

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G396		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/25/2012	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 153 S EMERSON INDIANAPOLIS, IN 46219			
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W0000	<p>This visit was for the investigation of complaint #IN00110348.</p> <p>This visit was in conjunction with a post-certification revisit survey to the investigation of complaint #IN00108235 completed on 6/15/12.</p> <p>Complaint #IN00110348: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W104, W125, W137 and W331.</p> <p>Dates of Survey: 7/19, 7/20 and 7/25/12</p> <p>Facility Number: 000910 AIMS Number: 100244430 Provider Number: 15G396</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/30/12 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.

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 1 additional client (F), the governing body failed to exercise general policy and operating direction over the facility to ensure a discharged client received her funds held by the facility in a timely manner.</p> <p>Findings include:</p> <p>The facility's discharge records were reviewed on 7/20/12 at 10:42 AM. The facility's 6/22/12 Change of Status Form indicated client F was discharged from the facility on 6/22/12. The facility's 6/22/12 Discontinuation of Service Plan indicated the client was discharged to her mother. The facility's 6/22/12 Change of Status, Discontinuation of Service Plan and/or undated Discharge Summary did not indicate the client's finances were given to the client upon discharge.</p> <p>Client F's financial records were reviewed on 7/19/12 at 3:10 PM. Client F's 7/1/11 to 7/19/12 Resident Fund Management Service (RFMS) account, held by the facility, indicated client F had \$59.83. The RFMS record indicated client F's account was closed on 7/5/12.</p>	W0104	<p><b>CORRECTION:</b> <i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the agency has released all of Client F's funds held by the facility to client F ni care of her healthcare representative.</i></p> <p><b>PREVENTION:</b> Facility professional staff will submit a Resident Financial Management System Check Request 72 hours prior to planned discharge dates in order to have the funds available for disbursement at the time of discharge. Additionally the Residential Manager or other designated staff will follow up with facility professional staff and the business department to assure finds are available for disbursement at the time of discharge.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Home Manager, Support Associates, Operations Team, Quality</p>	08/24/2012			

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	<p>Confidential interview G indicated as of 7/19/12, client F had not received her money from Voca/Res-care.</p> <p>Interview with administrative staff #1 on 7/20/12 at 8:35 AM indicated client F's account was closed on 7/5/12. Administrative staff indicated client F's mother had called and indicated client F had not received her money from the facility. Administrative staff indicated client F should have received her money by now. Administrative staff #1 stated "I guess we will have to issue another check."</p> <p>This federal tag relates to complaint #IN00110348.</p> <p>9-3-1(a)</p>		Assurance Team		

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on interview and record review for 1 additional (client F), the facility failed to ensure the rights of the client in regard to a judicial hearing as the facility was not present during the hearing to assist with representation of the client since the client was a resident of the group home/facility.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 7/19/12 at 7/19/12 at 1:00 PM. The facility's 6/19/12 reportable incident report indicated "[Client B] (Individual Supported by ResCare) was moving a chair to sit down, when [client F] (Individual supported by ResCare) jerked the chair away. [Client B] then displayed an obscene hand gesture toward [client F]. [Client F] began slapping and punching [client B] in the face, arm, and back. During the scuffle, [client F's] hand got caught in her own ponytail hair piece and she pulled it out of her head. Staff intervened and redirected both individuals to quiet areas. Both individuals were</p>	W0125	<p><b>CORRECTION:</b> <i>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Specifically, Client F has moved out of the facility and no other individuals who reside at the facility have current legal obligations.</i></p> <p><b>PREVENTION:</b> Facility professional staff will be retrained regarding the need to communicate with corrections and court officials to remain aware of incarcerated clients and clients with ongoing legal obligations, to remain aware of court dates and other legal deadlines. The QDDPD will be expected to attend all clients' court dates and other legal proceedings. The QDDP will</p>	08/24/2012			

