

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G633	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 153 WHITE OAK WAY NORTH VERNON, IN 47265
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00197963.</p> <p>Complaint #IN00197963 - Substantiated, Federal/State deficiencies related to the allegation(s) are cited at W149, W153 and W331.</p> <p>This visit was done in conjunction with the post certification revisit (PCR) to the extended recertification and state licensure survey completed February 17, 2016.</p> <p>Dates of Survey: April 21 and 22, 2016.</p> <p>Facility Number: 001206 Provider Number: 15G633 AIMS Number: 100240180</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/4/16.</p>	W 0000		
W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>			

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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	<p>mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to implement policies and procedures which prohibited neglect of clients. The facility failed to ensure incidents with injury were immediately reported to the administrator and other officials in regards to client A.</p> <p>Findings include:</p> <p>Review of facility incidents, investigations and BDDS/Bureau of Developmental Disabilities Services reports on 4/21/16 at 2:30 PM indicated the following:</p> <p>A BDDS report dated 4/12/16 indicated the facility's day program manager (staff #11) reported on 4/12/16 at 8:30 AM, client A had a "large bruise on [client A's] right shoulder. The bruise starts at the top of her shoulder and goes down to her breast area. Staff reported the bruise to the facility nurse and was advised to take [client A] to urgent care to be seen. Urgent care ordered X-rays to be completed. The results of the X-rays showed a fracture at the distal end of her right clavicle, displaced. [Client A] was referred to ortho (orthopaedic/bone specialist) and was advised to wear a sling on her upper extremity until her</p>	W 0149	<p><b>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</b></p> <p><b>Corrective Action:</b></p> <ul style="list-style-type: none"> <li>· Residential Manager to receive corrective action for failure to ensure incident on 4-4-16 was reported to supervisor timely.</li> </ul> <p><b>(Attachment B)</b></p> <ul style="list-style-type: none"> <li>· Residential Manager to receive training on abuse/neglect policy by 5-20-16.</li> <li>· LPN terminated from employment with ResCare for failure to assess individual after fall on 4-4-16 within the nursing guidelines. <b>(Attachment C)</b></li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The Residential Manager will notify Program Manager and Quality Assurance Manager according to the incident reporting guidelines and procedures for all reportable incidents.</li> <li>· Nurse over the</li> </ul>	05/22/2016			

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	<p>ortho evaluation...Tylenol PRN (as needed) for pain."</p> <p>A BDDS report dated 4/12/16 by Quality Assurance Manager/QA #12 indicated an incident on 4/4/16 at 6:50 AM wherein client A had a seizure while sitting at breakfast without her helmet and she fell off of her chair. "Staff reported [client A] tried to catch herself on the way down landing on her elbow and wrist. Staff checked for injuries and noted red marks with slight bruising on her right elbow and wrist approximately 1 1/2-2 inches long." The BDDS report indicated the date of knowledge of this 4/4/16 incident was 4/12/16.</p> <p>A BDDS follow up report (date unknown) to the 4/12/16 report indicated the client had seen the orthopedist and had a CT (imaging procedure) of her shoulder on 4/18/16. She returned to the orthopedist on 4/19/16 and the diagnosis was a right distal clavicle fracture. Client A was to wear the sling and return to the orthopedist in 4 weeks. "The facility investigation concluded the injury was caused by a fall on 4-4-16."</p> <p>An investigation dated 4/12-17/16 by QAM #12 into the fractured clavicle sustained by client A indicated the injury had been sustained during a seizure with</p>		<p>homewill ensure all individuals with incidents of injury are assessed within 24hours.</p> <p><b>Measures to be put intoplace:</b></p> <ul style="list-style-type: none"> <li>· The ResidentialManager will notify Program Manager and Quality Assurance Manager according tothe incident reporting guidelines and procedures for all reportable incidents.</li> <li>· Nurse over the home will ensure all individuals with incidents of injuryare assessed within 24 hours.</li> </ul> <p><b>Monitoring of CorrectiveAction:</b></p> <ul style="list-style-type: none"> <li>· Nursing assessments to be completed within 24 hours whenever there is 1)injury, 2) signs/symptoms of illness, 3) changes in skin condition.</li> <li>· Quality Assurance Manager to ensure contact with nurse has been madeafter all incidents to ensure assessment has been completed if necessary.</li> <li>· Program Manager,Assistant</li> </ul>	

