

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2012
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 428 S 15TH ST RICHMOND, IN 47374
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W0000	<p>This visit was for the investigation of Complaint #IN00103666.</p> <p>Complaint #IN00103666: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W331 and W368.</p> <p>Survey dates: February 13, 14, 15, 2012</p> <p>Facility Number: 000857 Provider Number: 15G341 AIM Number: 100243690</p> <p>Survey Team: Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/22/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0149	<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.</p> <p>Based on record review and interview, the facility neglected to implement its written policy and procedures to prevent neglect of 1 of 4 sampled clients in regard to medication administration (client A).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 02/13/2012 at 1:45 p.m. An Indiana Division of Disability and Rehabilitative Services report, dated 02/06/2012 at 7:45 a.m., indicated, "...[Client A]...did not receive the following morning medications as scheduled: 1) Baclofen (muscle relaxer) 10 mg (milligram); 2) Zyrtec (allergy relief medication) 10 mg.; 3) Keppra (anti seizure medication) 500 mg.; 4) Os-Cal 500 mg+Vit D (calcium supplement with vitamin D) ; 5) K-Dur (potassium supplement) 20 MEQ (millequivalent); 6) Vimpat (anti seizure medication) 300 mg.; 7) Dilantin (anti seizure medication) 100 mg.; 8) Miralax (treats constipation)17 gm (grams) in 8 ounces of water. Due to staff error, [client A] instead received the following: 1) Acyclovir (treats infections caused by the herpes virus) 400 mg.; 2) Baclofen</p>	W0149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</i> Specifically, the staff responsible for administering incorrect medication to Client A has received written corrective action and has received retraining regarding proper administration of medication per the agency's medication administration procedures. The nurse and supervisor suspended the responsible staff's medication administration duties pending the completion of his retraining.</p> <p>PREVENTION: All direct support staff have been retrained regarding medication administration procedures. Professional staff will monitor administration of medication on an ongoing basis and perform no less than one observation of a complete medication administration session per quarter for all direct support staff, to assure medications are administered and handled per agency policy. In addition the nurse will observe professional staff perform a complete medication administration session no less than annually. Additionally, members of the</p>	03/16/2012			

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	<p>(muscle relaxer)15 mg.; 3) Doxycycline (antibiotic) 100 mg.; 4) Claritin (allergy relief medication) 10 mg.; 5) Trileptal (anti seizure medication) 900 mg.; 6) Os-Cal (calcium supplement)500 mg.; 7) Phenobarbital (anti seizure medication) 60 mg.; 8) Miralax (for constipation)17 gm. in 8 ounces of water; 9) Topamax (anti seizure medication) 200 mg. Staff contacted [client A's] neurologist, [physician's name], and he stated to hold all of [client A's] medications until 7:00 AM on 2/7/12. Staff also notified the facility nurse...At 12:05 AM, on 2/7/12, [client A] began experiencing body jerks on his left side of his face and left arm which lasted between two and three minutes. [Client A] was able to swallow and was given Ativan 2 mg per protocol. [Client A] began experiencing left side body jerks again and staff called 911...EMS...transported [client A] to [hospital] for evaluation and treatment...."</p> <p>The facility's "Investigation Summary," dated 02/13/2012 was reviewed on 02/14/2012 at 10:00 a.m. The summary indicated, "...[client A] experienced a seizure on 2-7-12 at 12:05 a.m....medication error had been made regarding [client A] on 2-6-12 at 7:45 a.m....Interview with [DSP (Direct Support Professional) #4] stated he was sorry the medication error occurred...</p>		<p>Operations Team will periodically monitor active treatment sessions on an ongoing basis to assure medications are administered without error. Responsible Parties:QDDPD, Support Associates, Operations Team, Health Services Team</p>				

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	<p>[DSP #4], admitted to giving [client A] someone else's medications because he prepared [client A's] and another individual's medications in advance of medication administration the morning of 2-6-12...[Client A] experienced adverse effects of the medication error due to the fact that [client A] began experiencing a seizure at 12:05 a.m. on 2-7-12...[Client A's] neurologist requested the group home staff 'Hold' all of [client A's] medications on 2-6-12...Conclusions: 1) The evidence substantiates that [DSP #4] committed a medication administration error while giving [client A] his 7 a.m. medications on 2-6-12...2) The evidence substantiates that [client A] experienced an adverse reaction to either the medication error and/or the 'Holding' of [client A's] medications as ordered by [physician]...."</p> <p>Client A's record was reviewed on 02/14/2012 at 1:19 p.m.</p> <p>Client A's MAR (Medication Administration Record), dated 02/01/2012-02/29/2012, indicated the following medications were not given on 02/06/2012 at 7:00 a.m.: Baclofen 10 mg, Zyrtec 10 mg, Keppra 500 mg, Os-Cal 500 mg+Vit D, K-Dur 20 MEQ, Vimpat 300 mg, Dilantin 100 mg, and Miralax 17 gm in 8 ounces of water.</p>						

