MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Sunlight Senior Living	HL27035004	June 30, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
400 Western Avenue	8:30 a.m.- 2:30 p.m.	August 31, 2016
Facility City:	**Investigator's Name and Title:**	
St. Paul	Rhylee Gilb, RN Special Investigator	

State:	ZIP:	County:
Minnesota	55103	Ramsey

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when facility staff failed to administer his/her antipsychotic medications and the client's mental health severely declined. The client was hospitalized.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the home care provider staff failed to administer a client his/her antipsychotic medication. The client experienced severe decompensation of mental health, was hospitalized and was civilly committed as a person who is mentally ill.

The client was living at home independently prior to his/her hospitalization. After discharge, the client started receiving medication administration services from the home care provider. The client had a history of severe mental illness, including schizophrenia for most of his/her life. The client was discharged from the hospital stable on clozapine (an antipsychotic). The client's mental health baseline included some anxiety, but was pleasant, cooperative and socially interactive.

Upon admission to the home care provider, the client arrived with enough supply of clozapine to last seven days and medications were ordered through the home care provider's pharmacy. However, the client's previous pharmacy had already filled the prescription, therefore the home care provider's pharmacy did not fill the order, and no clozapine was delivered to the home care provider. When the client's initial supply ran out, the client did not receive clozapine for the next six days, and began to deteriorate mentally with increasing behaviors. The client experienced decreased appetite, auditory and visual hallucinations, aggression, and withdrawal. The home care provider did not inform the client's physician until the fifth day without the medication, and the client was seen by the physician on the sixth day. The physician re-ordered clozapine so the pharmacy could refill the medication with a new prescription, but with deterioration of mental status, the client was hospitalized the following day before the medication supply arrived.

During an interview with home care provider staff, staff stated the client's clozapine was delivered from the pharmacy in bubble packs and needed to be dispensed each evening. The staff stated clients on clozapine often need routine labs before the medication is dispensed from the pharmacy. When the medication supply was out and none was in the overflow supply, they updated the nurse.

During an interview, the Registered Nurse (RN) Supervisor stated s/he was aware there was no clozapine supply for the client on the first day the medication was out. S/he stated s/he contacted the pharmacy who stated they could not refill the medication, because it was already filled by another pharmacy. The RN Supervisor stated it took a few days to go through different contacts to find the client's previous home pharmacy and determine the supply was delivered to the client's previous home. The RN Supervisor updated the home care provider's pharmacy who stated they would fill the clozapine with a new written prescription by the physician. S/he stated she updated the physician, who stated s/he would see the client the following day and re-order the clozapine. The RN Supervisor explained the client was sent to the hospital the following day for uncontrolled psychotic behaviors.

During an interview with the client's psychiatric physician, the physician stated s/he had worked with the client for about ten years. The physician stated the client had a long history of managing schizophrenia symptoms, like paranoia and disorganized thinking with antipsychotic medication. The physician did not prescribe the dose of clozapine for the client while in the hospital, but stated if the client had not taken that medication in a week, s/he could get sedated and there was potential for the client's white blood cell count to drop. S/he stated without receiving clozapine, s/he would expect to see the client become delirious and psychotic due to the sudden change in medication. The physician stated for patients on clozapine, it is typical to do a slow taper when decreasing the medication and not suddenly stop the drug.

The client was hospitalized during the on-site investigation. During the hospitalization, the client was placed under civil commitment by the court. An interview was not conducted with the client.

During an interview with the client's family, the family member stated the client was happy, excited, met other clients, and used the piano during the first week with this provider. After that week, the family member stated the client had a significant change in mental status. The family member stated the client experienced a panic attack, called every hour speaking in a nonsensical manner, and started swearing and hitting people. The family member stated s/he was not aware the client was out his/her antipsychotic medication until after the client was hospitalized.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The home care provider failed to obtain a supply of the client's antipsychotic medication for six days and the proper medication was not administered. The client's suffered serious mental health symptoms and required hospitalization for decompensation.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☐ Physician Progress Notes
- ☒ Facility Incident Reports
- ☒ Service Plan

Other pertinent medical records:

- ☒ Other, specify:

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: n/a

Were residents selected based on the allegation(s)? ○ Yes ○ No ◉ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: the client was hospitalized

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ○ Yes ◉ No ○ N/A

Specify: unable to contact

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: _____

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: _____

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: four

Physician Interviewed: ◉ Yes ○ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ◯ Yes, date subpoena was issued _____ ◯ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Cleanliness