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	<p>fall on 4/4/16 at 6:50 AM.</p> <p>Review of nursing notes dated 4/6/16 included in the investigation indicated LPN #2 had not assessed client A until 4/6/16 and noted..."on 4/4/16 60 sec (second) seizure fall &amp; (and) sl (slight) bruising--noted on shoulder...wears helmet @ (at) all X's (times) except when sleeping...." There was no indication the client's range of motion had been assessed or if the LPN had done a complete visual body check for other injuries.</p> <p>The investigation indicated House Manager/HM #3 had been notified of client A's seizure and fall on the morning of 4/4/16 with red marks on her wrist and the start of bruising on her arm. HM #3 did not report the bruise to her supervisor because it was consistent with the fall.</p> <p>Review of nursing notes in the investigation indicated client A fell and hit her head at day program on 3/22/16. Client A sustained a laceration to the top center of her forehead at the hairline. She was sent to the ER (Emergency Room) and the laceration was glued.</p> <p>The "On-Call Tracking" notes included in the investigation for 4/4/16 at 6:51 AM by LPN #3, indicated she received a call regarding client A indicating she had a "60 sec seizure-fell didn't hit head--slight</p>		<p>Executive Director, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within theyear. The results will be shared with all team members.</p>	

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	<p>bruising on shoulder." No nurse saw client A until 4/6/16 and client A was not referred for medical treatment until 4/12/16.</p> <p>Interview with QAM #12 on 4/22/16 at 10:56 AM indicated client A's 4/4/16 incident had not been reported according to policy/procedure by HM #3. That was why the 4/4/16 incident with injury was reported late (4/12/16). The interview indicated the facility's on call LPN #3 had been notified by facility staff on 4/4/16 at 6:51 AM. But no nurse saw client A until 4/6/16 (LPN #2) and she did not receive medical attention until 4/12/16. The interview indicated LPN #2 was currently under suspension until the agency could determine (possible negligence) the next course of action regarding LPN #2.</p> <p>Review of the revised 5/28/12 facility policy entitled "Abuse, Neglect, &amp; (and)Exploitation" on 4/21/16 at 2:00 PM indicated, in part:</p> <p>"[Agency] does not tolerate abuse, neglect, or exploitation of any persons served. All employees are required to report allegations or suspected incidents of abuse, neglect, and exploitation. All alleged or suspected abuse, neglect, and/or exploitation will be immediately</p>			

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W 0153 Bldg. 00	<p>investigated. Appropriate corrective action will be taken to ensure prevention of any further occurrence." ..."Neglect' means the failure of an individual to provide the treatment , care, goods or services that are necessary to maintain the health or safety of a person we support." ..."All employees will immediately report any allegation or suspicion of abuse, neglect, or exploitation to his/her immediate supervisor."</p> <p>The facility failed to implement written policy and procedures to ensure the facility reported a fall with injury of client A. Please see W153.</p> <p>This federal tag relates to complaint #IN00197963.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure incidents with injury were immediately reported to the</p>	W 0153	<b>W153: The facility must ensure that all allegations of mistreatment, neglect or abuse, as well</b>	05/22/2016

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	<p>administrator and other officials in regards to client A.</p> <p>Findings include:</p> <p>Review of facility incidents, investigations and BDDS/Bureau of Developmental Disabilities Services reports on 4/21/16 at 2:30 PM indicated the following:</p> <p>A BDDS report dated 4/12/16 indicated the facility's day program manager (staff #11) reported on 4/12/16 at 8:30 AM, client A had a "large bruise on [client A's] right shoulder. The bruise starts at the top of her shoulder and goes down to her breast area. Staff reported the bruise to the facility nurse and was advised to take [client A] to urgent care to be seen. Urgent care ordered X-rays to be completed. The results of the X-rays showed a fracture at the distal end of her right clavicle, displaced. [Client A] was referred to ortho (orthopaedic/bone specialist) and was advised to wear a sling on her upper extremity until her ortho evaluation...Tylenol PRN (as needed) for pain."</p> <p>A BDDS report dated 4/12/16 by Quality Assurance Manager/QA #12 indicated an incident on 4/4/16 at 6:50 AM wherein client A had a seizure while sitting at</p>		<p><b>asinjuries of unknown source, are reported immediately to the administrator or toother officials in accordance with State law through establishedprocedures. CorrectiveAction:</b></p> <ul style="list-style-type: none"> <li>· ResidentialManager to receive corrective action for failure to ensure incident on 4-4-16was reported to supervisor timely <b>(AttachmentB).</b></li> <li>· ResidentialManager and Support Associates to receive training on abuse/neglect policy andprocedures by 5-20-16.</li> <li>· LPN terminatedfrom employment with ResCare for failure to assess individual after fall on4-4-16 within the nursing guidelines <b>(AttachmentC)</b></li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The ResidentialManager will notify Program Manager and Quality Assurance Manager according tothe incident reporting guidelines and procedures for all</li> </ul>		

