

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 05/15/2012	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 5/1/12, 5/2/12, 5/3/12, 5/4/12, 5/9/12 and 5/15/12.</p> <p>Facility Number: 000685 Provider Number: 15G666 AIMS Number:100474600</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 5/18/12 by Tim Shebel, 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.

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W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation and interview for 1 of 4 sampled clients (#1) plus one additional client (#7), the facility failed to ensure the clients used United States currency.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/3/12 from 5:20 AM through 7:40 AM. At 5:30 AM client #7 was encouraged by HM (Home Manager) #1 to participate in a money counting activity. HM #1 utilized a tray of plastic coins and fake paper money to conduct the counting activity with client #7. HM #1 asked client #7 to identify the fake one dollar bill and identify the fake penny, nickel, dime and quarter. HM #1 then encouraged client #1 to participate in the activity and point to the penny, nickel, dime and quarter. HM #1 stated, "[Client #1], show me how much to buy a pop." Client #1 identified two fake quarters and handed them to HM #1.</p> <p>Interview with PD (Program Director) #1 on 5/4/12 at 2:40 PM indicated staff used</p>	W0126	<p>CORRECTION: <i>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Specifically for Clients #1 and #7, staff now use United States currency when providing money management training. PREVENTION:</i> Facility professional staff will be retrained regarding the need to assure all clients have an opportunity to hold their own money to the maximum extent possible based on their current assessed level of competency as well as the fact that actual United States currency should be used during money management training activities.</p> <p>RESPONSIBLE PARTIES: QDDPD, Home Manager, Support Associates, Operations Team, Quality Assurance Team</p>	06/14/2012			

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	<p>fake money to run money management goals with the clients.</p> <p>Interview with AS (Administrative Staff) #2 on 5/4/12 at 2:40 PM indicated staff should not use fake money to train the clients.</p> <p>9-3-2(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 10 incident of abuse, neglect or injuries of unknown origin reviewed for 1 of 4 sampled clients (#1), the facility failed to complete a thorough investigation in regards to client #1's missing television.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, internal incident reports and investigations was conducted on 5/3/12 at 9:15 AM. The review indicated the following:</p> <p>1. BDDS report dated 11/23/11 indicated on 11/23/11, "Staff returned to the residence after taking one of [client #1's] housemates to a medical appointment. When completing a walk through of the house, staff noted [client #1's] television was missing. All doors and windows were locked at the time staff and consumers left the house. There was no evidence of forced entry and no other household items appeared to be missing. A facility summary of investigation was not provided for review regarding this</p>	W0154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the facility will assure an investigation into Client #1's missing television is located and/or competed and available for review.</p> <p>PREVENTION: Once completed, the facility will turn in investigation packets to the Quality Assurance Team for review and filing. Additionally, the QDDPD will maintain a copy of each investigation at the facility.</p> <p>RESPONSIBLE PARTIES: QDDP, Support Associates, Operations Team, Quality Assurance Team</p>	06/14/2012

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	<p>incident.</p> <p>Interview with AS (Administrative Staff) #1 on 5/3/12 at 11:54 AM. AS #1 indicated an investigation into the missing television should have been completed. AS #1 was unable to provide an investigation regarding client #1's missing television.</p> <p>9-3-2(a)</p>				

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 2 additional clients (#6 and #8), the facility failed to ensure the HRC (Human Rights Committee) reviewed and approved the use of door alarms and the restriction from access to knives for clients #1, #2, #3, #4, #6 and #8.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/2/12 from 5:45 PM through 7:40 PM. Clients #2, #3, #4, #5, and #6 were present in the home throughout the observation period. At 5:45 PM upon entering the back door of the group home an alarm was activated with the opening of the door. When the door was shut the alarm was deactivated. When clients #3, and #4 exited the front door at 6:10 PM, an alarm sounded each time the door was opened. At 6:35 PM HM (Home Manager) #1 was preparing the evening</p>	W0264	<p>CORRECTION: <i>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Specifically, the interdisciplinary team has reviewed Client #3's recent behavioral data and consensually agrees that keeping knives and other sharps secured is no longer indicated. Additionally the IDT has reviewed Client #2 and Client #3's recent behavior data and consensually agree that door alarms are not currently needed to prevent elopement.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the need to obtain prior written informed consent and Human Rights Committee approval for all restrictive programs prior to implementation. Additionally, the agency has established a</p>	06/14/2012			

