

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G236	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2013
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5990 E 500 N CHURUBUSCO, IN 46723
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: July 23, 24, 25, and 29, 2013.</p> <p>Facility number: 000759 Provider number: 15G236 AIM number: 100243290</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/6/13 by Dotty Walton, QIDP and Ruth Shackelford, QIDP.</p>	W000000		

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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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement policy and procedures for 1 additional client (client #8) by failing to administer medications per physician's orders which resulted in client #8's hospitalization.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/23/13 at 4:00 PM and included the following medication errors:</p> <p>-A BDDS report dated 12/20/12 at 9:00 PM indicated client #8 was taken to the ER (emergency room) via ambulance after staff noticed client #8 "not acting herself and appeared lethargic." Client #8's vital signs were low and she was "unresponsive to staff and 911 was called." Client #8 was treated at the hospital with medication and her vital signs improved. Client #8 was admitted to the hospital for observation and discharged on 12/29/13. A report dated 12/21/12 at 4:00 PM indicated on 12/21/12 it was discovered client #8 had accidentally been given 100 mg</p>	W000149	<p>The facility will ensure that written policies and procedures prohibit mistreatment, neglect or abuse of the client. The Residential Manager and QIDP will complete weekly medication passing observations to ensure policies and procedures are followed. (original POC to survey completed 7/29/13) * this was added to our plan of correction that was resubmitted on 8/26/13. All staff were retrained on medication administration procedures on 8/16/13. The QIDP and agency nurse have implemented a new system to pass medications to each consumer. This system utilizes color coordination. Each consumer now has their own medication box to keep medications individualized. All medications in the consumer's box are color coordinated with the MAR to match the time given. All staff have been trained on this new system.</p>	08/27/2013	

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	<p>(milligrams) of morphine (narcotic pain reliever) prescribed for client #4. The error was discovered when client #8's doctor informed facility staff that client #8 had morphine in her system. A follow up report dated 1/1/13 indicated the staff who had given the medication had neglected to follow medication administration procedures and had been terminated.</p> <p>The Director of Operations of Supported Group Living was interviewed on 7/23/13 at 4:35 PM and indicated the medication error when client #8 had received client #4's morphine in error had resulted in her hospitalization, and staff had been terminated for the medication error.</p> <p>The facility's Operations Standard Reporting Abuse/Neglect/Exploitation/Mistreatment dated 6/11 was reviewed on 7/29/13 at 10:100 AM and indicated in part, "ResCare strictly prohibits abuse/neglect/exploitation/mistreatment." The policy indicated medication errors would be reported including, "wrong medication given; wrong medication dosage given; missed medication-not given; medication given wrong route; or medication error that jeopardizes an individual's health and welfare and requires medical attention...All incident</p>						

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	<p>reports are used as a basis for examining individual safety, are tracked through a database and reviewed by ResCare Northern Region Indiana management team, support team and safety committee. The database allows for examination of trends in incidents per home, individual, location, type of injury, etc. The safety committee will make recommendations to the management team to improve the quality of services provided to individual (sic)....."</p> <p>9-3-2(a)</p>						

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 additional client (client #8), the ISP (Individualized Support Plan) failed to promote client #8's independence by failing to address her wheelchair use for safety at day services.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 7/24/13 from 5:20 PM until 6:40 PM and on 7/25/13 from 6:35 AM until 7:56 AM. Client #8 did not use a wheelchair during the observations and walked throughout the group home during the observation.</p> <p>Observations were completed at the day services on 7/25/13 from 9:00 AM until 9:40 AM. During the observation, client #8 sat in a wheelchair with seat belt fastened. She leaned forward in her wheelchair to attempt to toss a bean bag into a target.</p> <p>The day service supervisor was interviewed on 7/25/13 at 9:30 AM. When asked about the use of the wheelchair by client #8, he stated, "We asked for an order for a wheelchair at day</p>	W000240	<p>The facility will ensure that the individual program plan will describe relevant interventions to support the individual toward independence. The wheelchair intervention at the workshop will be added to the ISP for client #8. A documentation form has been developed to track getting client #8 in and out of her wheelchair and independently walking for 15 minutes, twice a day. Staff were trained on this documentation on 8/16/13. The QIDP will complete weekly observations to ensure that the plan is implemented as written.</p>	08/27/2013	