☒ Facility Tour

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A

Was equipment being operated in safe manner: ◯ Yes ◯ No ◉ N/A

Were photographs taken: ◯ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

Minnesota Board of Nursing

The Office of Ombudsman for Mental Health and Developmental Disabilities

Saint Paul Police Department

Ramsey County Attorney

St. Paul City Attorney

Minnesota Department of Health

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	H27035	A. BUILDING: _____ B. WING _____	C 08/31/2016

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On 6/30/16, a complaint investigation was initiated to investigate complaint #27035004 . At the time of the survey, there were 51 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights:	0 325		

Minnesota Department of Health

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0 325	Continued From page 1 (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to administer a client's antipsychotic medication for six days for one of one clients (C1). C1 experienced a psychotic breakdown requiring hospitalization. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 was admitted to the licensee on 4/7/16, with diagnoses that included schizophrenia, depression and anxiety. Review of C1's service plan dated 4/7/16 indicated C1 required assistance with medication administration, medication storage and medication ordering. C1's hospital record physician note dated 3/27/16 indicated C1 was hospitalized due to non compliance with medications while living independently. Hospital discharge orders dated 4/6/16 included an order for clozapine 300 milligram (mg) daily at bedtime (hour of sleep)(HS) for schizophrenia.	0 325		

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0 325	Continued From page 2 C1 admitted to the licensee with a seven day supply of the medication. C1's hospital discharge summary indicated C1 stabilized on clozapine. C1's medication administration record (MAR) for April 2016 was reviewed. C1 received clozapine 300 mg daily at HS 4/7/16 through 4/13/16. On 4/14/16 through 4/19/16 licensee staff omitted C1's clozapine, a total of six days. The reason for omittance was indicated for 4/14/16, 4/16/16, 4/17/16, and 4/18/16 as clozapine not available. The pharmacy log for C1's admission was reviewed. On 4/6/16 the pharmacy received the hospital discharge orders and began processing medications to be dispensed to the licensee. The log affirmed the order was processed on 4/6/16 and a ship date for medications was scheduled for 4/7/16. However, the log indicated no supply of clozapine was shipped. The pharmacy client profile printed on 4/8/16 provided to the licensee also indicated under the 'fill date' column, clozapine was not filled. A refill request for clozapine 300 mg was received on 4/15/16 from the licensee. There was an error in refilling the clozapine requiring a predispense authorization by the prescriber. The pharmacy called the licensee on 4/15/16 at 5:37 p.m. with no answer. On 4/18/16 at 9:38 a.m., the pharmacy left a voicemail for the director of nursing. On 4/19/16, a new order for: -clozapine 50 mg daily at HS for one week, -then increase to clozapine 10mg daily at HS for one week, -then increase to clozapine 150 mg daily at HS for one week, -then increase to clozapine 200 mg daily at HS for one week, -then increase to clozapine 300 mg daily at HS.	0 325		

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0 325	Continued From page 3 The order was processed on 4/20/16 and a ship date scheduled for 4/20/16. C1's physician notes indicated the physician was notified on 4/18/16 at 5:25 p.m. C1 had been out of supply of clozapine for the last five days and the licensee staff had been unable to refill from the pharmacy. C1's nursing progress notes dated 4/18/16 through 4/20/16, indicated C1 stated to the registered nurse (RN)-A, "I feel sick" and "I hear voices." C1 had been out of clozapine supply for five days and began having delusions. On 4/191/16, C1 experienced disconnected thoughts, auditory hallucinations and began refusing medications and food. On 4/20/16, on the night shift C1 began using profanity towards staff and pulled pants down to moon (show buttocks to) staff. C1 then told staff there was a hammer in her room and she was going to kill herself, staff found the hammer and removed it from C1's room. When the day shift staff arrived in the morning, C1 hit a staff member in the face. Staff redirected C1 and when staff turned around, C1 came back up from behind the staff member and grab her shirt. C1 was transferred to the hospital at 7:33 a.m. on 4/20/16. On 6/30/16, at 1:25 p.m. an interview with the trained medication assistant (TMA)-C stated she made a phone call to the nurse and informed her C1 had no supply of Clozapine. TMA-C stated after not receiving her Clozapine, C1 became more withdrawn, locking herself in her room and refusing to eat. During an interview on 6/30/16, at 12:50 p.m. with the RN-A, stated she was aware there was no supply of Clozapine on 4/14/16 and C1 had	0 325		

