

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2014
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SANIBEL DR FORT WAYNE, IN 46815
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W000000	<p>This visit was for a Post Certification Revisit (PCR) to a PCR completed 8/12/14 to a PCR completed on 5/16/14 to the investigation of complaint #IN00145521 completed on 3/21/14.</p> <p>This visit was in conjunction with the investigation of Complaint #IN00154715.</p> <p>This visit was in conjunction with a post certification revisit survey (PCR) to a PCR completed 8/12/14 to the fundamental recertification and state licensure survey completed on 5/16/14.</p> <p>Complaint #IN00145521: Not corrected.</p> <p>Dates of Survey: 9/16, 9/17, 9/18, 9/19, 9/22, 9/23, and 9/24/2014.</p> <p>Facility number: 001195 Provider number: 15G658 AIM number: 100474580</p> <p>Surveyors: Susan Eakright, QIDP-TC Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/6/14 by Ruth</p>	W000000		

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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W000104	<p>Shackelford, QIDP.</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview for 4 of 4 sampled clients (clients A, B, C, and D), and for 3 additional clients (clients E, F, and G), the governing body failed to exercise general policy and operating direction over the facility to develop and implement policy and procedures to maintain mattresses in good condition, to ensure assessments were completed, failed to ensure clients had an accounting of their funds, failed to ensure staff were trained to implement health care protocols, and to provide oversight to ensure clients received care and services.</p> <p>Findings include:</p> <p>1. Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. There was a finished board attached to the adjacent wall of the front door.</p> <p>Observations were completed at the group home on 9/17/14 from 11:10 AM</p>	W000104	<p>The governing body will exercise general policy, budget, and operating direction over the facility. The QIDP will complete observations at least three times weekly. The operations team will complete observations three times a week. The operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy are completed. Operations team members will review and approve all investigations.</p>	10/24/2014

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	<p>until 12:35 PM. At 11:57 AM client B was directed to make his bed. Client B dragged a plastic sheet down the hallway. Client B's bed was standing up against a wall in his bedroom and had 44 circular rust stains on the fabric coinciding with the coils. The mattress was wet to touch. Clients A and F's mattresses had plastic wrapped around the entire mattress with the shipping label intact. Client A's mattress had a yellow stain 6 inches in diameter beneath the plastic. Client A's mattress had 2 pillows under the sheets, one of which was stained with darkened areas across the surface. Client E's mattress was upside down with a mesh type cover underneath the sheets on his bed. The residential manager (RM) and staff #4 turned client E's mattress over revealing two 1 and 1/2 feet in diameter brown stains. Client D's nebulizer machine lay on the counter uncovered.</p> <p>Staff #13 was interviewed on 9/17/14 at 11:58 AM and indicated there were holes in the plastic mattress cover which kept the mattress moist. Staff #13 stated "They clean the plastic and when they spray, it doesn't dry. Now the whole mattress is wet." When asked if the mattress was wet from cleaning or urine, she stated, "A little of both." Staff #13 indicated she would not want to sleep on the mattress.</p>			

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	<p>The RM was interviewed on 9/17/14 at 12:15 PM and stated the plastic covers with the shipping labels wrapped around the mattresses were "Not technically meant as a protector." She indicated she would not want to sleep on the stained mattresses.</p> <p>Staff #4 was interviewed on 9/17/14 at 12:25 PM and indicated clients B and C were incontinent at night. She indicated clients A and E made their beds independently. Staff #4 stated "I never check the mattresses, so that explains a lot."</p> <p>Confidential Interview #1 indicated the Director of Supported Group Living (DSGL) had asked client A to cover a hole in the wall next to the front door so the surveyor would not see it during a previous visit and the hole had since been fixed by placing a board over the hole.</p> <p>Confidential Interview #2 indicated client A had been asked by the DSGL to cover the hole in the wall with a coat so the surveyor would not see the hole during a previous visit and client A had hung a coat on the coat rack over the hole to cover it up.</p> <p>The Executive Director (ED) was interviewed on 9/18/14 at 2:00 PM. She</p>			

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	<p>indicated new mattresses had been purchased and were ready for clients to sleep on that same evening. When asked what mattresses clients slept on for the evening of 9/17/14, she indicated she would need to check. No additional information was provided in regards to what mattresses the clients slept on the night of 9/17/14. The ED indicated she would look into the facility policy and procedures in regards to care and maintenance of the group home including durable equipment and furnishings. No policy and procedure was provided to address maintenance of the condition of the home and its furnishings.</p> <p>A blank Home Environment Checklist (undated) was reviewed on 9/19/14 at 11:00 AM and indicated in part, "Beds: Mattress(es): In Good Repair". There were no instructions provided as to when the checklist was to be completed and who was responsible for completing the checklist.</p> <p>2. Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. Client D's nebulizer sat on the kitchen counter uncovered.</p> <p>The RM was interviewed on 9/17/14 at 11:30 AM. When asked if client D's nebulizer was to be stored on the kitchen</p>			

