

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE MAIN AND JEFFERSON DUPONT, IN 47231
---	---

(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
W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Survey Dates: February 18, 20, 24, 28 and March 3, 2014</p> <p>Facility Number: 000852 Provider Number: 15G334 AIM Number 100243920</p> <p>Surveyor: Jo Anna Scott, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/10/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 additional clients (clients #5, #6, #7 and #8), the governing body failed to exercise operating direction over the facility to ensure repairs were made to</p>	W000104	<p><b>W104: The governing body must exercise general policy, budget, and operating direction over facility.</b></p> <p><b>Corrective action:</b></p>	04/02/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G334		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/03/2014	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE MAIN AND JEFFERSON DUPONT, IN 47231			
(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			
	<p>the kitchen cabinet and broken towel racks.</p> <p>Findings include:</p> <p>During the observation period on 2/18/14 from 3:30 PM to 7:00 PM, the kitchen cabinet door under the kitchen sink had an area of 5" (inches) wide at the bottom and 8" high at the top in a triangular shape without any finish. The veneer covering the door was chipping off in pieces. Staff #4 indicated on 2/18/14 at 3:45 PM clients #1, #2, #3, #4, #5, #6, #7 and #8 all worked in the kitchen and assisted with wiping the cabinets off and could get pieces of the veneer off.</p> <p>Observations of the bathroom facility on the first floor were conducted on 2/18/14 at 3:35 PM. The towel rack on the wall was broken.</p> <p>Interview with staff #4 on 2/18/14 at 3:40 PM stated "There is only one restroom on the first floor and all the clients use it when they are downstairs." Staff #4 indicated the kitchen cabinet door had started chipping some time ago and should have been replaced.</p> <p>9-3-1(a)</p>		<p>Maintenance requests have been submitted for needed repairs (Attachment A).</p> <p><b>How we will identify others:</b> Clinical Supervisors will review homes to ensure that Maintenance requests have been submitted for needed repairs.</p> <p><b>Measures to be put in place:</b> Weekly Preventative Maintenance checklist has been implemented (Attachment B).</p> <p><b>Monitoring of Corrective Action:</b> EDOM Site Visit Checklist will be completed bi monthly by Operations Manager to ensure that maintenance requests are completed (Attachment C).</p> <p><b>Completion Date:</b> 4-2-2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE MAIN AND JEFFERSON DUPONT, IN 47231
---	---

