

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 02/04/2015
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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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W000000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00160125.</p> <p>Complaint #IN00160125 - Substantiated, a federal/state deficiency related to the allegation is cited at W154.</p> <p>Dates of Survey: February 2, 3, and 4, 2015.</p> <p>Surveyor: Dotty Walton, QIDP.</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 completed 2/13/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS			

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>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure the client had a surrogate to assist him in decision making.</p> <p>Findings include:</p> <p>Observations of client C were done on 2/02/15 from 3:45 PM to 7:00 PM and on 2/03/15 from 6:10 AM until 7:30 AM. Client C was observed to require staff assistance with all areas of his daily routine, medications, mealtime, toileting, handwashing and he was non-verbal; he only made vocalizations.</p> <p>Record review for client C was done on 2/03/15 at 9:39 AM. The review indicated the client had a guardian to help him with decision making but the guardian had asked to be relieved of his duty. The client had an 8/12/14 Individual Support Plan/ISP which indicated his diagnoses included but were not limited to, profound level of intellectual disability, psychotic disorder, dysphasia and PKU (Phenylketonuria, an</p>	W000125	<p>W125: The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> · Client C, Informed Consent Assessment (Attachment A) has been completed and team will begin to locate appropriate advocate, Health Care Representative, and/or guardian per assessment. · Application submitted to Thrive Alliance. (Attachment B) <p>How we will identify others:</p>	03/06/2015

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W000154	<p>enzyme deficiency). The ISP indicated the client was not independent in activities of daily living and required staff assistance in all areas of his daily life.</p> <p>Interview with the Qualified Developmental Disabilities Professional designee (QDDP) #1 on 2/04/15 at 3:00 PM indicated client C required the assistance of a guardian but had not had one at least since 6/2014. The client's father, then a brother, had been his guardian. The brother had resigned his guardianship but another surrogate had not been found for the client at the time of the survey.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 1 additional client (D), the facility failed to conduct a thorough investigation</p>	W000154	<p>The QIDP will review other client's legal status and complete updated informed consents and review with team for appropriate follow-up.</p> <p>Measures to be put in place:</p> <ul style="list-style-type: none"> All staff inserviced on Informed Consent forms. (Attachment C). <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> Clinical Supervisor, 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. <p>Completion Date: 3-6-15</p> <p>W154: The facility will have evidence that all alleged</p>	03/06/2015	

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	<p>regarding the client's injury which resulted in a fracture.</p> <p>Findings include:</p> <p>Review of the facility's investigations and reports to the Bureau of Developmental Disabilities Services/BDDS was done on 2/02/15 at 1:30 PM and 2/04/15 at 2:00 PM. The reports indicated, in part, the following:</p> <p>A BDDS report dated 11/25/14 indicated client D had fallen after toileting at the day program (agency owned/operated) on 11/24/14 at 11:00 AM. He fell onto his left side, went to urgent care for evaluation and on to the ER (emergency room) for x-rays. His diagnosis was "displaced left humeral neck (shoulder) fracture." Surgery was asked for by the orthopedist for "intramedullary left proximal humeros (sic)" repair. This was done. He was discharged from the hospital on 12/03/14. There was no investigation regarding this incident which ascertained what happened so further injuries could be avoided.</p> <p>Interview with Program Manager #1 on 2/04/2015 at 1:30 PM indicated the fracture and the surrounding events should have been investigated.</p>		<p>violations are thoroughly investigated.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> · Clinical Supervisor has been in serviced on completing a thorough investigation, including documenting all pertinent information regarding an incident and BDDS reporting guidelines. (Attachment D) · Clinical Supervisor to receive investigation and plan of correction training from ISDH Surveryor Supervisor on 2-26-15. · Clinical Supervisor in serviced on all investigation forms, including form to determine if client's rights were violated. (Attachment D& E) <p>How we will identify others:</p> <ul style="list-style-type: none"> · Investigation Committee, including Executive Director will review all investigations to ensure that all required information is documented and any follow-up required has 				

