessment documented Client #1's transfer to the hospital. Client #1 was transferred onto a gurney and left the medical center for the hospital Hospital at 9:30 a.m. c. A nursing assessment, completed 4/26/17 at 4:15 p.m., documented Client #1 returned to the medical center from the hospital and appeared a little sleepy, but able to ambulate with standby assist. Client #1's parents were at his/her bedside and requested medications be held until	W 368		

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W 368	Continued From page 5 tomorrow. Review on 5/17/17 of the document titled Woodward Resource Center (WRC) Nursing Protocols, identified nursing protocols which included and in bold letters the following: "Clozapine given to the wrong person may be fatal!" Additional record review on 5/30/17 revealed the facility's medication administration procedure. The procedure indicated no presetting of medications allowed. Medications should be prepared just prior to administration, and according to the physician's order. Only one individual's medications should be prepared at a time. Client #1's diagnosis included bipolar disorder, intermittant explosive disorder, attention deficient hyperactivity disorder and moderate intellectual disabilities. Review on 5/17/17 of WRC Type 1 Incident Investigation report revealed Client #1 received the following medications prescribed for another client on4/26/17, Clozaril 150 mg, Inderal 20 mg, Lithium 750 mg and Clorazepate 15mg. Staff A also administered Client #1's routine medications that included Depakote 750 mg, Klonopin 1.5 mg and Cogentin 1.5 mg. When interviewed on 5/9/17 at 12:30 p.m. Staff A said she administered medications on 4/26/17 when Client #1 received another client's medication in addition to his/her own prescribed medications. She confirmed the other client's medications Client #1 received included Clozaril. She said the morning had been hectic and although the policy/protocol directed that Clozaril be passed first, the client to receive the	W 368		

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W 368	Continued From page 6 medication would not get out of bed so she administered other client medications. She confirmed Staff B functioned as the "helper" to witness the administration of Clozaril per protocol. She said Staff B signed the "helper" checklist after she popped the pills and placed them in a medication cup. She said after Client #1 took the Clozaril she contacted the nurse and administered activated charcoal. Once the nurse arrived Client #1 was sent to med center and then on to Mercy hospital. When interviewed on 5/17/17 at 10:45 a.m. Staff B admitted he signed the "helper" checklist before visually identifying the correct person. Staff B stated he should have completed each step of the protocol before signing the items as completed. Staff B sstated he could not say whether Client #1 grabbed the medications or Staff A handed the medications to Client #1. When interviewed on 5/9/17 at 1:00 p.m. Staff C (nurse) said Staff A called her to report Client #1 she gave Client #1 another client's Clozaril. Staff C said she asked Staff A why the Clozaril wasn't administered first per protocol and Staff A said the client who should have received the Clozaril would not get out of bed, so Staff A administered other medications. Staff A confirmed Staff B should not have signed the "helper" checklist before he ensured the medication aide identified the correct person. She said Staff A told her that Staff B had signed off on the "helper" checklist before Client #1 received the Clozaril. Interviews and record review confirmed the "helper" signed off that all steps of the protocol had been completed without actually following and ensuring the steps had been followed. This	W 368		

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W 368	Continued From page 7 resulted in Client #1 receiving Clozaril (clozapine) a potentially fatal medication not intended for the client. This posed as an additional safety threat when Client #1 had the accumulation of his/her own medications and the other resident's medications, including the Clozaril.	W 368		

LK 6/16/17 CAC 6/13/17

Woodward Resource Center (WRC)
Standard Level Plan of Correction for DIA Investigation #67753-I

Tag W-104 - Governing Body - 483.410(a)(1): The governing body must exercise general policy, budget, and operating direction over the facility.

Individual response

WRC reviewed the Clozapine Protocol and determined it was appropriate with no revisions necessary.

Responsible: Superintendent
Date due: 6/8/17

Systemic response

WRC will continue to provide competency-based training and monitor employees to ensure they perform their duties effectively and competently.

