

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G397	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/26/2012
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250		
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W0000	<p>This visit was for investigation of complaint #IN00117940.</p> <p>Complaint #IN00117940: Substantiated. Federal and state deficiencies related to the allegations are cited at W149 and W157.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: October 18, 19, 25, and 26, 2012.</p> <p>Facility Number: 000911 Provider Number: 15G397 AIMS Number: 100244420</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 11/2/12 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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W0149	<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.</p> <p>Based on observation, record review, and interview for 1 of 7 reviewed BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility neglected to implement their corrective action for environmental bed bug infestation for 7 of 7 clients living in the group home (clients A, B, C, D, E, F, and G).</p> <p>Findings include:</p> <p>During the 10/18/12 observation period from 5:40am until 7:40am, clients A, B, C, D, E, F, and G independently walked throughout the group home including the double bay attached garage of the group home. At 6:05am, client G walked to the garage, tore opened a plastic bag, removed clothing which he set on the floor of the garage, selected a shirt, returned to his room, and at 6:15am, client G came to the kitchen dressed in a shirt from the garage. At 6:15am, Facility Staff (FS) #1 stated staff should supervise clients when the clients go into the garage "because we have bedbugs" and the group home was chemically sprayed. FS #1 stated she "did not see" client G go into</p>	W0149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, Facility staff have been retrained on the agency's bed bug infestation policy and an increased supervisory presence in the home has confirmed proper implementation of bed bug eradication procedures and protective measures.</i></p> <p>PREVENTION: All new staff will be trained on bed bug procedures upon hire and annually there after. Any temporary staff assigned to cover shifts in the home will be trained on bed bug procedures prior to working in the home. The Program Manager Supervised Group Living and/or Clinical Supervisor will visit the facility no less than weekly to perform visual observation of clothing storage and other protective measures until the agency's contracted pest control specialists confirm the eradication of the bed bugs. Members of the Quality Assurance team will also conduct periodic audits of the facility to assure protective measures remain in place.</p> <p>Responsible Parties:</p>	11/25/2012			

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	<p>the garage. At 6:15am, observation indicated the attached two care garage had twenty (20) plus plastic totes filled with client clothing. At 6:15am, FS #1 stated the plastic bags piled "over four feet tall" were torn open and clothing which belonged to the clients was open to air and laid on the garage floor. From 6:15am until 7:40am, client G entered and exited the garage without supervision at least four additional times. Client G each time selected a different shirt, changed into the selected garage shirt and wore without heat treatment completed.</p> <p>On 10/18/12 at 9AM, the facility's BDDS Reports were reviewed from 07/01/12 through 10/18/12.</p> <p>-A 10/15/12 BDDS Report for an incident on 9/10/12 at 11am, indicated the group home "underwent a chemical pest control treatment [name of company] Exterminators for the removal of bed bugs...One more treatments are scheduled for the home 10/27/12. In the time between treatments, staff will insure that all clothing and items are washed, dried on high heat, bagged, and/or contained per specifications of the exterminator to limit further exposure and spread of the pest. Protective gowns and booties are provided for staff if they desire to use them (sic)."</p>		QDDPD, Direct Support Professionals, Operations Team, Quality Assurance Team				

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	<p>On 10/18/12 at 11:30am, a review of the facility's 10/02/2012 "Dos and Don'ts If You Have Bedbugs" policy/procedure and the Quality Assurance Manager (QAM) was interviewed. The policy and procedure indicated "Don't count on freezing temperatures to kill your bedbugs...Putting things out on the patio on a cold winter may slow things down." The policy indicated bedbugs can be killed by the use of a hot dryer for "twenty (20) minutes." The QAM stated the group home staff were to have ensured that client A, B, C, D, E, F, and G's personal clothing and extra cloth items were kept in the unheated garage and "sealed inside bags and plastic totes" to prevent and to limit the "potential exposure" to bedbugs. The QAM stated staff were to have ensured each clients' personal belonging were "sealed in a tote or bag," kept in the garage, and staff were to supervise each client when the client wanted an item from a sealed bag or tote. The QAM stated "everything should be sealed" to killed the infestation of bedbugs.</p> <p>On 10/26/12 at 1:30PM, an interview with the QAM was conducted. The QAM indicated it was neglect when facility staff neglected to implement the corrective action to ensure staff supervised clients when the client selected clothing which</p>						

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	<p>was being chemically treated for bedbugs. The QAM stated the facility's corrective action was for "all" clothing to be washed and heat treated to prevent further exposure to bedbugs.</p> <p>On 10/18/12 at 10AM, a review of the facility's 09/14/07 Policy on "Abuse, Neglect, Exploitation" indicated, "Adept employees actively advocate for the rights and safety of all individuals...All allegations or occurrences of abuse, neglect and exploitation shall be reported the the appropriate authorities...The incident types are: Suspected abuse, neglect or exploitation...Residential problems, Environmental/structural problems...".</p> <p>This federal tag relates to complaint #IN00117940.</p> <p>9-3-2(a)</p>				