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	This federal tag relates to complaint #IN00160125. 9-3-2(a)		been completed. Measures to be put in place: · Investigation Committee, including Executive Director will review all investigations to ensure that documentation is present as to the circumstances of incident, including interventions, staff deployment and witnesses interviewed. Monitoring of Corrective Action: · Investigation Committee, including Executive Director will review all completed investigations to ensure that circumstances of incidents have been thoroughly investigated, including deployment of staff, interventions, and witness interviews completed. · Clinical Supervisor will review all incident reports and report all unknown injuries and begin investigation. · Clinical Supervisor, Program Manager, Executive Director, Business Manager,		

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 additional client (E), the facility failed to reimburse the client's missing money.</p> <p>Findings include:</p> <p>Review of the facility's investigations and reports to the Bureau of Developmental Disabilities Services/BDDS was done on 2/02/15 at 1:30 PM and 2/04/15 at 2:00 PM. The reports indicated, in part, the following:</p> <p>On 10/21/14 client E had missing money in the amount of \$20.00. The investigation of 10-22 to 28/14, indicated \$20.00 was missing from client E's home cash account. This was substantiated but the money had not been reimbursed at the</p>	W000157	<p>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.</p> <p>Completion Date: 3-6-15</p> <p>W157: Facility will ensure that appropriate corrective action is taken, if alleged violation is verified.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> Clinical Supervisor has been in serviced on completing a thorough investigation, including documenting all pertinent information regarding an incident, BDDS reporting guidelines and completing recommendations within 5 buisness days of completed investigation. (Attachment D) 	03/06/2015

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	<p>time of the survey.</p> <p>Interview with Program Manager #1 on 2/04/2015 at 2:00 PM indicated it was the policy of the agency to report, thoroughly investigate and implement corrective actions regarding incidents of financial exploitation. The interview indicated the reimbursement money for client E was requested by Program Manager #1 on 1/30/15.</p> <p>9-3-2(a)</p>		<ul style="list-style-type: none"> · Clinical Supervisor to receive investigation and plan of correction training from ISDH Surveryor Supervisor on 2-26-15. · Clinical Supervisor in serviced on all investigation forms, including form to determine if client's rights were violated. (Attachment D & E) <p>How we will identify others:</p> <ul style="list-style-type: none"> · Clinical Supervisor and Program Manager will review all incidents, to ensure that allegations of abuse or neglect have been reported in a timely manner and appropriate action has been taken. · Investigation Committee, including Executive Director will review all investigations to ensure that all required information is documented and any follow-up required has been completed. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · The Residential Manager will complete weekly Active 		

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			<p>treatment observations (Attachment F) to ensure that clients are free from abuse and neglect, client to client aggression, injuries of unknown origin and theft of client's personal belongings or medications.</p> <ul style="list-style-type: none"> Investigation Committee, including Executive Director will review all investigations to ensure that documentation is present as to the circumstances of incident, including interventions, staff deployment and witnesses interviewed. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> The provider will ensure compliance through oversight by the RM weekly check list (Attachment G) Clinical Supervisor, 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. 		

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W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.		<ul style="list-style-type: none"> Clinical Supervisor and Program Manager will review monthly staff meetings for Abuse and Neglect training, Reporting Procedures and ensure that annual training is current, will periodically review annual ISP documentation for staff training, including Day Program staff. Investigation Committee, including Executive Director will review all investigations to ensure that all allegations of abuse or neglect, client to client, and injury of unknown origin have been thoroughly investigated and that proper follow up recommendation/ corrective action, if warranted, has been given per established policies and procedures. <p>Completion Date: 2-19-15</p>	