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	<p>checked for injury. [Client B] sustained a 1/4" (inch) scratch on her forehead. No other injuries apparent...[Client F] called the [name of police department] and reported herself to the police. The police arrived, and [client F] was taken to jail...."</p> <p>Confidential interview G indicated client F was arrested and taken to jail for the 6/19/12 incident. Confidential interview G indicated the Program Coordinator called her and told her of client F's arrest on 6/19/12. Confidential interview G indicated they then called the police station to find out what was going on and what was going to happen with client F. Confidential interview G indicated the group home/Rescare did not show up for client F's hearing which was held the following morning on 6/20/12. Confidential G indicated the judge was not pleased no one from the agency had showed up.</p> <p>Interview with administrative staff #1, staff #1 and Program Coordinator (PC) #1 on 7/20/12 at 8:35 AM indicated client F called the police on herself after hitting client B. Interview with staff #1 indicated client B was taken to a local emergency room for treatment. Staff #1 indicated the police department did not call phone her to tell her of the court hearing. Staff #1 indicated the police department would</p>		<p>provide the residential Manager and Quality Assurance Manager with updates regarding client's legal staus and obligations to facilitate appropriate administrative follow-up.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team</p>		

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	<p>normally call her. PC #1 indicated she phoned the police station the following day on 6/20/12 and they told her the court hearing was going to be at 1:00 PM on 6/20/12. PC #1 indicated she later learned the court hearing was at 8:30 AM on 6/20/12. Administrative staff #1 indicated the court hearings were normally held at 8:30 AM the following morning. Administrative staff #1 indicated no one from Res-Care was present at client F's hearing. Administrative staff #1, staff #1 and PC #1 indicated client F was still a resident at the group home on 6/20/12.</p> <p>This federal tag relates to complaint #IN00110348.</p> <p>9-3-2(a)</p>						

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W0137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on interview and record review for 3 of 3 sampled clients (A, B and C) and for 1 additional client (F), the facility failed to maintain and/or periodically update a system which accounted for the clients' personal possessions.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Confidential interview G indicated the facility did not keep up with client F's clothing/personal possessions. Confidential interview G indicated client F had jeans and other clothing items which were bought for client F after the client was admitted to the group home. Confidential interview G indicated client F did not get all her things when she moved out of the group home. Confidential interview G indicated some of client F's clothing/personal possessions (jeans and other clothes) were missing. Confidential interview G indicated at one point client F had a pair of new tennis shoes come up missing.</li> </ol> <p>Client F's record was reviewed on 7/19/12 at 1:58 PM. Client F's undated face sheet</p>	W0137	<p><b>CORRECTION:</b> <i>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Specifically, the facility will update each client's personal effects inventory.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to maintain and update personal effects inventories. Direct support staff will be trained on the need to add new items to clients' inventories as they are brought into the home. Additionally, the facility will turn in copies of each clients' personal effects inventory to the Program Manager Supervised Group Living twice annually in April and October, to facilitate monitoring of the facility's system for accounting for clients' personal possessions.</p>	08/24/2012			

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	<p>indicated client F was admitted to the group home on 8/26/10. Client F's 8/26/10 Personal Effects Inventory form indicated client F's mother filled out the form when client F was admitted to the group home. The inventory form indicated client F's personal possessions inventory had not been updated since the client was admitted to the group home. The form indicated client F had 13 pants/jeans upon admission to the group home. The form did not indicate what client E took with her when she was discharged from the facility in 7/12.</p> <p>Interview with administrative staff #1, PC (Program Coordinator) #1 and staff #1 on 7/20/12 at 8:35 AM indicated clients' personal possessions were to be inventoried at admission and updated annually or when new items were purchased. Staff #1 indicated she thought client F's personal possession inventory sheet had been updated recently, but staff #1 could not locate the updated inventory sheet. Administrative staff #1 and PC #1 indicated the client did have a pair of shoes which was not accounted for. Administrative staff #1 and PC #1 indicated money was given to the mother to purchase another pair of shoes. PC #1 indicated client F's mother picked up the client's clothes and personal possessions when the client moved out of the group</p>		<p><b>RESPONSIBLE PARTIES:</b> QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team</p>				

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	<p>home. Staff #1 and PC #1 indicated client G's mother threw some of the items away. Staff #1 indicated only a few hair items remained at the group home for client F. When asked if the facility completed an inventory of items the client took with her when discharged, staff #1 indicated she thought they did, but was not able to locate the personal inventory sheet. Administrative staff #1 indicated the group home should have updated the client's personal possessions inventory sheet when new items were purchased and/or brought into the group home. Administrative staff #1 stated the group home had recently been given a "directive" to complete personal possessions inventory sheets on all clients. Administrative staff #1 indicated he was not able to locate any personal possession sheets for client F.</p> <p>2. Client A's record was reviewed on 7/19/12 at 11:16 AM. Client A's record indicated the client did not have a personal possessions inventory record/sheet of the client's personal possessions held at the facility.</p> <p>Client C's record was reviewed on 7/19/12 at 11:49 AM. Client C's record indicated the client did not have a personal possessions inventory record/sheet of the client's personal</p>						