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0 325	Continued From page 4 admitted with enough supply to last one week. RN-A stated she contacted the pharmacy and found C1's previous home pharmacy had filled Clozapine and therefore the pharmacy could not fill the medication. RN-A stated it took a few days to determine which pharmacy had filled the medication. She explained she reached out to C1's social worker and relative. RN-A stated C1's relative was not sure of what pharmacy it was either, and it took the social worker a few days to return her phone call. On 8/11/16, at 1:15 p.m. an interview with C1's Mental Health Case Manager stated she had known C1 for sixteen years and this was the worst case of psychosis from not receiving a medication that she had seen. The Case Manager stated C1's baseline did have anxiety, however C1 was cooperative, polite and pleasant to work with. The Case Manager explained C1's mental health was affected by not receiving Clozapine indicated by C1's bizarre behavior, mooning people, hallucinations and disregard for safety. The Case Manager stated, while at the licensee, C1 walked out into traffic. The Case Manager also stated C1 believed she had killed someone and had their blood on her hands. The Case Manager stated, because of this severe mental decline, C1 was mentally committed in May 2016. Previously C1 had been independent, only requiring assistance with medications. The Case Manager stated the licensee never contacted to her to assist the staff with refilling the Clozapine or to discuss C1's change in behaviors. In an interview with C1's family member on 7/13/16, at 5:00 p.m., the family member stated C1 was doing well at the licensee the first week, C1 was happy, excited, met some friends and	0 325		

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0 325	Continued From page 5 used the piano. The family member explained after the first week, C1 mental status changed. C1 experienced a panic attack and was calling the family member every hour, making nonsensical speech. The family member stated C1 started to cuss and hit people. The family member stated the licensee did not notify her C1 was out of Clozapine until after C1 was hospitalized. The licensee policy titled "Medication and Supplies Reordering" dated 1/1/15, indicated the licensee staff will assist clients to make sure medications are ordered and available as needed. Staff will plan for needs of clients for refills on prescriptions and contact the pharmacy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 935 SS=G	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8. Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when	0 935		

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0 935	Continued From page 6 medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to administer clozapine as ordered to one of one client (C1) reviewed. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's policy titled "Medication Administration Documentation" dated 1/1/15, indicated the unlicensed staff will chart in each client's medication administration record (MAR) any problems with medication administration. The licensee's policy titled "Medication Errors" dated 1/1/15, indicated whenever a medication error occurs, the staff will contact the licensed nurse and explain the situation. The licensed nurse will give instructions which may include contacting the physician, the client's family and/or 911. The staff will complete a medication error report and document in the client's progress notes and include what actions were taken to correct the situation.	0 935		

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0 935	Continued From page 7 C1's medical record was reviewed. C1 was admitted to the licensee on 4/7/16, with diagnoses that included schizophrenia, depression and anxiety. Review of C1's service plan dated 4/7/16 indicated C1 required assistance with medication administration, medication storage and medication ordering. C1's hospital record physician note dated 3/27/16 indicated C1 was hospitalized due to non compliance of medications while living independently. Hospital discharge orders dated 4/6/16 included an order for clozapine 300 milligram (mg) daily at bedtime (hour of sleep)(HS) for schizophrenia. C1 admitted to the licensee with a seven day supply of the medication. C1's hospital discharge summary indicated C1 stabilized on clozapine. C1's MAR for April 2016 was reviewed. C1 received clozapine 300 mg daily at HS 4/7/16 through 4/13/16. On 4/14/16 through 4/19/16 licensee staff omitted C1's clozapine, a total of six days. The reason for omittance was indicated for 4/14/16, 4/16/16, 4/17/16, and 4/18/16 as clozapine not available. There was no record of a medication error report for the missed doses of clozapine. On 6/30/16, at 1:25 p.m. an interview with the trained medication assistant (TMA)-C stated she made a phone call to the nurse and informed her C1 had no supply of clozapine. TMA-C stated after not receiving her clozapine, C1 became more withdrawn, locking herself in her room and refused to eat. During an interview on 6/30/16, at 12:50 p.m. with the RN-A, stated she was aware there was no	0 935		

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0 935	Continued From page 8 supply of clozapine on 4/14/16 and C1 had admitted with enough supply to last one week. RN-A stated she contacted the pharmacy and found C1's previous home pharmacy had filled Clozapine and therefore the pharmacy could not fill the medication. RN-A stated it took a few days to determine which pharmacy had filled the medication. She explained she reached out to C1's social worker and relative. RN-A stated C1's relative was not sure of which pharmacy it was either, and it took the social worker a few days to return her phone call. RN-A stated C1's physician was updated on 4/18/16 and on 4/19/16 C1's physician saw the client and wrote a new prescription for clozapine. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 935		
02015 SS=G	626.557, Subd. 3 Timing of Report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in	02015		

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	H27035	A. BUILDING: _____ B. WING _____	C 08/31/2016