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	<p>Based on observation, record review and interview for 3 of 3 sampled clients (A, B, and C), and 3 additional clients (D, E and F), the facility failed to ensure clients participated in family style dining and meal preparation.</p> <p>Findings include:</p> <p>Observations of clients A, B, C, D, E and F (at the group home) were done on 2/02/15 from 3:45 PM to 7:00 PM. Staff #5 was observed to prepare items for clients' lunches by opening packages of individual pudding cups, jello cups, and fruit cups and stacking one of each on the kitchen counter. Staff #10, who was in training, was cleaning out the clients' lunch containers. No clients assisted the staff with these tasks. Staff #5 and #10 put chicken and vegetables on the stove to cook and continued the lunch preparation. Individual casseroles were taken from the cabinet and placed in the clients' lunch containers along with the fruit, jello and pudding. Staff #5 and #10 prepared baggies of cheese puffs and small cookies for the clients and packed them in the lunches. Staff prepared the meal of chicken with noodles, pineapple, and vegetables. Clients A, B, C, D, E, and F were not involved in the meal preparation. Staff #5 custodially modified client B and C's chicken which</p>	W000488	<p>W488: DINING AREAS AND SERVICE; the facility must assure that each client eats in a manner consistent with his or her developmental level. Corrective Action:</p> <ul style="list-style-type: none"> · All staff inserviced on Family Style Dining, formal and informal active treatment (Attachment C) · All staff have been in-serviced on individual dining plans, formal dining goals and dining/prep/clean-up. (Attachment C) · QIDP will update assessment packets for each individual annually/as needed and will complete/train/implement formal programming goals for each individual based on assessed skill set. <p>How will we identify others:</p> <ul style="list-style-type: none"> · The Residential Manager will complete weekly Active treatment observations 	03/06/2015	

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	<p>was to be a mechanically ground consistency. Client A's food was pured by staff #5 without client A being involved in the process. Staff took up the food and placed it into serving bowls. The food was taken into the dining room by means of a cart. Clients were not involved in these tasks. Staff assisted clients to fill their plates with hand over hand assistance.</p> <p>Record review for client A was done on 2/03/15 at 11:20 AM. The review indicated an ISP dated 3/12/14. The ISP did not indicate a contraindication for client A being involved in meal/lunch preparation.</p> <p>Record review for client B was done on 2/03/15 at 10:30 AM. The review indicated an Individual Support Plan/ISP dated 8/14. The ISP did not indicate a contraindication for client B being involved in meal/lunch preparation.</p> <p>Record review for client C was done on 2/03/15 at 9:39 AM. The review indicated an ISP dated 8/12/14. The ISP did not indicate a contraindication for client C being involved in meal/lunch preparation.</p> <p>Interview with the Qualified Developmental Disabilities Professional</p>		<p>(Attachment F) to ensure that all dining plans are being completed correctly.</p> <ul style="list-style-type: none"> · Residential Manager, Clinical Supervisor, and Program Manager will offer immediate correction, training and feedback to all staff during observations. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · The Residential Manager will complete weekly Active treatment observations (Attachment F) to ensure that all dining plans and active treatment are occurring. · Clinical Supervisor will give immediate feedback to staff during observations. · Any staff observed not following programming plans, including family style dinning, will be subject to corrective action up to and including termination. · All staff will be trained on active treatment and continuous training at all opportunities based on each individuals assessed skill set. 				

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	<p>designee (QIDP) #1 on 2/03/15 at 1:00 PM indicated it was expected that clients should participate in cooking and lunch packing/preparation to the extent of their capabilities (physical prompting if needed).</p> <p>9-3-8(a)</p>		<ul style="list-style-type: none"> · All staff will be trained on dining plans upon admission, annually, and with any implemented changes quarterly. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · QIDP will review plans quarterly with IDT to ensure all issues are being addressed. · The Residential Manager will complete weekly Active treatment observations (Attachment F) to ensure that all dining plans are being completed correctly. · Clinical Supervisor, 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. <p>Completion Date: 3-6-15</p>		