(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
W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation and interview for 2 of 5 clients (clients #2 and #5) receiving medication, the facility failed to ensure staff were sufficiently trained to ensure the Medication Administration Record (MAR) was reviewed before administering the medication.</p> <p>Findings include:</p> <p>During the observation period on 2/20/14 from 5:55 AM to 8:00 AM, the morning medication pass started at 6:00 AM. Client #2 came to the medication room at 6:00 AM and staff #5 removed a plastic container holding bubble packs of client #2's medication and popped out the following pills without looking at the MAR: Divalproex 250 mg (milligram) and 500 mg (seizures), Chlorpromazine 20 mg (psychosis), Fenofibrate 145 mg (triglycerides), Lisinopril 5 mg (hypertension), Lorazepam 1 mg (anxiety), Metformin 500 mg (diabetes),</p>	W000189	<p><b>PROVIDER IDENTIFICATION</b> #: 15G334 <b>NAME OF PROVIDER:</b> <b>RESCARE COMMUNITY ALT.,</b> <b>SOUTHCENTRAL</b> <b>ADDRESS: Main &amp; Jefferson</b> <b>Dupont, Indiana 47231</b> <b>SURVEY EVENT ID #: OELM11</b></p> <p><b>DATE SURVEY COMPLETED:</b> 03/03/2014</p> <p><b>PROVIDER'S PLAN OF CORRECTION ADDENDUM 3</b> <b><u>W189: A more frequent monitoring system is needed to ensure compliance</u></b></p> <ul style="list-style-type: none"> <li>·All staff will complete Core A and Core B during orientation and training.</li> <li>·Prior to being able to pass meds independently: <ul style="list-style-type: none"> <li>·All staff will show 100% proficiency during two supervised Medication Passes.</li> <li>·Both supervised passes will be done with a Residential Manager within 14 days of completing Orientation.</li> </ul> </li> </ul>	03/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/03/2014
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE MAIN AND JEFFERSON DUPONT, IN 47231		
(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	
	<p>Trihexphenidyl 2 mg (parkinson symptoms) and Zetia 10 mg (cholesterol). Client #2 took the medication without staff #5 checking the MAR.</p> <p>Client #5 came to the medication room at 6:15 AM and staff #5 removed a plastic container with his name from the cabinet. The plastic container contained client #5's medicine in bubble packs and staff #5 popped out the medicine without looking at the MAR. Client #5 received Benazepril 10 mg (ACE inhibitors), Certavite Tab Senior (diet supplement), Gemfibrozil 600 mg (hyperlipidemia), Metformin 100 mg (diabetes) and Nexium 40 mg (gastroesophageal reflux). Staff #5 did not check the MAR before giving the medication to client #5.</p> <p>The interview with staff #6, Register Nurse (RN), was conducted on 2/28/14 at 11:00 AM. Staff #6, RN, stated "The MAR should be checked three times before the medication is prepared for the clients."</p> <p>9-3-3(a)</p>		<ul style="list-style-type: none"> <li>·All staff will complete 1 Medication Pass with the Nurse during training and prior to being able to pass medication independently.</li> <li>·The third and final proficiency pass with the nurse must be completed within 14 days of the completion of orientation.</li> <li>·Clinical Supervisor will perform Active Treatment Observations two (2) times weekly to ensure all medication passes are being completed correctly.</li> <li>·Nurse will be in home weekly and perform Medication Room Weekly Checklist one (1) time weekly to ensure compliance.</li> <li>·Nurse will observe one (1) Medication pass weekly in home.</li> <li>·All staff will demonstrate MAR/ Medication Pass compliance annually. (Attachment A)</li> </ul> <p><b><u>How we will identify others:</u></b> Clinical Supervisors will perform weekly Active Treatment Observations, including medication administration, to ensure that medications are dispensed correctly. <b><u>Measure to be put in place:</u></b> Nursing Coordinators will perform Medication Administration Active Treatment observations Bi-annually. <b><u>Monitoring of Corrective Action:</u></b> Director of Health Services will review Nursing Active Treatment observations to ensure that</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G334		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/03/2014	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE MAIN AND JEFFERSON DUPONT, IN 47231			
(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			
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 4 sampled clients (client #4), the facility failed to ensure a hearing evaluation had been conducted.</p> <p>Findings include:</p> <p>The record review for client #4 was conducted on 2/20/14 at 10:54 AM. The record indicated client #4 was admitted to the home on 2/25/13. There was no indication client #4 had a hearing evaluation.</p> <p>Interview with staff #6, RN (Registered Nurse) on 2/28/14 at 11:00 AM indicated client #4 showed no signs of hearing loss but he should have had a hearing evaluation.</p> <p>9-3-6(a)</p>	W000323	<p>medications are dispensed correctly.</p> <p>-</p> <p><b>W323: The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</b></p> <p><b>Corrective action:</b> · Client #4 has a Hearing Evaluation scheduled for 4-22-2014.</p> <p><b>How we will identify others:</b> Nursing Coordinators will review Hearing evaluations to ensure that hearing has been checked annually or per Physician order.</p> <p><b>Measures to be put in place:</b> A weekly Nursing Coordinator checklist (Attachment F) has been implemented to ensure that Hearing evaluations are</p>	03/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G334		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/03/2014	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE MAIN AND JEFFERSON DUPONT, IN 47231			
(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			
W000340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on observation and interview for 1 of 4 sampled clients (client #1), the facility failed to ensure staff practiced good hygiene while preparing the medication for administration.</p> <p>Findings include:</p> <p>During the observation period on 2/20/14 from 5:55 AM to 8:00 AM, the medication pass was started at 6:00 AM. Client #1 came to the medication room at 7:00 AM and staff #5 got a plastic cup and started popping the pills out of the bubble packs into the plastic cup. The</p>	W000340	<p>checked weekly to ensure compliance.</p> <p><b>Monitoring of Corrective Action:</b> Manager of Health Services will perform bi-monthly Nurse Checklist to ensure that Vision examinations occur annually or per Physician order.</p> <p><b>Completion Date:</b> 3-19-2014</p> <p><b>W340: Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventative health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</b></p> <p><b>Corrective action:</b> Staff #5 has been inserviced on Medication</p>	03/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/03/2014
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE MAIN AND JEFFERSON DUPONT, IN 47231		
(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	
W000440	<p>Certavite (diet supplement) fell on the table top that had not been cleaned. Staff #5, wearing gloves, picked up the pill and dropped it into the plastic cup and handed the cup to client #1. Client #1 turned the cup up and put all the pills into his mouth at one time.</p> <p>Interview with Staff #6, Registered Nurse, on 2/28/14 at 11:00 AM indicated the staff had been trained that anytime a pill was dropped it was not to be given to the client and a new pill was to be administered. Staff #6 indicated the dropped pill was to be destroyed.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for</p>	W000440	<p>Administration (Attachment D).</p> <p><b>How we will identify others:</b> Clinical Supervisors will perform weekly Active Treatment Observations (Attachment E), including medication administration, to ensure that medications are dispensed correctly.</p> <p><b>Measures to be put in place:</b> Nursing Coordinators will perform Medication Administration Active Treatment observations (Attachment E) bi-annually.</p> <p><b>Monitoring of Corrective Action:</b> Director of Health Services will review Nursing Active Treatment observations to ensure that medications are dispensed correctly.</p> <p><b>Completion Date:</b> 3-19-2014</p> <p><b>W440:</b> The facility must hold</p>	04/02/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G334		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/03/2014	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE MAIN AND JEFFERSON DUPONT, IN 47231			
(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			
	<p>4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 additional clients (clients #5, #6, #7 and #8), the facility failed to ensure an evacuation drill was conducted quarterly on the night shift.</p> <p>Findings include:</p> <p>The record review of evacuation drills was conducted on 2/20/14 at 2:03 PM. The record indicated there was a night shift drill conducted on 2/27/13 for clients #1, #2, #3, #4, #5, #6, #7 and #8 but not another one conducted until 9/17/13. There was no record of an overnight drill conducted in March, April, May, June, July, or August, 2013.</p> <p>Interview with administrative staff #2 on 2/28/14 at 3:00 PM indicated they were unable to find where a drill had been conducted in the second quarter of 2013 on the night shift.</p> <p>9-3-7(a)</p>		<p>evacuation drills at least quarterly for each shift of personnel.</p> <p>·</p> <p><b>Corrective action:</b></p> <p>· Clinical Supervisor will be inserviced on completing evacuations.</p> <p><b>How we will identify others:</b></p> <p>Clinical Supervisors will review drills to ensure that drills have been completed per policy.</p> <p><b>Measures to be put in place:</b></p> <p>Clinical Supervisors will review drills to ensure that drills have been completed per policy.</p> <p><b>Monitoring of Corrective Action:</b></p> <p>Quality Assurance will continue to receive drills and monitor compliance.</p> <p><b>Completion Date:</b> 4-2-2014</p>				