

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G658		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/03/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SANIBEL DR FORT WAYNE, IN 46815			
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 29, 30, May 1, 2, and 3, 2013.</p> <p>Facility number: 001195 Provider number: 15G658 AIM number: 100474580</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed May 8, 2013 by Dotty Walton, 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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W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #3 and #4), to ensure staff were trained to competency to administer medications per physician's orders without error.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/29/13 at 3:30 PM and included the following medication errors:</p> <p>1. A report dated 2/26/13 indicated client #4 did not receive his 8:00 PM Niaspan (cholesterol lowering medication) 1000 mg (milligrams) from 2/1/13 through 2/26/13. The medication was not placed in with client #4's other 8:00 PM medications. The group home nurse was notified and his primary care physician. The report indicated the incident was investigated and staff were retrained and given disciplinary action.</p> <p>The investigation into the incident was reviewed on 4/30/13 at 1:15 PM. The</p>	W000192	<p>The facility will ensure that training, for all employees who work with clients, will focus on skills and competencies directed toward clients' health needs. All staff will be retrained on medication administration procedures, making sure that they are following all procedures. The med coach will be trained to recheck all medications at the beginning of the month and as new orders arrive to assure all medications are available for all clients. The agency nurse will be notified of anytime medications are delivered to the home. The RM and QMRP will complete monthly medication passing observations to assure that staff are following proper med passing procedures.</p>	05/31/2013	

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	<p>investigation indicated staff #4, #6, #11 and #12 had administered client #4's 8:00 PM medications without giving him the Niaspan, yet had documented they had given him the medication. The investigation indicated all staff working at the group home were retrained on the administration of medication.</p> <p>2. A report dated 5/12/12 indicated client #3 received an additional 50 mg dose of Seroquel (anti-psychotic) for 11 days (5/2/12-5/12/12). The report indicated client #3's physician had reduced his Seroquel from 50 mg to 25 mg twice daily. The report indicated all staff had been retrained on administration of medication and client #3's physician had been notified.</p> <p>Client #3's physician's orders dated 4/20/12 were reviewed on 5/3/13 at 11:00 AM and indicated "Reduce Seroquel to 25 mg BID (twice daily)."</p> <p>Client #3's MAR (Medication Administration Record) dated 5/12 indicated client #3's Seroquel 50 mg twice daily had been changed 5/1/12 and documentation indicated client #3 had received 25 mg of Seroquel as indicated in the physician's order during the month of May.</p>			

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	<p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 5/3/13 at 1:45 PM. She indicated client #3's medication change of 25 mg Seroquel twice daily had arrived in the group home in the evening on 5/1/12. She indicated staff (unidentified) had removed client #3's 50 mg Seroquel dosage from client #3's medications for 8:00 PM, but had not removed the 50 mg dosage for the 7:00 AM medications. She indicated as a result, despite the documentation indicating client #3 had received 25 mg of Seroquel daily in the month of May, 2012, he had in fact received 75 mg of Seroquel daily from 5/2/12-5/12/12. She indicated on 5/12/12, staff #6 noticed the discrepancy and notified the nurse and the error was corrected.</p> <p>The Program Manager was interviewed on 5/2/13 at 3:00 PM and indicated staff were retrained to pass medications by the nurse to address their errors in medication administration and staff should have not failed to give the medication and then documented it as having been administered. She indicated the nurse observed a medication administration by each staff involved to ensure their competence.</p> <p>The Quality and Compliance coordinator</p>						