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	<p>A physician's order, dated, 02/06/2012 (no time documented) , indicated, "Hold all medications on 2-6-12. Resume all ordered medications 2-7-12 (at) 7 a.m...."</p> <p>A "Nursing Summary", indicated, "2/6/12 Received call from [DSP #4] direct staff reporting he had given [client A] another consumer's meds (medications)...2/7/12 Received call from DSP #7 reporting [client A] having seizure like activity. Instructed her to keep him safe, note time and activity involved and call 911 if seizure ct (continued)...2/7/12 Received call from DSP #7. She called 911...2/7/12 Release back to group home...Assessed VS (vital signs)...."</p> <p>A "SEIZURE RECORD," dated 02/07/2012 at 12:05 a.m., indicated, "...EYE TWITCH...ARM JERK L (left)...FACE TWITCH...transported to [hospital]...MEDICATION GIVEN: Ativan 2 mg...."</p> <p>During an interview on 02/14/2012 at 9:45 a.m., DSP #4 stated the medication error on 02/06/2012 at 7:00 a.m. occurred, "because I prepped medications in advance" of the medication administration time. He stated he, "grabbed the wrong medication cup" and gave client A another individual's medications.</p>						

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	<p>During an interview on 02/14/2012 at 3:10 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the facility investigation indicated DSP #4 gave another individual's medications to client A on 02/06/2012 at 7:00 a.m.</p> <p>The facility's "Abuse, Neglect, Exploitation" policy, dated 09/14/2007 was reviewed on 02/13/2012 at 2:35 p.m. The policy indicated, "...Medical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to...administering (sic) medications as prescribed...."</p> <p>This federal tag relates to complaint #IN00103666.</p> <p>9-3-2(a)</p>			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed to ensure nursing services obtained clarification of physician orders The facility failed to ensure nursing services revised a health risk plan when needed, and did not ensure facility staff were trained to meet the health needs for 1 of 4 sampled clients (client A).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 02/14/2012 at 1:19 p.m.</p> <p>The client's diagnosis included, but was not limited to, epilepsy.</p> <p>A physician's order, dated 01/26/2012, indicated, "...Ativan 2 mg #30 [one] PO (by mouth) PRN (as needed) seizure...."</p> <p>A physician's order, dated 01/31/2012, indicated, "...Ativan 2 mg #30 [one] PO PRN seizures. Use every 1-2 hours as needed...."</p> <p>The MAR (Medication Administration Record), dated 02/01/2012-02/29/2012 indicated, "...Ativan 2 mg prn as soon as seizure occurs but make sure [client A]</p>	W0331	<p>CORRECTION: <i>The facility must provide clients with nursing services in accordance with their needs.</i> Specifically, after discussing ambiguities with Client A's Comprehensive High Risk Plan for seizures with the interdisciplinary team, Client A's neurologist has discontinued the order Ativan 2 mg for seizures. The current Comprehensive High Risk Plan for seizures is now functional and appropriate.</p> <p>PREVENTION: The facility nurse will coordinate future efforts to obtain clarification for conflicting physician's orders and high risk plans will be updated accordingly. Members of the Operations Team and the Director of Health Services will periodically compare Comprehensive High Risk Plans with physician's orders to assure the plans coincide with the physician's instructions. Responsible Parties:QDDPD, Support Associates, Operations Team, Health Services Team</p>	03/16/2012			