WRC management team will continue to develop, monitor, and revise, as necessary, policies and operating directions which ensure the necessary staffing, training resources, equipment and environment to provide clients with active treatment and to provide for their health and safety.

New employees that work directly with clients receive training on the Clozapine Protocol which includes Clozapine helper expectations during new employee orientation and annually thereafter

Certified Medication Aides (CMAs), RTWs, RTTs, RTSs, TPMs and Nurses will be retrained on the Clozapine Protocol which includes Clozapine helper expectations and annually thereafter.

CMAs will continue to be monitored passing medications on a routine basis by Nurses and Treatment Program Managers.

Responsible: Assistant Superintendent and Administrator of Nursing
Date due: 7/6/17

Tag W-368 – Health Care Services - 483.460(k)(1): All drugs are administered in compliance with the physician's orders.

On April 26, 2017 Client 1 received his/her morning medications at 8:15am. At approximately 8:45am Client 1 took and ingested (Client 2's) medications including Clozapine. RTW A immediately reported the medication variance to the nurse, activated charcoal was administered per facility protocol and, out of an abundance of caution, Client 1 was quickly transferred WRC Medical Center. Upon arriving at WRC Medical Center, Client 1 was alert but slightly drowsy and his/her speech was slightly more difficult to understand than normal. Nursing assessment determined all vital signs were within normal limits for Client 1 at that time, but, out of an abundance of caution, Client 1 was transferred to Mercy Medical ER by ambulance per protocol at 9:24 AM. Client 1 returned from Mercy Hospital ER (without admission) to WRC Medical

Center at 4:15 PM that afternoon. Client 1 spent the night at WRC Medical Center for routine monitoring per facility protocol. RTW A reported the medication variance to supervisory personnel immediately on April 26, 2017. Following the report, an internal investigation was initiated and report was made to DIA. Client 1 did not experience any significant physical adverse effects from the medication error, the facility complied with its protocol, and Client 1 was treated with an abundance of caution.

WRC's internal investigation and WRC's Incident Review Committee found that the Certified Medication Aide (CMA), (RTW A), did not ensure the correct client received the Clozapine medication. The Clozapine medication checker, also a CMA, (RTW B) signed off on the Clozapine medication before the medication was given to the correct individual.

DIA found that facility staff failed to consistently administer medications according to physician's orders. A client received another individuals medications, in addition to his/her own. Staff also failed to follow facility protocol for the administration of Clozapine. The protocol required a staff witness/helper ensure the medication would be administered to the appropriate client. The staff assigned the responsibility of the helper admitted to signing off in the helper checklist without ensuring each step was followed.

Individual response

WRC fully reviewed this self-reported incident.

RTW A received appropriate discipline on May 15, 2017.
RTW B received appropriate discipline on May 16, 2017.
RTW A and RTW B were re-trained on the Clozapine Protocol which includes Clozapine helper expectations.
Staff assigned to 103 Cherry who work directly with Client #1 were re-trained on the Clozapine Protocol which includes Clozapine helper expectations.

Responsible: Team 2 Treatment Program Administrator
Date due: 5/25/17

Systemic response

WRC will continue to provide competency-based training and monitor employees to ensure they perform their duties effectively and competently.

WRC management team will continue to develop, monitor, and revise, as necessary, policies and operating directions which ensure the necessary staffing, training resources, equipment and environment to provide clients with active treatment and to provide for their health and safety.

New employees that work directly with clients receive training on the Clozapine Protocol which includes Clozapine helper expectations during new employee orientation and annually thereafter

Certified Medication Aides (CMAs), RTWs, RTTs, RTSs, TPMs and Nurses will be retrained on the Clozapine Protocol which includes Clozapine helper expectations and annually thereafter.

CMAs will continue to be monitored passing medications on a routine basis by Nurses and Treatment Program Managers.

Responsible: Assistant Superintendent and Administrator of Nursing
Date due: 7/6/17