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	<p>possessions held at the facility.</p> <p>Client B's record was reviewed on 7/19/12 at 12:09 PM. Client B's record indicated the client did not have a personal possessions inventory record/sheet of the client's personal possessions held at the facility.</p> <p>Interview with administrative staff #1, PC (Program Coordinator) #1 and staff #1 on 7/20/12 at 8:35 AM indicated client A, B and C's personal possessions were to be inventoried at admission and updated annually or when new items were purchased. Staff #1 indicated she thought client A, B and C's personal possession inventory sheets had been updated recently, but staff #1 could not locate the updated inventory records.</p> <p>Administrative staff #1 indicated the group home should have updated the clients' personal possessions inventory sheets when new items were purchased and/or brought into the group home. Administrative staff #1 stated the group home had recently been given a "directive" to complete personal possessions inventory sheets on all clients. Administrative staff #1 indicated he was not able to locate any personal possession sheets for clients A, B and C.</p> <p>This federal tag is related to complaint</p>						

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (A and B) and for 1 additional client (F), the facility's nursing services failed to meet the health needs of the clients.</p> <p>Findings include:</p> <p>1. During the 7/19/12 observation period between 6:10 AM and 7:50 AM, at the group home, client A was given a bowl of cereal with milk, crackers and juice to drink for her breakfast. Staff #1 and staff #2 explained to the client she did not get to eat bread/toast and/or have a cup of coffee due to the client's stomach being upset which caused the client to vomit. Staff #1 explained to the client she would have to watch what she ate until the client saw her doctor.</p> <p>Client A's record was reviewed on 7/19/12 at 11:16 AM. Client A's Progress Notes indicated the following:</p> <p>-7/14/12 "[Client A] got a stomach ache this evening because she ate too much at dinner time. I have to give her some Mylanta because she felt like throwing up."</p>	W0331	<p><b>CORRECTION:</b> <i>The facility must provide clients with nursing services in accordance with their needs. Specifically, for Client A, the facility nurse will be retrained regarding the need to complete face to face assessments when staff report non-routine health concerns. Direct support staff will be retrained regarding parameters for notifying the nurse regarding Client B's blood sugar as well as the need to document all contact with the nurse. Additionally the facility nurse and professional and direct support staff will be retrained regarding the need to obtain discontinue orders when a physician switches or replaces medications in the same class.</i></p> <p><b>PREVENTION:</b> Facility professional staff will review progress notes and medical documentation on an ongoing basis, and will follow-up with the facility nurse and the Health Services Manager as needed to assure all clients receive appropriate</p>	08/24/2012			

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	<p>-7/15/12 "[Client A] is still complaining that her stomach is bothering her. She didn't eat all of her dinner. She threw up a little around 7:30 and didn't take a shower tonight."</p> <p>-7/16/12 "[Client A] didn't eat her dinner roll yesterday because she said it makes her stomach hurt."</p> <p>-7/17/12 "At dinner, [client A] said that the bun on her hamburger hurt her chest and soon after she threw up. I called the nurse and she said that [client A] can't have breads, acidic juices, ex (example) (orange juice), or milk until sees the doctor."</p> <p>Client A's 6/12 physician's orders indicated client A's diagnoses, included, but were not limited to, Hiatal Hernia, and Erosive Esophagitis.</p> <p>Client A's record and/or July nurse note did not indicate client A had been assessed by the facility's nurse and/or had an appointment made with the client's doctor in regard to the client's complaints.</p> <p>Interview with staff #3 on 7/19/12 at 7:45 AM indicated client A had been complaining about her stomach. Staff #3 stated "We have to make an appointment.</p>		<p>nursing services. Additionally, the nurse will continue to provide administrative staff with medical issue reports to assist with increasing accountability and compliance with agency standards. Health Services, Quality Assurance and Operations Teams members have increased their presence in the home</p> <p>-monitoring healthcare records and active treatment until the governing body has determined that corrective measures have been implemented. Periodic monitoring will then continue no less than monthly with Operations and Quality Assurance Team members providing guidance and support as needed to ensure nursing services requirements are met.</p> <p><b>RESPONSIBLE PARTIES:</b> QDDPD, Health Services Team, Home Manger, Support Associates, Operations Team, Quality Assurance Team</p>				