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	<p>breakfast without her helmet and she fell off of her chair. "Staff reported [client A] tried to catch herself on the way down landing on her elbow and wrist. Staff checked for injuries and noted red marks with slight bruising on her right elbow and wrist approximately 1 1/2-2 inches long." The BDDS report indicated the date of knowledge of this 4/4/16 incident was 4/12/16.</p> <p>A BDDS follow up report (date unknown) to the 4/12/16 report indicated the client had seen the orthopedist and had a CT (imaging procedure) of her shoulder on 4/18/16. She returned to the orthopedist on 4/19/16 and the diagnosis was a right distal clavicle fracture. Client A was to wear the sling and return to the orthopedist in 4 weeks. "The facility investigation concluded the injury was caused by a fall on 4-4-16."</p> <p>An investigation dated 4/12-17/16 by QAM #12 into the fractured clavicle sustained by client A indicated the injury had been sustained during a seizure with fall on 4/4/16 at 6:50 AM. The investigation indicated House Manager/HM #3 had been notified of client A's seizure and fall on the morning of 4/4/16 with red marks on her wrist and the start of bruising on her arm. HM #3 did not report the bruise to her supervisor</p>		<p>reportable incidents.</p> <ul style="list-style-type: none"> <li>Nurse over thehome will ensure all individuals with incidents of injury are assessed within24 hours.</li> </ul> <p><b>Measures to be put intoplace:</b></p> <ul style="list-style-type: none"> <li>The ResidentialManager will notify Program Manager and Quality Assurance Manager according tothe incident reporting guidelines and procedures for all reportable incidents.</li> <li>Nurse over the home will ensure all individuals with incidents of injuryare assessed within 24 hours.</li> </ul> <p><b>Monitoring of CorrectiveAction:</b></p> <ul style="list-style-type: none"> <li>Nursing assessments to be completed within 24 hours whenever there is 1)injury, 2) signs/symptoms of illness, 3) changes in skin condition.</li> <li>Quality Assurance Manager to ensure contact with nurse has been madeafter all incidents to ensure assessment has been completed if necessary.</li> <li>Program</li> </ul>	

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W 0331 Bldg. 00	<p>because it was consistent with the fall.</p> <p>Interview with QAM #12 on 4/22/16 at 10:56 AM indicated client A's 4/4/16 incident had not been reported according to policy/procedure by HM #3. That was why the 4/4/16 incident with injury was reported late (4/12/16).</p> <p>This federal tag relates to complaint #IN00197963.</p> <p>9-3-2(a)</p> <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 for 1 of 3 sampled clients (A), the facility failed to ensure the client received nursing services in accordance with her needs.</p> <p>Findings include:</p> <p>Review of facility incidents, investigations and BDDS/Bureau of Developmental Disabilities Services reports on 4/21/16 at 2:30 PM indicated the following:</p> <p>A BDDS report dated 4/12/16 indicated</p>			W 0331	<p>Manager,Assistant Executive Director, Executive Director, Business Manager, HR Manager,Nursing Manager will perform Best In Class reviews at all locations within theyear. The results will be shared with all team members.</p> <p><b>W331: The facility must provide clients withnursing services in accordance with their needs. Corrective Action:</b></p> <ul style="list-style-type: none"> <li>· LPN #2 was terminated from employment with thecompany (<b>Attachment C</b>).</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· The ResidentialManager will</li> </ul>		05/22/2016

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	<p>the facility's day program manager (staff #11) reported on 4/12/16 at 8:30 AM, client A had a "large bruise on [client A's] right shoulder. The bruise starts at the top of her shoulder and goes down to her breast area. Staff reported the bruise to the facility nurse and was advised to take [client A] to urgent care to be seen. Urgent care ordered X-rays to be completed. The results of the X-rays showed a fracture at the distal end of her right clavicle, displaced. [Client A] was referred to ortho (orthopaedic/bone specialist) and was advised to wear a sling on her upper extremity until her ortho evaluation...Tylenol PRN (as needed) for pain."</p> <p>A BDDS report dated 4/12/16 by Quality Assurance Manager/QA #12 indicated an incident on 4/4/16 at 6:50 AM wherein client A had a seizure while sitting at breakfast without her helmet and she fell off of her chair. "Staff reported [client A] tried to catch herself on the way down landing on her elbow and wrist. Staff checked for injuries and noted red marks with slight bruising on her right elbow and wrist approximately 1 1/2-2 inches long." The BDDS report indicated the date of knowledge of this 4/4/16 incident was 4/12/16.</p> <p>A BDDS follow up report (date</p>		<p>notify Program Manager and Quality Assurance Manager according to the incident reporting guidelines and procedures for all reportable incidents.</p> <ul style="list-style-type: none"> <li>Nurse over the home will ensure all individuals with incidents of injury are assessed within 24 hours.</li> </ul> <p><b>Measures to be put in place:</b></p> <ul style="list-style-type: none"> <li>The Residential Manager will notify Program Manager and Quality Assurance Manager according to the incident reporting guidelines and procedures for all reportable incidents.</li> <li>Nurse over the home will ensure all individuals with incidents of injury are assessed within 24 hours.</li> </ul> <p><b>Monitoring of Corrective Action:</b></p> <ul style="list-style-type: none"> <li>Nursing assessments to be completed within 24 hours whenever there is 1) injury, 2) signs/symptoms of illness, 3) changes in skin condition.</li> <li>Quality Assurance Manager to ensure contact with nurse has been</li> </ul>	