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	<p>services," and indicated client #8 didn't watch for other peers. He indicated client #8 had misstepped and turned her ankle causing a fracture in the past while at day services. When asked if there was a plan for client #8's wheelchair use to increase her independence, he indicated client #8 had opportunities during the day to be out of the wheelchair, but there was not a written plan or documentation of her time out of the wheelchair.</p> <p>Client #8's record was reviewed on 7/25/13 at 3:40 PM. Client #8's 11/8/12 Individual Support Plan (ISP) did not include instructions for when client #8 was to use a wheelchair or when she was to be out of the wheelchair to promote her independence from its use at day services. A 5/30/13 ISP modifications note included a PT (physical therapy) evaluation for 5/8/13 with the recommendation "...[client #8's] wheelchair has been moved to a PRN (as needed) status...."</p> <p>The Director of Operations of Supported Group Living was interviewed on 7/25/13 at 3:41 PM and indicated there was no further information other than the ISP modification note regarding the use of client #8's wheelchair at day services. She indicated the day services supervisor was developing a plan with documentation</p>			

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	regarding the use of the wheelchair while at day services. 9-3-4(a)				

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 2 additional clients (clients #6 and #8) to administer medications per physician's orders.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/23/13 at 4:00 PM and included the following medication errors:</p> <p>1. A BDDS report dated 12/20/12 at 9:00 PM indicated client #8 was taken to the ER (emergency room) via ambulance after staff noticed client #8 "not acting herself and appeared lethargic." Client #8's vital signs were low and she was "unresponsive to staff and 911 was called." Client #8 was treated at the hospital with medication and her vital signs improved. Client #8 was admitted to the hospital for observation and discharged on 12/29/13. A report dated 12/21/12 at 4:00 PM indicated on 12/21/12 it was discovered client #8 had accidentally been given 100 mg (milligrams) of morphine (narcotic pain reliever) prescribed for client #4. The</p>	W000368	<p>The facility will ensure that written policies and procedures prohibit mistreatment, neglect or abuse of the client. The Residential Manager and QIDP will complete weekly medication passing observations to ensure policies and procedures are followed. (original POC to survey completed 7/29/13) * this was added to our plan of correction that was resubmitted on 8/26/13. All staff were retrained on medication administration procedures on 8/16/13. The QIDP and agency nurse have implemented a new system to pass medications to each consumer. This system utilizes color coordination. Each consumer now has their own medication box to keep medications individualized. All medications in the consumer's box are color coordinated with the MAR to match the time given. All staff have been trained on this new system.</p>	08/27/2013			

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	<p>error was discovered when client #8's doctor informed facility staff that client #8 had morphine in her system. A follow up report dated 1/1/13 indicated the staff who had given the medication had not followed medication administration procedures and had been terminated.</p> <p>2. A BDDS report dated 1/2/13 indicated client #8 had been given Clonazepam (seizure/sedative) .5 mg at 12:45 PM. "After the medication was administered, the DSP (direct support professional) discovered the medication had been discontinued." The DSP notified the QDDP (Qualified Developmental Disabilities Professional) of day services immediately and client #8's nurse and physician were also notified. "Corrective action (unspecified) was administered to the DSP according to Medication Error Policy 102.A," and indicated the day services medical director "reviews and signs off on all medication errors."</p> <p>3. A BDDS report dated 5/22/13 indicated client #6 was inadvertently given an extra dose of her Clozapine (anti-psychotic) at 4:00 PM and 8:00 PM on 5/21/13 and 5/22/13. The report indicated staff's medication passing privileges had been suspended until they had been retrained on medication administration procedures by the nurse, and client #6's vital signs</p>						

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	<p>were monitored for a week.</p> <p>Web MD website http://www.webmd.com/drugs/drug-5194-Clozaril+Oral.aspx?drugid=5194&drugname=Clozaril+Oral was reviewed on 7/25/13 at 3:30 PM and indicated in part, "While Clozapine can provide great benefits, it can rarely cause serious, possibly fatal side effects. For this reason, clozapine is used when other treatments have not worked or you cannot take them. This medication can cause a serious immune system problem called agranulocytosis (low white blood cells)...Clozapine can also cause seizures, especially in higher doses...This medication may rarely cause an inflammation of the heart muscle (myocarditis). Clozapine can cause a big drop in blood pressure...."</p> <p>The Director of Operations of Supported Group Living was interviewed on 7/23/13 at 4:35 PM and indicated the medication error when client #8 had received client #4's morphine in error had resulted in her hospitalization, and staff had been terminated for the medication error.</p> <p>9-3-6(a)</p>				

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