

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 02/20/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE MAIN AND JEFFERSON DUPONT, IN 47231			
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of survey: February 18, 19 and 20, 2013</p> <p>Facility Number: 000852 Provider Number: 15G334 AIM Number: 100243920</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>The following federal deficiency reflects state findings in accordance with 460 IAC 9. Quality Review completed 2/28/13 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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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 3 of 4 sampled clients (#1, #2 and #4), the facility's nurse failed to ensure the Medication Administration Record (MAR), physician's orders and pharmacy labels matched, and failed to address client issues as identified in nursing assessments.</p> <p>Findings include:</p> <p>1. Observations of client meals, activities and medication administrations were conducted at the group home on 2/18/13 from 4:04 PM to 6:00 PM and on 2/19/13 from 5:30 AM to 7:15 AM. Client #1 was observed to be edentulous. Client #1 was observed to talk to staff #6 on 2/19/13 at 6:20 AM while his mouth contained 10 assorted pills/capsules of medication before swallowing them.</p> <p>Review of client #1's record on 2/19/13 at 9:00 AM included a 4/26/12 reviewed on 7/15/12, "Assessment Risk of Choking" which indicated client #1 was assessed as having the following risk factors for choking: reduced chewing ability/edentulous, was over the age of 40 years, and took the antianxiety medication lorazepam 1 mg. (milligrams) twice daily.</p>	W0331	<p>Corrective action:</p> <ul style="list-style-type: none"> · Client #1's High Risk Plan has been reviewed and updated (Attachment A). · New goal has been implemented for Client #1 (Attachment A). · Nursing Manager has been inserviced on ensuring that medication labels match the physician's orders (Attachment B). · Client #2's High Risk Plan has been reviewed and updated (Attachment C). · LPN #8 has been terminated. · Client #4's High Risk plan has been reviewed and updated (Attachment D). · Staff have been inserviced on updated High Risk Plans, Dining plans, new goals (Attachment C). <p>How we will identify others:</p>	03/12/2013			

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	<p>The facility's choking risk assessment indicated "any checked areas should be individualized in the plan of care as appropriate." The record review indicated the LPN had not added the client's risk factors (age, lack of focus, edentulous and medication) regarding choking into his 9/27/12 program plan/nursing plans of care.</p> <p>Interview with client #1 on 2/19/13 at 6:15 AM indicated he had dentures but did not wear them.</p> <p>Interview with staff #6 on 2/19/13 at 6:22 AM indicated client #1 lacked the ability to focus on tasks and his propensity to talk required multiple prompts to follow directions.</p> <p>2. At 4:44 PM, client #2 was administered phenytoin 100 mg (milligrams) (generic form of anticonvulsant medication Dilantin) by staff #4. Client #2's medication label and the medication administration record/MAR (reviewed at 4:45 PM on 2/18/13) indicated 3 capsules by mouth of 100 mg. phenytoin once daily for seizures 7 AM, 4:30 PM and 8 PM.</p> <p>Review of client #2's record on 2/19/13 at 8:10 AM indicated his primary care physician (PCP) had increased his</p>		<p>Nursing Coordinators will review High Risk Plans to ensure that they are individualized and contain all necessary info, including Dining plans, if needed. Nursing Coordinators will review MAR's, prescription labels, and physician's orders to ensure the accuracy of labels.</p> <p>Measures to be put in place: A weekly Nursing Coordinator checklist has been implemented (Attachment D).</p> <p>Monitoring of Corrective Action: Director of Health Services, Director of Supervised Group Living, and Quality Assurance will perform periodic service reviews to ensure that all nursing standards, including High Risk Plans, Dining Plans, medication labels, MAR's, are complete and individualized.</p>				

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	<p>Dilantin to 100 mg. 4 times daily on 8/23/12. The client's medication levels had been tested and the dosage had subsequently been adjusted/lowered to 60 mg. in the morning and 100 mg. three times daily on 10/22/12. The physician's 90 day review document signed on 1/13/13, supplied by the agency owned pharmacy, indicated the incorrect dosage orders consistent with the medication labels of Dilantin/phenytoin 100 mg. capsules once daily, 7 AM, 4:30 PM, and 8 PM. LPN #9 had not ensured the medication label, MAR and the physician's orders had been clarified to reflect the correct dosages and times of the Dilantin (60 mg. once daily, and 100 mg. three times daily). The 8:10 AM 2/19/13 record review indicated a choking risk plan for client #2 developed by LPN #9 on 10/24/12. The choking risk plan indicated client #2 had a history of choking and was on a pureed diet in the past as a result of the choking incident. The record review indicated a 11/30/12 dining plan which indicated client #2 was edentulous and he was on a regular diet with thin liquids; there was no mention of his past history of choking or the upgrade of his diet from pureed consistency. Client #2 was not edentulous during observations at the facility on 2/18/13 from 4:04 PM to 6:00 PM and on 2/19/13 from 5:30 AM to 7:15 AM.</p>		<p>Completion Date: 3-12-2013</p>	
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	<p>Interview with the Qualified Developmental Disabilities Professional/QDDP on 2/19/13 at 10:00 AM indicated the facility's former nurse, LPN #8, was responsible for clarifying the physician's orders and reconciling client #2's paperwork/prescription medication labeling/physician's orders.</p> <p>3. Client #4 was observed to be edentulous during observations at the facility on 2/18/13 from 4:04 PM to 6:00 PM and on 2/19/13 from 5:30 AM to 7:15 AM.</p> <p>Review of client #4's record on 2/19/13 at 6:46 AM and 9:45 AM indicated LPN #8 had completed an "Assessment Risk of Choking" on 4/26/12 reviewed on 7/15/12, which indicated no risk factors for client #4 regarding choking. A 4/26/12 nursing quarterly by LPN #8 indicated client #4 was edentulous but this decreased ability to chew food was not noted on the risk assessment and no nursing care plan was in client #4's record regarding his lack of teeth.</p> <p>Interview with Director of Health Services on 2/20/13 at 3:22 PM indicated it was the responsibility of the nurse assigned to the facility to reconcile assessments, revise clients' programs/care</p>						

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	plans, and to monitor client prescriptions, medication package labeling and the medication administration record to ensure they were accurate. 9-3-6(a)				