

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/28/2011
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN46226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
W0000	<p>This visit was for a Post Certification Revisit (PCR) to the investigation of complaint #IN00090863 completed on 06/30/11.</p> <p>Complaint #IN00090863: Not corrected.</p> <p>This visit was in conjunction with an investigation of complaints #IN00097492 and #IN00098913.</p> <p>Dates of survey: 10/24/11, 10/25/11, 10/26/11 and 10/28/11.</p> <p>Surveyor: Robert Bauermeister, Medical Surveyor III</p> <p>Facility Number: 000685 Provider Number: 15G666 AIMS Number: 100474600</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 12/5/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/28/2011
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN46226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
W0210	<p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on interview and record review for 8 of 8 clients living in the home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to reassess the clients' ability to evacuate the home during the overnight shift.</p> <p>Findings Include:</p> <p>On 10/26/11 at 5:30 AM the emergency drill</p>	W0210	<p>CORRECTION: <i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</i> Specifically, the facility has conducted overnight shift evacuation drills to assess clients' ability to evacuate the facility during hours they are typically asleep. PREVENTION: Professional staff will be retrained regarding the need to conduct evacuations drills on each shift for all staff each quarter. The Operations Team will review and track all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled. Responsible Parties: QDDPD, Support Associates, Operations Team</p>	12/17/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/28/2011	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN46226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>records for the last year (10/26/10 to 10/26/11) were reviewed. All of the clients residing in the home (clients #1, #2, #3, #4, #5, #6, #7 and #8), participated in the drills. The reports indicated for the 5 emergency fire drills held during the overnight shift (10/11/11, 08/25/11, 05/26/11, 04/06/11 and 02/02/11) occurred between 7:00 AM and 7:15 AM.</p> <p>On 10/26/11 at 5:15 AM staff #7, assigned to the overnight shift, stated "the drills were run around 7:00 AM because there were 8 clients to evacuate and earlier in the morning I am the only staff on duty." An additional staff reported for duty at 6:30 AM.</p> <p>A review of the Initial Incident Reports for 08/01/11 to 10/24/11 on 10/24/11 at 11:00 AM indicated:</p> <p>Client #3, 08/09/11 at 10 AM - "leaned to the left, lost her balance and fell to the floor. ... Noticed elbow was red and swollen. Examined by nurse put an ice pack on the swollen area."</p> <p>Client #3, 09/26/11 at 5:35 AM - "[Client #3] cried out and observed her sitting on the bathroom floor. ... Called 911. EMS arrived and transported [client #3] to the [name of hospital] ER [Emergency Room] for evaluation and treatment. Admitted for further testing indicated she has a UTI. ... Will receive an MRI [Magnetic Resonance Imaging] and OT [Occupational Therapy] and PT[Physical Therapy] eval to rule out medical issue." As a result of the assessments client #3 was recommended to use a walker, wheelchair and gait belt. The MRI, OT and PT reports did not include</p>						

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

PRINTED: 12/27/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/28/2011
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN46226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>an assessment of her ability to evacuate the house.</p> <p>This federal tag relates to complaints #IN00097492 and #IN00098913.</p> <p>9-3-4(a)</p>				