

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250
---	---

(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
--------------------	--	---------------	---	----------------------

W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: February 20, 21, 24, 28 and March 4, 2014</p> <p>Facility Number: 001021 Provider Number: 15G507 AIM Number: 100245130</p> <p>Surveyor: Jo Anna Scott, QIDP</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/12/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000136	<p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on observation and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 additional clients (clients #5, #6, #7 and #8), the facility failed to</p>	W000136	<p>W136: Protection of Client's Rights Corrective Action: (Specific) A salon in the community has been contacted to set up appointments for each consumer that wants a haircut.</p>	04/03/2014

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: 15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250		
(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>provide the opportunity for clients to go into the community to get hair cuts.</p> <p>Findings include:</p> <p>During the observation period on 2/20/14 from 3:30 PM to 6:30 PM, Clients #1, #2, #3, #4, #5, #6 and #8 were in the home and a former employee came for a visit. The former employee left the home when she found out the home was in survey and indicated she would return at another time to cut the clients' hair.</p> <p>Interview with staff #5 on 2/20/14 at 4:00 PM indicated the former staff was a beautician and had been coming to the home to cut the hair of clients #1, #2, #3, #4, #5, #6, #7 and #8 for over a year. Staff #5 stated it was "much easier" for them to get haircuts in the home than to go to a barber shop or beauty shop.</p> <p>9-3-2(a)</p>		<p>How others will be identified: (Systemic) The Residential Manager will ensure that staff takes all consumers that want haircuts into the community to get haircuts.</p> <p>Measures to be put in place: A salon in the community has been contacted to set up appointments for each consumer that wants a haircut.</p> <p>Monitoring of Corrective Action: The Residential Manager will ensure that all consumers have had their routine haircuts in a community salon. Program Manager will review P Card receipts monthly to ensure that all consumers that want haircuts have financial documentation of their haircut in the financial record.</p> <p>Completion date: 04/03/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250		
(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	
W000249	<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 on observation, record review and interview for 1 of 4 sample clients (client #4), the facility failed to ensure the staff implemented training objectives and the client participated in activities.</p> <p>Findings include:</p> <p>During the observation period on 2/20/14 from 3:30 PM to 6:30 PM, client #4 was sitting in a wheelchair in the kitchen at 3:30 PM. Client #4 prompted staff #7 on how to properly load the dishwasher at 4:05 PM. The client left the area at 4:10 PM to go to the medication room, received his medication, and immediately went back to the kitchen. Client #4 did not assist with the meal preparation or setting the table for dinner.</p> <p>During the observation period on 2/24/14 from 10:30 AM to 3:00 PM, client #4 was again sitting in the kitchen drinking coffee and watching the back door and did not have training objectives</p>	W000249	<p>W249: Program Implementation Corrective Action: (Specific) All staff will be in-serviced on active treatment, goals and Behavior Support Plans for all clients in the home. How others will be identified: (Systemic) The Residential Manager will make random visits at least 3 times weekly to monitor and ensure that client program plans are being implemented as written. Measures to be put in place: All staff will be in-serviced on active treatment, goals and Behavior Support Plans for all clients in the home. Monitoring of Corrective Action: The Residential Manager will make random visits at least 3 times weekly to monitor and ensure that client program plans are being implemented as written. The Program Manager will make random monthly visits to ensure that consumer plans, goals and active treatment are being followed and performed as written. Completion date: 04/03/14</p>	04/03/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G507		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250			
(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>implemented by staff.</p> <p>During the morning medication pass on 2/21/14 from 6:55 AM to 8:00 AM, client #4 came to the medication room at 7:10 AM. Staff #5 did not implement a medication training objective.</p> <p>The record review for client #4 was conducted on 2/21/14 at 2:33 PM. The Individual Support Plan dated 11/29/13 indicated the following training objectives:</p> <ol style="list-style-type: none"> 1. "[Client #4] will identify his Oyster Calcium..." 2. "[Client #4] will display mealtime safety and good etiquette..." 3. "[Client #4] will communicate to staff where he would like to go for a recreational outing..." 4. "[Client #4] will complete his PT (Physical Therapy)..." 5. "[Client #4] will put soap on his wash cloth..." 6. "[Client #4] will brush his teeth daily..." 7. "[Client #4] will state his phone number..." 8. "[Client #4] will gather items needed for shaving..." <p>Interview with staff #5 on 2/24/14 at 3:00 PM indicated client #4 didn't like to leave the kitchen and often stayed in the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250		