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, for 1 of 1 allegations of abuse, neglect, and/or mistreatment for 1 of 7 clients living in the group home (client A), the agency staff failed to immediately report to the Administrator in accordance to state law for an allegation of rape.</p> <p>Findings include:</p> <p>On 10/18/12 at 9am, the facility's BDDS (Bureau of Developmental Disability Services) Reports from 7/2012 through 10/18/2012 were reviewed.</p> <p>-A 10/13/12 BDDS report for an incident on 10/9/12 at 11:30am, indicated "[Client A] was overheard talking on the phone (at the group home) by the Residential Manager (RM). [The RM] heard [Client A] tell there person he loved them. [Client A] next told a peer that he believed that [name of a staff person] told the [RM] about a relationship with [name of staff person]. [Client A] then told [RM] that [name of staff person] had called him names on 10/8/12. [RM]</p>	W0153	<p>CORRECTION: <i>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, Meridian Health Services has been informed of their Behavioral Clinician, Jackie Shears', failure to report allegations of abuse. Jackie Shears is no longer assigned to work with Client A.</i></p> <p>PREVENTION: The agency provided Meridian Health Services staff with inservice training regarding reporting responsibilities to ResCare Indianapolis administrative staff as well as law enforcement entities pursuant to the Elder Justice Act. The Quality Assurance Manager has established a dialog with the Meridian Health Services Office Administrative Manager to assure that training toward proper reporting protocols is ongoing to assure allegations are reported as required.</p> <p>Responsible Parties: QDDPD, Operations Team,</p>	11/25/2012

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	<p>suspended [name of staff person] pending an investigation." The report indicated "An investigation was initiated into the incident. Preliminary information received by the [RM] from the [Agency's] Behavioral Consultant (BC) indicated [Client A] had seen the [BC] on 10/8/12. [Client A] reported to the BC that he had sexual intercourse with [the name staff person]. [Client A] then told the BC that he and [name of staff person] layed on the couch and his bed together." The report indicated client A was taken to the hospital for "alleged sexual assault."</p> <p>On 10/26/12 at 1:30PM, an interview with the Quality Assurance Manager (QAM) was conducted. The QAM indicated the facility followed the BDDS guidelines to immediately report to the Administrator and according to state law allegations of abuse, neglect, and/or mistreatment. The QAM indicated the BC did not immediately report the allegation of sexual assault for client A.</p> <p>9-3-2(a)</p>		Quality Assurance Team		

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review, and interview for 1 of 7 reviewed BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility failed to implement corrective action for environmental bedbug infestation for 7 of 7 clients living in the group home (clients A, B, C, D, E, F, and G).</p> <p>Findings include:</p> <p>During the 10/18/12 observation period from 5:40am until 7:40am, clients A, B, C, D, E, F, and G independently walked throughout the group home including the double bay attached garage of the group home. At 6:05am, client G walked to the garage, tore opened a plastic bag, removed clothing which he set on the floor of the garage, selected a shirt, returned to his room, and at 6:15am, client G came to the kitchen dressed in a shirt from the garage. At 6:15am, Facility Staff (FS) #1 stated staff should supervise clients when the clients go into the garage "because we have bedbugs" and the group home was chemically sprayed. FS #1 stated she "did not see" client G go into the garage. At 6:15am, observation</p>	W0157	<p>CORRECTION: <i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, Facility staff have been retrained on the agency's bed bug infestation policy and an increased supervisory presence in the home has confirmed proper implementation of bed bug eradication procedures and protective measures.</i></p> <p>PREVENTION: All new staff will be trained on bed bug procedures upon hire and annually thereafter. Any temporary staff assigned to cover shifts in the home will be trained on bed bug procedures prior to working in the home. The Program Manager Supervised Group Living and/or Clinical Supervisor will visit the facility no less than weekly to perform visual observation of clothing storage and other protective measures until the agency's contracted pest control specialists confirm the eradication of the bed bugs. Members of the Quality Assurance team will also conduct periodic audits of the facility to assure protective measures remain in place.</p> <p>Responsible Parties: QDDPD, Direct Support Professionals, Operations Team,</p>	11/25/2012			

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	<p>indicated the attached two car garage had twenty (20) plus plastic totes filled with client clothing. At 6:15am, FS #1 stated the plastic bags piled "over four feet tall" were torn open and clothing which belonged to the clients was open to air and laid on the garage floor. From 6:15am until 7:40am, client G entered and exited the garage without supervision at least four additional times. Client G each time selected a different shirt, changed into the selected garage shirt and wore without heat treatment completed.</p> <p>On 10/18/12 at 9AM, the facility's BDDS Reports were reviewed from 07/01/12 through 10/18/12. -A 10/15/12 BDDS Report for an incident on 9/10/12 at 11am, indicated the group home "underwent a chemical pest control treatment [name of company] Exterminators for the removal of bed bugs...One more treatments are scheduled for the home 10/27/12. In the time between treatments, staff will insure that all clothing and items are washed, dried on high heat, bagged, and/or contained per specifications of the exterminator to limit further exposure and spread of the pest. Protective gowns and booties are provided for staff if they desire to use them (sic)."</p> <p>On 10/18/12 at 11:30am, a review of the</p>		Quality Assurance Team		