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	<p>Started vomiting in PM." Staff #3 stated the nurse said just to give her "orange juice and meds." Staff #3 indicated client A had been complaining of her stomach for 2 days.</p> <p>Interview with staff #1 on 7/20/12 at 8:35 AM indicated client A would need to go to the doctor to be check in regard to the client's stomach complaints. Staff #1 indicated she thought facility staff had made an appointment for the client to go to the doctor. Staff #1 could not determine if an appointment had been scheduled.</p> <p>Interview with LPN #1 on 7/20/12 at 10:30 AM stated client A had "quite a few stomach complaints." LPN #1 indicated client A had been seen for her complaints in the past and would be going to the doctor again. LPN #1 stated client A would "over eat and make herself sick." LPN #1 indicated she was aware of client A's complaints as the on-call nurse had been contacted.</p> <p>2. Client B's record was reviewed on 7/19/12 at 12:09 PM. Client B's 6/1/12 physician's orders indicated client B's diagnosis included, but was not limited to Non-Insulin Dependent Diabetes Mellitus. Client B's 6/1/12 physician's orders indicated daily blood sugar</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G396	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/25/2012
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 153 S EMERSON INDIANAPOLIS, IN 46219
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	<p>readings were to be completed due to the client's diabetes. Client B's 6/1/12 physician's orders indicated "CHECK BLOOD SUGAR EVERY MORNING. CALL NURSE IF UNDER 70 OR OVER 200." Client B's 6/2012 Daily Blood Sugar Recordings indicated on 6/30/12, client B's blood sugar reading was 66.</p> <p>Client B's 6/2012 nurse notes did not indicate the facility nurse was notified in regard to the 6/30/12 low blood sugar reading.</p> <p>Interview with staff #1, Program Coordinator (PC) #1 on 7/20/12 at 8:35 AM indicated the facility staff should have called the facility's nurse in regard to the low blood sugar reading.</p> <p>Interview with LPN #1 on 7/20/12 at 10:30 AM indicated she was not notified of the 6/30/12 66 blood sugar reading for client B.</p> <p>3. Client F's record was reviewed on 7/19/12 at 1:58 PM. Client F's 6/12 physician's orders indicated client F's diagnosis included, but was not limited to, Type II Diabetes. Client F's 6/15/12 physician's order indicated client F was started on Janumet 50/1000 milligrams two times a day for diabetes.</p>			

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	<p>Client F's 6/14/12 Record of Visit indicated "(change) to Janumet 50/1000 (1 tablet) po (by mouth) BID (two times a day)."</p> <p>Client F's 6/12 Medication Administration Record (MAR) indicated client B received Glucophage 500 milligrams twice daily for non-insulin dependent diabetes and then the Glucophage was discontinued on 6/15/12 at the PM dose. Client B's MAR indicated client B's Janumet was started on 6/15/12 at the 5 PM dose.</p> <p>Client F's 6/14/12 nurse notes indicated client F saw her doctor on 6/14/12. The nurse note indicated client F was to have labs drawn and an ultrasound on the client's thyroid and to return to the doctor in 3 months. Client F's nurse note failed to indicate any documentation in regard to medication changes made on 6/14/12. Client F's 6/14/12 nurse note did not clearly indicate the facility's nurse sought clarification and/or documentation in regard to client F's Glucophage being discontinued.</p> <p>Interview with administrative staff #1, staff #1 and Program Coordinator (PC) #1 on 7/20/12 at 8:35 AM indicated client F was started on Janumet for the client's diabetes. Administrative staff #1</p>						

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	<p>indicated client F's 6/14/12 Record of Visit did not clearly indicate client B's Glucophage had been discontinued. Staff #1 indicated she thought LPN #1 went on the doctor's appointment with the client on 6/14/12.</p> <p>Interview with LPN #1 on 7/20/12 at 10:30 AM indicated she went on the doctor's appointment with client F on 6/14/12.</p> <p>This federal tag relates to complaint #IN00110348.</p> <p>9-3-6(a)</p>			