

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G336	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3814 WALDEN RUN FORT WAYNE, IN 46815
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W 000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00161445.</p> <p>Complaint #IN00161445: Substantiated, federal and state deficiencies related to the allegations are cited at W154 and W249.</p> <p>Dates of Survey: January 15, 16 and 20, 2015.</p> <p>Facility number: 000854 Provider number: 15G336 AIM number: 100243900</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/26/15 by Dotty Walton, QIDP and Ruth Shackelford, QIDP.</p>	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS			

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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Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based upon record review and interview for 1 of 3 sampled clients (client A), the facility failed to complete a thorough investigation into an allegation of bruising of unknown origin.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 1/15/15 at 4:15 PM. A BDDS report dated 12/17/14 indicated staff found an 8 and 1/2 cm (centimeter) by 3 cm bruise to the right side of her pelvis by her pubic area. The report indicated two days earlier, client A was in her room and began to fall. Staff was able to break her fall. "However [client A] brushed against her bed rail as she fell into staff." The report indicated there was no bruising at the time of the incident. "The bruise is consistent to wear (sic) [client A] brushed up against the bed rail." Corrective action indicated client A's risk plan in place was being followed, was reviewed and remains appropriate. "Staff will continue monitoring [client A] to prevent further falls."</p>	W 154	<p>W154 The facility will have evidence that alleged violations are thoroughly investigated. All Residential Managers and QIDPs have been retrained on thorough investigations. The training emphasized that all staff and or clients who may have something to add to the investigation are to be interviewed. Investigations will be reviewed and approved weekly by the Clinical Supervisor and the Program Manager.</p>	02/19/2015
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	An investigation into the incident completed 12/23/14 and signed by the QIDP (Qualified Intellectual Disabilities Professional) indicated in a summary of interviews "...on 12/14/14 [client A] had fallen asleep in her wheelchair in the living room so he (staff #6) helped wheel her into her bedroom. [Staff #6] states [client A] stood on his toes when she was raised from her wheelchair and when he tried to move his feet, they caught on her side mat and the both of them fell over onto [client A's] bed. [Staff #6] states that they fell over against [client A's] bed rail and the rail may have caused her bruise. [Staff #6] states that he himself received a 'wicked looking' bruise that appeared on his left [buttocks] and went around the side of his left leg wrapping toward the front." The investigation included statements from staff #5, #6 and #7. The conclusion indicated client A's bruise "may have occurred from a fall onto her bed where her bed rails are located. Several staff indicated that they believe the bruise came from her fall on 12/14/14. The bruise is consistent where she hit the bed rail." The investigation did not identify who the "several staff" were indicated in the summary/conclusion of the investigation and did not address the discrepancy between the date of client A's fall indicated as two days prior to the			

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	<p>discovery of her bruising as documented in the BDDS report and the date of her actual fall on 12/14/14. There was no evidence any other staff in the home were included in the investigation of client A's bruising.</p> <p>The QIDP was interviewed on 1/15/15 at 4:53 PM. She indicated she had determined the cause of client A's bruising based upon interviews of staff including staff #7, #5 and #6. She indicated other staff worked in the home from the time of client A's fall on 12/14/14 until her bruising was found on 12/17/14, but were not interviewed. The QIDP indicated the BDDS reports sometimes include information that is not correct upon investigation of incidents and the information in the BDDS report was thought to be correct at the time. She indicated the investigation did not address the discrepancy.</p> <p>Staffing records for the home were reviewed on 1/16/15 at 3:00 PM and indicated staff #1, #2, #3 and #4 worked in the group home in the time period of 12/14/14-12/17/14.</p> <p>The Manager of Supported Group Living (MSG) was interviewed on 1/16/15 at 3:00 PM. She indicated all staff who worked in the home from 12/14/14 until</p>			

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W 249 Bldg. 00	<p>12/17/14 should have been interviewed. She indicated the "several staff" indicated in the investigation summary should have been identified in the investigation.</p> <p>This federal tag relates to complaint #IN00161445.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based upon observation, record review and interview, the facility failed for 1 of 3 sampled clients (client A), to implement her fall risk plan.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 1/16/15 from 11:20 AM to 12:00 PM. Client A</p>	W 249	W249 As soon as the interdisciplinary team has formulated a client's IPP, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the IPP. Disciplinary action has been given	03/16/2015

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	<p>did not have her wheelchair alarm attached to her clothing and did not have on her gait belt during the observation. Client A was sleeping in her bed until 11:35 AM when staff #8 heard client A's voice. Staff #8 did not have client A's hand held video monitor with her when she answered the door or walked through the group home until client A awakened.</p> <p>Client A's records were reviewed on 1/16/15 at 1:58 PM. A fall risk plan dated 4/23/14 and updated 12/11/14 indicated "Staff will ensure [client A] has her helmet and chair alarm on at all times when awake." An Inservice Sign-in Sheet dated 10/30/14 indicated client A's "monitor must be used while she is in her bed in her room. This means you carry the monitor with you. If you see [client A] through the monitor attempting to get out of bed, you must go to her and provide redirection/assistance...Continue to follow [client A's] risk plan for falls...."</p> <p>The group home Medication Coach (MC) was interviewed on 1/16/15 at 11:46 AM and indicated client A should be using her chair alarm when seated in her wheelchair and have her gait belt on while she is awake.</p> <p>The Manager of Supported Group Living (MSGL) was interviewed on 1/16/15 at 2:50 PM and indicated client A was to use an audio bed alarm as well as a video monitor when sleeping to prevent her from falls. She indicated staff are to carry the video monitor or have the monitor within eyesight while client A is sleeping.</p> <p>This federal tag relates to complaint #IN00161445.</p> <p>9-3-4(a)</p>		to the staff member who did not follow client A's plan. All staff will be retrained on following all clients' IPP and Risk plans. QIDP will do observations three times per week to include assuring that staff are following all clients' plans. Residential Manager will be in the home at least 5 days per week and will monitor staff to assure that they are following all client's IPP and risk plans	

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

PRINTED: 03/18/2015
FORM APPROVED
OMB NO. 0938-0391

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