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	<p>facility's 10/02/2012 "Dos and Don'ts If You Have Bedbugs" policy/procedure and the Quality Assurance Manager (QAM) was interviewed. The policy and procedure indicated "Don't count on freezing temperatures to kill your bedbugs...Putting things out on the patio on a cold winter may slow things down." The policy indicated bedbugs can be killed by the use of a hot dryer for "twenty (20) minutes." The QAM stated the group home staff were to have ensured that client A, B, C, D, E, F, and G's personal clothing and extra cloth items were kept in the unheated garage and "sealed inside bags and plastic totes" to prevent and to limit the "potential exposure" to bedbugs. The QAM stated staff were to have ensured each clients' personal belonging were "sealed in a tote or bag," kept in the garage, and staff were to supervise each client when the client wanted an item from a sealed bag or tote. The QAM stated "everything should be sealed" to killed the infestation of bedbugs.</p> <p>On 10/26/12 at 1:30PM, an interview with the QAM was conducted. The QAM indicated the facility staff failed to implement the corrective action to ensure staff supervised clients when the client selected clothing which was being chemically</p>						

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	<p>treated for bedbugs. The QAM stated the facility's corrective action was for "all" clothing to be washed and heat treated to prevent further exposure to bedbugs.</p> <p>This federal tag relates to complaint #IN00117940.</p> <p>9-3-3(a)</p>			

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, for 7 of 7 clients (clients A, B, C, D, E, F, and G) living in the group home for 1 of 1 allegations of abuse, neglect, and/or mistreatment, the facility failed to provide evidence that staff were trained to immediately report suspected abuse, neglect, and/or mistreatment in accordance to state law for an allegation of rape.</p> <p>Findings include:</p> <p>On 10/18/12 at 9am, the facility's BDDS (Bureau of Developmental Disability Services) Reports from 7/2012 through 10/18/2012 were reviewed.</p> <p>-A 10/13/12 BDDS report for an incident on 10/9/12 at 11:30am, indicated "[Client A] was overheard talking on the phone (at the group home) by the Residential Manager (RM). [The RM] heard [Client A] tell there person he loved them. [Client A] next told a peer that he believed that [name of a staff person] told the [RM] about a relationship with [name of staff person]. [Client A] then told</p>	W0189	<p>CORRECTION: <i>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</i> Specifically, Facility staff have been retrained on the agency's bed bug infestation policy and an increased supervisory presence in the home has confirmed proper implementation of bed bug eradication procedures and protective measures.</p> <p>PREVENTION: All new staff will be trained on bed bug procedures upon hire and annually there after. Any temporary staff assigned to cover shifts in the home will be trained on bed bug procedures prior to working in the home. The Program Manager Supervised Group Living and/or Clinical Supervisor will visit the facility no less than weekly to perform visual observation of clothing storage and other protective measures until the agency's contracted pest control specialists confirm the eradication of the bed bugs. Members of the Quality Assurance team will also conduct periodic audits of the facility to assure protective measures remain in place.</p>	11/25/2012

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	<p>[RM] that [name of staff person] had called him names on 10/8/12. [RM] suspended [name of staff person] pending an investigation." The report indicated "An investigation was initiated into the incident. Preliminary information received by the [RM] from the [Agency's] Behavioral Consultant (BC) indicated [Client A] had seen the [BC] on 10/8/12. [Client A] reported to the BC that he had sexual intercourse with [the name staff person]. [Client A] then told the BC that he and [name of staff person] layed on the couch and his bed together." The report indicated client A was taken to the hospital for "alleged sexual assault."</p> <p>On 10/26/12 at 1:30PM, an interview with the Quality Assurance Manager (QAM) was conducted. The QAM indicated the facility followed the BDDS guidelines to immediately report to the Administrator and according to state law allegations of abuse, neglect, and/or mistreatment. The QAM indicated the BC did not immediately report the allegation of sexual assault for client A. The QAM indicated the Behavior Consultant had no training to immediately report allegations of abuse, neglect, and/or mistreatment and no training on reporting suspicion of a crime available for review.</p>		<p>Responsible Parties: QDDPD, Direct Support Professionals, Operations Team, Quality Assurance Team</p>	
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	<p>On 10/18/12 at 10AM, a review of the facility's 09/14/07 Policy on "Abuse, Neglect, Exploitation" indicated, "All allegations or occurrences of abuse, neglect and exploitation shall be reported the the appropriate authorities...The incident types are: Suspected abuse, neglect or exploitation...."</p> <p>On 10/18/12 at 10AM, a review of 10/25/11 "Elder Justice Act: Reporting Reasonable Suspicion of a Crime Against a Resident" indicated "The facility must ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source are reported immediately to the administrator or to other officials in accordance with State law through established procedures."</p> <p>9-3-3(a)</p>			