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	<p>counter, the RM stated, "It looks like it needs to be cleaned."</p> <p>Client D's record was reviewed on 9/17/14 at 3:53 PM. An Individual Support Plan (ISP) dated 5/28/14 indicated a Risk Plan for altered elimination thru (sic) Ileostomy (an surgical opening in the belly made during surgery to move waste out of the small intestine which is expelled into a small bag). The plan indicated "Staff/Guardian will be trained on normal color/consistency/and odor. Staff/Guardian will be trained on Ileostomy and how to empty/clean and change drainage bag. Staff/Guardian will be trained on importance of documentation of BM (bowel movement) output...Staff will be trained on when and how to notify the nurse...." The plan indicated the staff responsible for implementation included Support Staff, RM, Med (medical coach), PC (program coordinator)/QIDP (Qualified Intellectual Disabilities Professional). The record indicated client D had been hospitalized for blood in his stoma and a yeast infection on 6/10/14.</p> <p>Staff #4 was interviewed on 9/17/14 at 12:25 PM and when asked about training on health care protocols, staff #4 indicated she had not been trained by the</p>			

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	<p>nurse on the care of client D's ileostomy and stated, "Another staff trained me."</p> <p>Training Verification for Sleep Apnea and CPAP (Continuous Positive Airway Pressure), Oxygen Equipment Maintenance, Nebulizer Treatment (all undated) and an Adaptive Equipment Cleaning/Maintenance form dated 1/2013 were reviewed on 9/18/14 at 12:00 PM. The CPAP and Nebulizer training indicated the masks should be cleaned daily with soap and water. After each nebulizer treatment, the mask/mouthpiece was to be rinsed with warm water and allowed to dry on a paper towel and covered with a paper towel.</p> <p>Staff training records completed by the nurse for Ostomy (surgically created opening in the abdomen) care were reviewed on 9/17/14 at 2:00 PM and indicated the previous medical coach, staff #8, #15, #2, #13 and #7 had been trained on 7/10/14. There was no evidence the RM, staff #3, #4, #6, #17, #10, #12, or #14 who worked in the group home as indicated in the staff list provided at the entrance conference had been trained on the care of client D's ileostomy. There was no evidence of client specific training for client D's nebulizer care including where it was to</p>			

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	<p>be stored.</p> <p>The Director of Nursing (DON) and LPN (Licensed Practical Nurse) were interviewed on 9/17/14 at 1:55 PM and indicated staff should be trained by the nurses on client D's protocol to care for his ileostomy and nebulizer. They indicated nursing staff were willing to train staff on clients' protocols, but were not always notified when new staff were hired. They indicated client D's nebulizer should be stored in the medication administration room after use and cleaning of the mask.</p> <p>Client D's September, 2014 MAR (medication administration record) was reviewed on 9/22/14 at 12:41 PM and indicated staff #4 had changed client D's ileostomy bag 14 times during the period from 9/15/14, 9/16/14, 9/17/14, 9/18/14 and 9/19/14.</p> <p>This deficiency was cited on 8/12/2014, on 5/16/2014, and on 3/21/2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>This federal tag relates to complaint #IN00145521.</p> <p>9-3-1(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement the agency's policy and procedure to document a thorough investigation into 1 of 1 incident of elopement (AWOL - Absent Without Leave) behavior involving 1 additional client (client G).</p> <p>Findings include:</p> <p>On 9/16/14 at 2:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 7/15/2014 through 9/16/2014 and indicated the following for client G:</p> <p>-An 8/16/14 BDDS report for an incident on 8/15/14 at 6:30pm, indicated client G wanted to go on an outing, a verbal exchange occurred between staff and client G, client G was "asked to wait," and client G left the group home AWOL (Absent Without Leave) out the door. The report indicated client G walked down the street to the gas station. The report indicated staff followed at a distance behind client G down the street. Client G was interviewed on 9/17/14 at 7:35 AM. Client G stated he walked to</p>	W000149	<p>The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The policy /procedure for reporting and investigation of abuse, neglect, exploitation and mistreatment of clients was reviewed and remains appropriate. All professional agency personnel involved in investigations received internal investigation training which was conducted by the Regional Quality Manager on 10/1/2014. In addition all staff involved in investigations attended a presentation 10/10/2014, conducted by ISDH supervisor regarding "How to conduct a thorough investigation" . The operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy are completed. To ensure that all investigations are thorough, specifically that all potential witnesses are interviewed and all relevant documents are reviewed, the operations team will meet weekly to discuss all allegations, review all investigations and ensure that all documentation and follow up have been completed. Persons responsible: QIDP, Operations</p>	10/24/2014			

