STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G334	A. BUILDING 00 B. WING	03/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
W 0000 Bldg. 00	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: 3/15/18, 3/16/18 and 3/19/18. Facility Number: 000852 Provider Number: 15G334 AIMS Number: 100243920 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed March 25, 2018 by #09182.	W 0000		
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION 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 for 1 of 4 sampled clients (#3) plus 2 additional clients (#5 and #7), the facility failed to ensure clients #3, #5 and #7's routine medications were administered as ordered by their physicians. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 3/15/18 at 11:18 AM. The review indicated the following: BDDS report dated 9/13/17 indicated, "At the 7 PM med (medication) pass last night 9/13/17 [client #3] was administered both his 7 PM and 7 AM meds. At 7 PM med pass [client #3] is to	W 0368	**W368: The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.** **Corrective action:** · Staff training on the medication administration policy including how to complete buddy checks to ensure medication errors are caught timely. (Attachment A) **How we will identify others:** · The Site Supervisor will conduct a medication pass	04/18/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	receive Gabapentin (nerve pain) 600 mg (milligram), Meloxicam (anti-inflammatory) 15 mg, Hydroxyzine (antihistamine) HCL 50 mg, Invega (schizophrenia) ER 6 mg, and Mirtazapine (antidepressant) 15 mg- he received his 7 PM meds correctly. In addition to receiving these above stated meds in error he was administrated (sic) his 7 AM meds including Sertraline (depression) HCL 50 mg, Lamotrigine (anticonvulsant) 200 mg and Famotidine (antacid) 20 mg. The error was discovered following the med pass with the buddy check. The staff notified [client #3's] PCP (Primary Care Physician) to report the med error and (the) doctor stated there should be no adverse effect but ordered to hold his 7 am meds that were given in error at 7 PM. Doctor said to only administrate (sic) if [client #3] was displaying agitation. Meds withhold (sic) this morning are Sertraline HCL 50 mg, Lamotrigine 200 mg and Famotidine 20 mg. [Client #3] is doing well and has not displayed any negative effects from this med error. The nurse will provide training to the staff to avoid further med errors." -BDDS report dated 10/23/17 indicated, "This morning during the 7 AM med pass staff discovered that [client #7] was not administrated (sic) his 8 PM medications last night 10/22/17. The medications that were omitted at 8 PM on 10/22/17 are: Divalproex (anticonvulsant) DR 500 mg (3 tablets), Metoprolol (beta blocker) 50 mg, quetiapine (antipsychotic) 100 mg, Ranitidine (heartburn) 150 mg, Gemfibrozil (cholesterol) 600 mg, Phenytoin (anticonvulsant) 100 mg (2 tablets). [Client #7] is doing well and has not experienced no (sic) negative effects from this med error." -BDDS report dated 11/6/17 indicated, "This morning during the 5:30 AM med pass staff discovered [client #3] was not given his		observation on a weekly basis and report any issues to the Area Supervisor and Nurse Coordinator. · All staff to be trained on medication administration during for their annual recertification. **Measures to be put in place:** · For no less than three consecutive months, the Area Supervisor will conduct a medication pass observation twice a month to ensure all medication administration policies are being followed and implemented. · For no less than two consecutive months, the Nurse Coordinator will conduct a medication pass observation once a week to ensure all medication administration policies are being followed and implemented. **Monitoring of Corrective Action:** · All medication observation forms will be sent to Program Manager and Nurse Manager for review. PM and NM will review observation forms and follow-up on any issues including any additional training or progressive corrective action if necessary. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations	