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	<p>can swallow. If he can't swallow, call 911. may repeat Ativan 2 mg after 15 min (minutes) if seizure continues...."</p> <p>A "Comprehensive High Risk Health Plan, dated 01/20/2012, indicated, "...1. Give DILANTIN as ordered on the MAR. 2. Give VIMPAT as ordered on the MAR. 3. Give KEPPRA as ordered on the MAR...." There was no documentation in the high risk health plan to address when and how to give Ativan.</p> <p>During an interview on 02/13/2012 at 3:20 p.m., DSP #3 indicated Ativan 2 mg could be given orally if client A was able to swallow when a seizure began. She indicated the medication could be repeated in 15 minutes if the seizure continued. DSP #3 indicated she would call 911 if the second dose of Ativan did not cease seizure activity.</p> <p>During an interview on 02/14/2012 at 3:10 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the High Risk Health Plan did not include instructions for using Ativan. She stated she and the House Manager had made "multiple attempts to clarify the conflicting Ativan orders." She indicated the facility nurse had not contacted the physician in efforts to resolve the confusion with the different orders.</p>						

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W0368	<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.</p> <p>Based on record review and interview, the facility failed to ensure medications were administered without error for 1 of 4 sampled clients (client A).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 02/13/2012 at 1:45 p.m. An Indiana Division of Disability and Rehabilitative Services report, dated 02/06/2012 at 7:45 a.m., indicated, "...[Client A]...did not receive the following morning medications as scheduled: 1) Baclofen (muscle relaxer) 10 mg (milligram); 2) Zyrtec (allergy relief medication) 10 mg.; 3) Keppra (anti seizure medication) 500 mg.; 4) Os-Cal 500 mg+Vit D (calcium supplement with vitamin D) ; 5) K-Dur (potassium supplement) 20 MEQ (millequivalent); 6) Vimpat (anti seizure medication) 300 mg.; 7) Dilantin (anti seizure medication) 100 mg.; 8) Miralax (treats constipation)17 gm (grams) in 8 ounces of water. Due to staff error, [client A] instead received the following: 1) Acyclovir (treats infections caused by the herpes virus) 400 mg.; 2) Baclofen (muscle relaxer)15 mg.; 3) Doxycycline</p>	W0368	<p>CORRECTION: <i>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</i> Specifically, the staff responsible for administering in correct medication to Client A has received written corrective action and has received retraining regarding proper administration of medication per the agency's medication administration procedures. The nurse and supervisor suspended the responsible staff's medication administration duties pending the completion of his retraining.</p> <p>PREVENTION: All direct support staff have been retrained regarding medication administration procedures. Professional staff will monitor administration of medication on an ongoing basis and perform no less than one observation of a complete medication administration session per quarter for all direct support staff, to assure medications are administered and handled per agency policy. In addition the nurse will observe professional staff perform a complete medication administration session no less than annually. Additionally, members of the Operations Team will periodically</p>	03/16/2012			

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	<p>(antibiotic) 100 mg.; 4) Claritin (allergy relief medication) 10 mg.; 5) Trileptal (anti seizure medication) 900 mg.; 6) Os-Cal (calcium supplement)500 mg.; 7) Phenobarbital (anti seizure medication) 60 mg.; 8) Miralax (for constipation)17 gm. in 8 ounces of water; 9) Topamax (anti seizure medication) 200 mg. Staff contacted [client A's] neurologist, [physician's name], and he stated to hold all of [client A's] medications until 7:00 AM on 2/7/12...."</p> <p>Client A's record was reviewed on 02/14/2012 at 1:19 p.m.</p> <p>Client A's MAR (Medication Administration Record), dated 02/01/2012-02/29/2012, indicated the following medications were not given on 02/06/2012 at 7:00 a.m.: Baclofen 10 mg, Zyrtec 10 mg, Keppra 500 mg, Os-Cal 500 mg+Vit D, K-Dur 20 MEQ, Vimpat 300 mg, Dilantin 100 mg, Miralax 17 gm in 8 ounces of water.</p> <p>A physician's order, dated, 02/06/2012 (no time documented) , indicated, "Hold all medications on 2-6-12. Resume all ordered medications 2-7-12 (at) 7 a.m...."</p> <p>During an interview on 02/14/2012 at 9:45 a.m., DSP #4 stated the medication error on 02/06/2012 at 7:00 a.m. occurred,</p>		<p>monitor active treatment sessions on an ongoing basis to assure medications are administered without error. Responsible Parties: QDDPD, Support Associates, Operations Team, Health Services Team</p>				

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	<p>"because I prepped medications in advance" of the medication administration time. He stated he, "grabbed the wrong medication cup" and gave client A another individual's medications.</p> <p>During an interview on 02/14/2012 at 3:10 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the facility investigation indicated DSP #4 gave another individual's medications to client A on 02/06/2012 at 7:00 a.m.</p> <p>This federal tag relates to complaint #IN00103666.</p> <p>9-3-6(a)</p>			