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	<p>the gas station nearby "A couple of days ago," and indicated he was not permitted to go by himself to the gas station.</p> <p>An undated investigation into client G's elopement was reviewed on 9/18/14 at 4:39 PM. The summary written by Clinical Supervisor #1 (CS #1) indicated client G had told staff he was going to the gas station and when asked to wait, he left the group home with staff following. The investigation failed to address or determine why staff had asked client G to wait before going to the gas station, causing client G to leave the home. No documented witness statements were available for review.</p> <p>CS #1 was interviewed on 9/18/14 at 2:41 PM and indicated client G was asked to wait to go to the gas station while staff were assisting other clients. She stated, "It was probably my wording, but that's what happened."</p> <p>The facility's Policy/Procedure for Reporting and Investigating Abuse, Neglect, Exploitation, and Mistreatment of clients dated 6/2011 was reviewed on 9/17/14 at 11:30 AM and indicated "All allegations or occurrences of abuse/neglect/exploitation/mistreatment shall be reported to the appropriate authorities through the appropriate</p>		Team including Executive Director	

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	<p>supervisory channels and will be thoroughly investigated under the policies of ResCare Northern Region Indiana, local, state and federal guidelines...Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse/neglect/exploitation should immediately notify the Director of Supported Group Living (group homes), then complete an Incident Report. The Director of Supported Group Living/Supported Living will then notify the Executive Director. This step should be done within 24 hours. The Director of the program (SGL or SL) or designee will report the suspected abuse, neglect or exploitation within 24 hours of the initial report to the appropriate contacts, which may include:...Bureau of Developmental Disabilities Service Coordinator...The Director of the Program (SGL or SL) will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures or investigations...One of the investigators will complete a detailed investigative case summary based on witness statements and other evidence collected...An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a</p>			
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W000154	<p>thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Director of Supported Living or SGL, and a Human Resources representative."</p> <p>This deficiency was cited on 8/12/2014, on 5/16/2014, and on 3/21/2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>This federal tag relates to complaint #IN00145521.</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.</p> <p>Based on record review and interview, the facility failed to document a thorough investigation into 1 of 1 incident of elopement involving 1 additional client (client G).</p> <p>Findings include:</p> <p>On 9/16/14 at 2:50pm, the facility's BDDS (Bureau of Developmental</p>	W000154	<p>The facility will have evidence that all alleged violations are thoroughly investigated. All professional agency personnel involved in investigations received internal investigation training which was conducted by the Regional Quality Manager on 10/1/2014. In addition all staff involved in investigations attended a presentation</p>	10/24/2014			

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	<p>Disabilities Services) reports were reviewed from 7/15/2014 through 9/16/2014 and indicated the following for client G:</p> <p>-An 8/16/14 BDDS report for an incident on 8/15/14 at 6:30pm, indicated client G wanted to go on an outing, a verbal exchange occurred between staff and client G, client G was "asked to wait," and client G left the group home AWOL (Absent Without Leave) out the door. The report indicated client G walked down the street to the gas station. The report indicated staff followed at a distance behind client G down the street. Client G was interviewed on 9/17/14 at 7:35 AM. Client G stated he walked to the gas station nearby "A couple of days ago," and indicated he was not permitted to go by himself to the gas station.</p> <p>An undated investigation into client G's elopement was reviewed on 9/18/14 at 4:39 PM. The summary written by Clinical Supervisor #1 (CS #1) indicated client G had told staff he was going to the gas station and when asked to wait, he left the group home with staff following. The investigation failed to address or determine why staff had asked client G to wait before going to the gas station, causing client G to leave the home. No documented witness statements were</p>		<p>10/10/2014, conducted by ISDH supervisor regarding "How to conduct a thorough investigation" . The operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy are completed. To ensure that all investigations are thorough, specifically that all potential witnesses are interviewed and all relevant documents are reviewed, the operations team will meet weekly to discuss all allegations, review all investigations and ensure that all documentation and follow up has been completed. Persons responsible: QIDP, Operations Team including Executive Director</p>	

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	<p>available for review.</p> <p>CS #1 was interviewed on 9/18/14 at 2:41 PM and indicated client G was asked to wait to go to the gas station while staff were assisting other clients. She stated, "It was probably my wording, but that's what happened."</p> <p>This deficiency was cited on 8/12/2014, on 5/16/2014, and on 3/21/2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>This federal tag relates to complaint #IN00145521.</p> <p>9-3-2(a)</p>				