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	<p>meal. HM #1 walked to the refrigerator in the kitchen and retrieved a knife from a cabinet directly above the refrigerator. The cabinet above the refrigerator was 6 feet in height and 2 feet back from the front of the refrigerator. At 7:20 PM staff #2 was preparing lunches for the next day's day services. Staff #2 went to the cabinet located above the refrigerator and retrieved a knife to cut salad items. Clients #1, #2, #3, #4, #6 and #8 were not able to physically access the knives.</p> <p>Observations were conducted at the group home on 5/3/12 from 5:20 AM through 7:40 AM. Clients #1, #2, #3, #4, #6, and #8 were present in the home throughout the observation period. At 5:20 AM upon entering the front door of the group home an alarm was activated with the opening of the front door. When the door was shut the alarm was deactivated.</p> <p>Client #1's record was reviewed on 5/4/12 at 12:44 PM. Client #1's ISP (Individual Support Plan) dated 6/11/11 did not indicate the use of door alarms or restrictions from knives. Client #1's BSP (Behavior Support Plan) dated 6/10/11 indicated the targeted behaviors of stealing and physical aggression. Client #1's BSP did not indicate the targeted behaviors of elopement or using items/knives as weapons. Client #1's</p>		<p>separate Quality Assurance Department to assist with auditing facility systems. Members of the Quality Assurance and Operations Teams will periodically review support documents and Human Rights Committee Records on an ongoing basis to assure prior written informed consent and HRC approval occurs for all restrictive programs.</p>				

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	<p>record did not indicate HRC (Human Rights Committee) approval for the use of the door alarms or being restricted from knives.</p> <p>Client #2's record was reviewed on 5/4/12 at 11:08 AM. Client #2's ISP dated 6/10/11 did not indicated the use of door alarms or restrictions from knives. Client #2's BSP dated 6/10/11 indicated the targeted behaviors of physical aggression, property destruction, compulsive eating and elopement. Client #2's BSP did not indicate the use of door alarms or restrictions from knives. Client #2's Modification of Rights form dated 6/10/11 indicated restriction of movement in regard to client #2's supervision outside the group home. Client #2's Modification of Rights form did not indicate the use of door alarms or restriction from knives. Client #2's record did not indicate HRC approval for the use door alarms or being restricted from knives.</p> <p>Client #3's record was reviewed on 5/4/12 at 12:18 PM. Client #3's BSP dated 9/27/11 indicated an incident involving client #3 threatening the use of a steak knife to harm her peers and staff on 4/30/10. Client #3's BSP did not indicate the use of door alarms or restriction from access to knives. Client #3's record did not indicate any further incidents</p>			

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	<p>involving knives after the 4/30/10 incident. Client #3's record did not indicate HRC (Human Rights Committee) approval for the use of the door alarms or being restricted from knives.</p> <p>Client #4's record was reviewed on 5/4/12 at 10:02 AM. Client #4's ISp dated 5/3/12 did not indicate the use of door alarms or the restriction of access to knives. Client #4's record did not indicate HRC (Human Rights Committee) approval for the use of the door alarms or being restricted from access to knives.</p> <p>Client #6's record was reviewed on 5/14/12 at 5:34 PM. Client #6's ISP dated 6/6/11 did not indicate the use of door alarms or restriction from access to knives. Client #6's BSP dated 6/6/11 did not indicate the use of door alarms or restriction form access to knives. Client #6's record did not contain HRC approval for the use of door alarms or being restricted from access to knives.</p> <p>Client #8's record was reviewed on 5/14/12 at 5:47 PM. Client #8's ISP dated 3/15/12 and BSP dated 3/15/12 did not indicate the use of door alarms or restriction from access to knives. Client #8's record did not contain HRC approval for the use of door alarms or being restricted from access to knives.</p>				

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	<p>Interview with PD (Program Director) #1 on 5/4/12 at 2:40 PM indicated the group home had door alarms on the front and back door. PD #1 indicated the group home kept the knives in a cabinet above the refrigerator in the kitchen. PD #1 indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 could not access the knives due to the height of the cabinet being out of the clients reach. PD #1 indicated HRC had not approved the use of door alarms or the restricting the clients' access to knives in the group home.</p> <p>9-3-4(a)</p>			
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