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	<p>was interviewed on 5/3/13 at 12:51 PM and indicated the facility used Living in the Community: Medication Administration Manual Core A and B for staff training in medication administration and staff did not follow through with that training when the medication administration errors occurred.</p> <p>The nursing manager was interviewed on 5/3/12 at 1:15 PM and indicated the error had occurred because group home staff had not followed policy and procedure for medication administration and had not followed their training in regarding procedures to check medication labels with the MAR before dispensing medication.</p> <p>The Living in the Community: Medication Administration Manual dated 2004 was reviewed on 5/3/13 at 9:15 AM and indicated "Make sure that the information on the medicine sheet corresponds exactly to the label on the individual's medication...Always remember to date and sign the medication sheet each time you administer a medication."</p> <p>9-3-3(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility's nursing services failed for 2 of 4 sampled clients (clients #3 and #4) to implement procedures to ensure medications were dispensed 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 4/29/13 at 3:30 PM and included the following medication errors:</p> <p>1. A report dated 2/26/13 indicated client #4 did not receive his 8:00 PM Niaspan (cholesterol lowering medication) 1000 mg (milligrams) from 2/1/13 through 2/26/13. The medication was not placed in with client #4's other 8:00 PM medications. The group home nurse was notified and his primary care physician. The report indicated client #4 had not experienced discomfort or ill effects from the missed medication. The incident was investigated and staff were retrained and given disciplinary action.</p> <p>The investigation into the incident was reviewed on 4/30/13 at 1:15 PM. The</p>	W000331	The facility will provide clients with nursing services in accordance with their needs. The staff will be trained to contact the nurse when any new medications arrive in order to receive directives from the nurse on when to start the med, how to transcribe it in the MAR and to assure that the nurse is informed of when the medication has arrived at the home. The nurse will follow-up to assure that all of the directives have been followed and the medication is being properly administered. The nurse will work with the Medical Coach at the beginning of the month to assure that all routine medications have arrived and are checked against the MAR to ensure that all medications for each consumer are readily available to be administered.	05/31/2013			

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	<p>investigation indicated staff #4, #6, #11 and #12 had administered client #4's 8:00 PM medications without giving him the Niaspan, yet had documented they had given him the medication. The investigation indicated all staff working at the group home were retrained on the administration of medication.</p> <p>2. A report dated 5/12/12 indicated client #3 received an additional 50 mg dose of Seroquel (anti-psychotic) for 11 days (5/2/12-5/12/12). The report indicated client #3's physician had reduced his Seroquel from 50 mg to 25 mg twice daily. The report indicated all staff had been retrained on administration of medication and client #3's physician had been notified.</p> <p>Client #3's physician's orders dated 4/20/12 were reviewed on 5/3/13 at 11:00 AM and indicated "Reduce Seroquel to 25 mg BID (twice daily)."</p> <p>Client #3's MAR (Medication Administration Record) dated 5/12 indicated client #3's Seroquel 50 mg twice daily had been changed 5/1/12 and documentation indicated client #3 had received 25 mg of Seroquel as indicated in the physician's order during the month of May.</p>			

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	<p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 5/3/13 at 1:45 PM. She indicated client #3's medication change of 25 mg Seroquel twice daily had arrived in the group home in the evening on 5/1/12. She indicated staff (unidentified) had removed client #3's 50 mg Seroquel dosage from client #3's medications for 8:00 PM, but had not removed the 50 mg dosage for the 7:00 AM medications. She indicated as a result, despite the documentation indicating client #3 had received 25 mg of Seroquel daily in the month of May, 2012, he had in fact received 75 mg of Seroquel daily from 5/2/12-5/12/12. She indicated on 5/12/12, staff #6 noticed the discrepancy, notified the nurse and the error was corrected.</p> <p>The nursing manager was interviewed on 5/3/13 at 1:15 PM and indicated the error had occurred because group home staff had not followed policy and procedure for medication administration, and had failed to store clients' medications correctly to prevent error. She indicated a new procedure had been developed in April, 2013 and the group home nurses had been trained to review client MARs weekly to ensure medications were being administered correctly. She indicated the group home nurse in February, 2013 was new and may not have been aware of</p>			

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	<p>procedures to check MARs and client medications for accuracy.</p> <p>An undated sheet regarding telephone medication order procedures was reviewed on 5/3/13 at 2:00 PM and indicated group home staff were to call the Emergency on call phone, "After every Dr's (Doctor's) appt (appointment) (DO NOT take prescriptions to a pharmacy, unless you make a copy, call me with any new orders)...When a new med (medication) arrives from the pharmacy or you picked up med from back up pharmacy or office. To receive directions on when to start and what to transcribe on MAR."</p> <p>9-3-6(a)</p>			

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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 of 4 sampled clients (clients #3 and #4) 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 4/29/13 at 3:30 PM and included the following medication errors:</p> <p>1. A report dated 2/26/13 indicated client #4 did not receive his 8:00 PM Niaspan (cholesterol lowering medication) 1000 mg (milligrams) from 2/1/13 through 2/26/13. The medication was not placed in with client #4's other 8:00 PM medications. The group home nurse was notified and his primary care physician. The report indicated client #4 had not experienced discomfort or ill effects from the missed medication. The incident was investigated and staff were retrained and given disciplinary action.</p> <p>The investigation into the incident was reviewed on 4/30/13 at 1:15 PM. The investigation indicated staff #4, #6, #11</p>	W000368	<p>The system for drug administration will assure that all drugs are administered in compliance with the physician's orders. All staff will be retrained on medication administration procedures, making sure that they are following all procedures. The med coach will be trained to recheck all medications at the beginning of the month and as new orders arrive to assure all medications are available for all clients. The agency nurse will be notified of anytime medications are delivered to the home. The RM and QMRP will complete monthly medication passing observations to assure that staff are following proper med passing procedures.</p>	05/31/2013			