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02015	Continued From page 9 the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.	02015		

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02015	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to report a vulnerable adult complaint for one of one client reviewed (C1) when the client had a psychotic break after not receiving clozapine (antipsychotic medication) for seven days. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 admitted to the licensee on 4/7/16, with diagnoses that included schizophrenia, depression and anxiety. Review of C1's service plan dated 4/7/16 indicated C1 required assistance with medication administration, medication storage and medication ordering. C1's hospital record physician note dated 3/27/16 indicated C1 was hospitalized due to non compliance of medications while living independently. Hospital discharge orders dated 4/6/16 included an order for clozapine 300 milligram (mg) daily at bedtime (hour of sleep)(HS) for schizophrenia. C1 admitted to the licensee with a seven day supply of the medication. C1's medication administration record (MAR) for	02015		

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02015	Continued From page 11 April 2016 was reviewed. C1 received clozapine 300 mg daily at HS 4/7/16 through 4/13/16. On 4/14/16 through 4/19/16 licensee staff omitted C1's clozapine, a total of six days. The reason for omittance was indicated for 4/14/16, 4/16/16, 4/17/16, and 4/18/16 as clozapine not available. The pharmacy log for C1's admission was reviewed. On 4/6/16 the pharmacy received the hospital discharge orders and began processing medications to be dispensed to the licensee. The log affirmed the order was processed on 4/6/16 and a ship date for medications was scheduled for 4/7/16. However, the log indicated no supply of clozapine was shipped. The pharmacy client profile printed on 4/8/16 provided to the licensee also indicated under the 'fill date' column, clozapine was not filled. A refill request for clozapine 300 mg was received on 4/15/16 from the licensee. There was an error in refilling the clozapine requiring a predispense authorization by the prescriber. The pharmacy called the licensee on 4/15/16 at 5:37 p.m. with no answer. On 4/18/16 at 9:38 a.m., the pharmacy left a voicemail for the director of nursing (DON). On 4/19/16, a new order was received for: -clozapine 50 mg daily at HS for one week, -then increase to clozapine 10mg daily at HS for one week, -then increase to clozapine 150 mg daily at HS for one week, -then increase to clozapine 200 mg daily at HS for one week, -then increase to clozapine 300 mg daily at HS. The order was processed on 4/20/16 and a ship date scheduled for 4/20/16. C1's nursing notes dated 4/20/16 indicated C1 was transported the hospital around 7:00 a.m. for	02015		

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02015	Continued From page 12 deteriorated mental status and behaviors. During an interview on 6/30/16 at 12:50 p.m. with the registered nurse (RN)-A, stated she was aware there was no supply of Clozapine on 4/14/16 and C1 had admitted with enough supply to last one week. RN-A stated she contacted the pharmacy and found C1's previous home pharmacy had filled Clozapine and therefore the pharmacy could not fill the medication. RN-A stated it took a few days to determine which pharmacy had filled the medication. She explained she reached out to C1's social worker and relative. RN-A stated C1's relative was not sure of which pharmacy it was either, and it took the social worker a few days to return her phone call. RN-A stated C1 was initially adjusting well to the home care provider, playing piano and engaging with a friend. However, as C1 went without Clozapine, C1 no longer engaged and C1's behaviors escalated. C1 used profanity words, inappropriate words and called staff and family names. C1 refused to eat and had visual hallucinations, such as staff were feeding her worms, saw blood and made reference to have killed someone. On 8/11/16, at 1:15 p.m. an interview with C1's mental health case manager stated she had known C1 for sixteen years and this was the worst case of psychosis from not receiving a medication that she had seen. The case manager stated C1's baseline did have anxiety, however C1 was cooperative, polite and pleasant to work with. The case manager explained C1's mental health was affected by not receiving Clozapine indicated by C1's bizarre behavior, mooning people, hallucinations and disregard for safety. The case manager stated, while at the licensee, C1 walked out into traffic. The case manager also	02015		

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02015	Continued From page 13 stated C1 believed she had killed someone and had their blood on her hands. The case manager stated, because of this severe mental decline, C1 became mentally committed in May 2016. Previously C1 had been independent, only requiring assistance with medications. The case manager stated the licensee never contacted to her to assist the staff with refilling the Clozapine or to discuss C1's change in behaviors. The licensee's policy titled "Vulnerable Adult Reporting Policy" dated 1/1/14, indicated the licensee will report any suspected neglect of a vulnerable adult in an event of failure to provide services of health care. The licensee is responsible for documenting the incident and reporting to the common entry point within twenty-four hours. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02015		