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	<p>unknown) to the 4/12/16 report indicated the client had seen the orthopedist and had a CT (imaging procedure) of her shoulder on 4/18/16. She returned to the orthopedist on 4/19/16 and the diagnosis was a right distal clavicle fracture. Client A was to wear the sling and return to the orthopedist in 4 weeks. "The facility investigation concluded the injury was caused by a fall on 4-4-16."</p> <p>An investigation dated 4/12-17/16 by QAM #12 into the fractured clavicle sustained by client A indicated the injury had been sustained during a seizure with fall on 4/4/16 at 6:50 AM. Review of nursing notes for client A dated 4/6/16 included in the investigation, indicated LPN #2 had not assessed client A until 4/6/16 and noted..."on 4/4/16 60 sec (second) seizure fall &amp; (and) sl (slight) bruising--noted on shoulder...wears helmet @ (at) all X's (times) except when sleeping..." There was no indication the client's range of motion had been assessed or if the LPN had done a complete visual body check for other injuries.</p> <p>The "On-Call Tracking" notes included in the investigation for 4/4/16 at 6:51 AM by LPN #3, indicated she received a call regarding client A indicating she had a "60 sec seizure-fell didn't hit head--slight</p>		<p>madeafter all incidents to ensure assessment has been completed if necessary.</p> <p>· Program Manager,Assistant Executive Director, Executive Director, Business Manager, HR Manager,Nursing Manager will perform Best In Class reviews at all locations within theyear. The results will be shared with all team members.</p>	

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	<p>bruising on shoulder." No nurse saw client A until 4/6/16 and client A was not referred for medical treatment until 4/12/16.</p> <p>Review of nursing notes in the investigation indicated client A fell and hit her head at day program on 3/22/16. Client A sustained a laceration to the top center of her forehead at the hairline. She was sent to the ER (Emergency Room) and the laceration was glued.</p> <p>Review of client A's record on 4/22/16 at 10:00 AM indicated her program had not been changed to using an armchair and/or keeping her helmet on during meals after the 3/22/16 fall with injury at the day program. The client was not wearing a helmet or using an armchair when she sustained the laceration to her forehead on 3/22/16.</p> <p>Interview with QIDP-d (Qualified Intellectual Disabilities Professional designee) #10 on 4/21/16 at 5:00 PM indicated client A now used an armchair for mealtime and kept her helmet on as well for safety. This did not occur until after the 4/12/16 report of the fracture.</p> <p>Interview with QAM #12 on 4/22/16 at 10:56 AM indicated the facility's on call LPN #3 had been notified of client A's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G633	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/22/2016
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 153 WHITE OAK WAY NORTH VERNON, IN 47265
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	<p>fall by facility staff on 4/4/16 at 6:51 AM. But no nurse saw client A until 4/6/16 (LPN #2) and she did not receive medical attention until 4/12/16. The interview indicated LPN #2 was currently under suspension until the agency could determine (possible negligence) the next course of action regarding LPN #2.</p> <p>Review of the facility's Health Services Policy and Procedure: "Physical Observations Nursing Progress Notes" undated, on 4/22/16 at 11:10 AM indicated, in part:</p> <p>"B. The following issues require immediate documentation and follow up until resolution occurs:</p> <ol style="list-style-type: none"> <li>1. injuries</li> <li>2. signs/symptoms of illness</li> <li>3. changes in skin condition...." <p>Interview with the Nursing Manager #1 on 4/22/16 at 11:15 AM indicated "immediately" meant as soon as reasonably possible, not to exceed 24 hours. The interview stated LPN #2 should have physically assessed client A "thoroughly" which would have included assessing her bruising and the range of motion of the affected areas after the fall on 4/4/16.</p> <p>This federal tag relates to complaint</p> </li></ol>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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