(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	
W000322	<p>kitchen drinking coffee instead of participating in any other activity with the other clients.</p> <p>9-3-4(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 4 sampled clients (client #1), the facility failed to ensure client #1 returned to the audiologist in two years as recommended.</p> <p>Findings include:</p> <p>The record review for client #1 was conducted on 2/21/14 at 10:05 AM. The record indicated client #1 had been to audiologist on 1/23/09. The progress note indicated client #1 had "abnormal auditory perception" and should return in 2 years. There was no indication client #1 had returned for the hearing test.</p> <p>Interview with staff #3 on 2/24/14 at 1:30 PM indicated the primary care doctor had not authorized another hearing evaluation and they had not had another evaluation done.</p>	W000322	<p>W322: Physician's Services Corrective Action: (Specific): Client # 1 will have an annual hearing evaluation scheduled with audiologist. All other consumer annual evaluations have been reviewed and found to be in compliance and up-to-date. The residential manager and the nurse will be in-serviced on ensuring that all clients have annual evaluations for hearing. How others will be identified: (Systemic): The Director of Health Services will review client charts at least quarterly to ensure that all clients are receiving annual vision and hearing evaluations. Measures to be put in place: Client # 1 will have an annual hearing evaluation scheduled with audiologist. All other consumer annual evaluations were reviewed and found to be in compliance and up-to-date. The Residential Manager and the nurse will be in-serviced on ensuring that all</p>	04/03/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250		
(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	
W000382	<p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 4 additional clients (clients #5, #6, #7 and #8), the facility failed to ensure the drugs were kept locked except when being prepared for administration.</p> <p>Findings include:</p> <p>During the observation period on 2/20/14 from 3:30 PM to 6:30 PM, the 4:00 PM medication pass started at 4:10 PM. Staff #5 passed client #3's medication, pushed his wheelchair to the living room and went to the bedroom of client #8 to prompt her to come to the medication room. Staff #5 did not lock the med cabinet and left the medication room door open while assisting client #3 and prompting client #8. Clients #1, #2, #3 and #5 were sitting in the living room</p>	W000382	<p>clients have annual evaluations for hearing. Monitoring of Corrective Action: The Director of Health Services will review client charts at least quarterly to ensure that all clients are receiving annual vision and hearing evaluations. Completion date: 04/03/14</p> <p>W382: Drug Storage and Record Keeping Corrective Action: (Specific) All staff will be in-serviced on General Guidelines for Medication Administration Policy and Procedure and the Medication Storage Policy and Procedure.How others will be identified: (Systemic) The Residential Manager will make random visits to the home at least 3 times weekly to ensure that staff is following the Medication Storage and the General Guidelines for Medication Administration Policy and Procedure. The Program Manager or Nurse will make random visits at least twice monthly to ensure that staff is following the Medication Storage and the General Guidelines for Medication Administration Policy and Procedure. Measures to be put in place: All staff will be in-serviced on General Guidelines for Medication Administration Policy and Procedure and the</p>	04/03/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250		
(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>across the hall from the medication room.</p> <p>During the observation period on 2/21/14 from 6:30 AM to 8:30 AM, the medication pass started at 6:55 AM. Staff #4 passed client #1's medication at 6:55 AM and when finished, left his medication box on the desk and pushed client #1 in his wheelchair to the living room and went to the kitchen to get client #4 in a wheelchair to come to the medication room. Client #1's medication was left on the desk, with the medication room door left open. Clients #2, #3, #4, #5, #6 and #8 were eating breakfast and getting ready to go to their day program.</p> <p>During the observation period on 2/24/14 from 10:30 AM to 3:00 PM, the medication room door was left open and a box of medication was left on the desk. This was found by staff #3, RN (Registered Nurse), and the surveyor at 1:30 PM.</p> <p>The interview with staff #3, RN, was conducted on 2/24/14 at 1:30 PM. Staff #3, RN, stated "The staff knows the medication is supposed to be kept locked when they are not in the room. They will be inserviced."</p>		<p>Medication Storage Policy and Procedure. Monitoring of Corrective Action: The Residential Manager will make random visits to the home at least 3 times weekly to ensure that staff is following the Medication Storage and the General Guidelines for Medication Administration Policy and Procedure. The Program Manager or Nurse will make random visits at least twice monthly to ensure that staff is following the Medication Storage and the General Guidelines for Medication Administration Policy and Procedure. Completion date: 04/03/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250		
(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	
	9-3-6(a)				