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	Gemfibrozil (cholesterol) 600 mg 1 tab at 5 PM on 11/5/17. [Client #3] receives the Gemfibrozil 600 mg 1 tab at 5:30 AM and 5 PM. [Client #3] is doing well and has not experienced any negative effects from this med error." -BDDS report dated 12/14/17 indicated, "Last evening during the 7 PM med pass staff administered Lorazepam (seizure) 1 mg to [client #5] in error. [Client #5] has an order for Lorazepam 1 mg but this medication is not given at the 7 PM med pass. Error is 7 PM med pass on 12/13/17 Lorazepam 1 mg given for an extra 1 mg dose for the day. [Client #5] is doing well and has not exhibited any negative effects from this med error." -BDDS report dated 1/25/18 indicated, "This morning at the 7 AM med pass staff noticed a med error has (sic) occurred on 1/23/18. [Client #5] receives Clozapine (antipsychotic) 100 mg (2 tabs) at 8 PM. Staff found that on 1/23/18 at the 8 PM med pass [client #5] only received 100 mg (1 tab) of his Clozapine instead of 200 mg (2 tabs) for an omission of 100 mg of the Clozapine. [Client #5] has not exhibited any negative effects from this med error." LPN #1 was interviewed on 3/16/18 at 2:00 PM. LPN #1 indicated medications should be given according to Physician's Orders. LPN #1 indicated when staff has a 2nd medication error they are required to watch a video training. LPN #1 indicated when staff has a 3rd medication error they are required to retake Core A/B classes. 9-3-6(a)		within the year. The results will be shared with all team members. **Completion Date: 4-18-18**	
W 0460	483.480(a)(1) FOOD AND NUTRITION SERVICES			

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Bldg. 00	Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 3 additional clients (#5, #6 and #7), the facility failed to ensure clients #1, #2, #3, #4, #5, #6 and #7 received a well balanced dinner. Findings include: Observations were conducted on 3/15/18 from 4:00 PM through 6:30 PM. At 5:45 PM clients #1, #2, #3, #4, #5, #6 and #7 were served pork chops, a baked potato, spinach and a fruit cup. At 5:50 PM client #1 asked staff if they could have cheese and sour cream for their potatoes. Staff #1 told client #1 they could not have additional condiments. At 5:55 PM client #3 asked staff #1 if they could have sour cream for their potato. Staff #1 indicated client #3 needed to use butter because it was a healthy option. Undated week 2 dinner menu was reviewed on 3/16/18 at 7:00 AM. The dinner menu indicated, "Pork steak, baked potato, chopped spinach, dinner roll, fruit salad, skim milk, margarine and sour cream." - Clients were not offered a dinner roll. Clients did not receive sour cream for their potatoes. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 3/16/18 at 2:00 PM. QIDP #1 indicated clients should have had a dinner roll. QIDP #1 indicated clients should have been allowed to have sour cream if it was on the menu. QIDP #1 indicated if clients wanted cheese on their baked potato staff should tell	W 0460	**W460: Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.** **Corrective action:** · All staff will be re-trained on providing a proper well-balanced diet including modified and specially-prescribed diets according to the menu located at the home. (Attachment A) · Staff will be in-service on proper food substitutions in the event certain foods are not liked or preferred by an individual. (Attachment A) **How we will identify others:** · The Site Supervisor will continue to ensure all foods are purchased and kept in the home on a weekly basis according to the dietary menu in the home. · Site Supervisor and Area Supervisor will complete mealtime observations on a regular basis to maintain oversight over the staff and ensure staff are following all dietary guidelines for each individual and the menu is followed. **Measures to be put in place:** · Site Supervisor to complete a weekly mealtime observation for no less than three consecutive	04/18/2018

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	them it's not a healthy option but they should be allowed to have it if they wanted it. 9-3-8(a)		months and ensure all menu items are available at mealtime. · Area Supervisor to complete a mealtime observation twice a month for no less than three consecutive months and ensure all menu items are available at mealtime. · QIDP-D to complete a mealtime observation once a month for no less than three consecutive months and ensure all menu items are available at mealtime. **Monitoring of Corrective Action**: · All mealtime observation forms and issues during observations will be given to Program Manager for review and follow-up including additional training with staff or appropriate progressive corrective action if necessary. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 5-10-17**	