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	<p>and #12 had administered client #4's 8:00 PM medications without giving him the Niaspan, yet had documented they had given him the medication. The investigation indicated all staff working at the group home were retrained on the administration of medication.</p> <p>2. A report dated 5/12/12 indicated client #3 received an additional 50 mg dose of Seroquel (anti-psychotic) for 11 days (5/2/12-5/12/12). The report indicated client #3's physician had reduced his Seroquel from 50 mg to 25 mg twice daily. The report indicated all staff had been retrained on administration of medication and client #3's physician had been notified.</p> <p>Client #3's physician's orders dated 4/20/12 were reviewed on 5/3/13 at 11:00 AM and indicated "Reduce Seroquel to 25 mg BID (twice daily)."</p> <p>Client #3's MAR (Medication Administration Record) dated 5/12 indicated client #3's Seroquel 50 mg twice daily had been changed 5/1/12 and documentation indicated client #3 had received 25 mg of Seroquel as indicated in the physician's order during the month of May.</p> <p>The QIDP (Qualified Intellectual</p>			

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	<p>Disabilities Professional) was interviewed on 5/3/13 at 1:45 PM. She indicated client #3's medication change of 25 mg Seroquel twice daily had arrived in the group home in the evening on 5/1/12. She indicated staff (unidentified) had removed client #3's 50 mg Seroquel dosage from client #3's medications for 8:00 PM, but had not removed the 50 mg dosage for the 7:00 AM medications. She indicated as a result, despite the documentation indicating client #3 had received 25 mg of Seroquel daily in the month of May, 2012, he had in fact received 75 mg of Seroquel daily from 5/2/12-5/12/12. She indicated on 5/12/12, staff #6 noticed the discrepancy, notified the nurse and the error was corrected.</p> <p>The Program Manager was interviewed on 5/2/13 at 3:00 PM and indicated staff were retrained to pass medications by the nurse to address their errors in medication administration and staff should have not failed to give the medication and then documented it as having been administered. She indicated the nurse observed a medication administration by each staff involved to ensure their competence.</p> <p>The nursing manager was interviewed on 5/3/13 at 1:15 PM and indicated the error had occurred because group home staff</p>			

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	had not followed policy and procedure for medication administration. 9-3-6(a)				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review, the facility failed to ensure a wheelchair was in good condition for 1 of 1 client who used a wheelchair for mobility (client #4).</p> <p>Findings include:</p> <p>Observations were completed at the group home on 4/30/13 from 6:15 AM until 8:05 AM. Client #4's left armrest of his wheelchair was missing 2 inches of the vinyl covered pad exposing the metal. The left armrest had a 4 inch split in the vinyl covering exposing the foam pad.</p> <p>The QIDP (Quality Intellectual Disabilities Professional) was interviewed on 4/30/13 at 7:05 AM. She indicated there had not been a work order regarding repairs to client #4's wheelchair initiated, and stated, "There will be."</p> <p>Client #4's record was reviewed on 4/30/13 at 2:30 PM and indicated he used an electric wheelchair for mobility.</p>	W000436	<p>The facility will furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces and other devices identified by the interdisciplinary team as needed by the client. The armrest on Client #4's wheelchair has been replaced. Staff will be retrained to notify the QMRP when adaptive equipment is in need of repair and will note on the adaptive equipment sheet that the repairs need to be made.</p>	05/31/2013

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SANIBEL DR FORT WAYNE, IN 46815		
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	<p>The QIDP was interviewed again on 5/3/12 at 3:00 PM and indicated there was a checklist kept in the client record to monitor the condition of adaptive equipment to be filled out by staff and there had not been any notations of the need for client #4's repair made in the checklist.</p> <p>Client #4's checklist for adaptive equipment was reviewed on 5/3/13 at 3:05 PM and did not indicate repairs needed to his wheelchair.</p> <p>9-3-7(a)</p>				