

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G236	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5990 E 500 N CHURUBUSCO, IN 46723
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: June 24, 25, 26 and 30, 2015.</p> <p>Facility number: 000759 Provider number: 15G236 AIM number: 100243290</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0120 Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on observation, record review, and interview, for 1 additional client (client #2), the outside services failed to ensure the facility's policy and procedures which prohibited abuse, neglect and mistreatment were implemented.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on</p>	W 0120	<p>W120: The facility must assure that outside services meet the needs of each client. The facility and the outside agency will meet on a monthly basis to discuss behavior plans, training needs, consumer needs and any issues that arise that need to be discussed. The Clinical Supervisor and QIDP will be in attendance from the facility and the Program Director from the outside agency will be in attendance. The QIDP will initially do twice weekly</p>	07/30/2015

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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	<p>6/24/15 at 4:00 PM. A BDDS report dated 4/27/15 indicated the outside services day services staff #1 reached inside client #2's pants to remove papers client #2 had taken from a classroom. Day services staff #2 asked day services staff #1 to stop and "told her that what she was doing was violating [client #2's] rights and not in her behavior training." Corrective action indicated staff #2 reported the incident "later that day... [Client #2] was assessed for injuries. At the time there was a 1/2 inch scratch on her stomach. There was no redness and it was not bleeding...." A follow up report dated 5/5/15 indicated "The investigation concluded and it was determined that [day services] staff member [day services staff #1] was emotionally abusive and used intimidation toward [client #2]." The report indicated day services staff #1's employment was terminated on 4/29/15.</p> <p>The Manager of Supported Group Living was interviewed on 6/24/15 at 2:00 PM and indicated the investigation into the incident had been completed by the facility's day services and the allegation had been substantiated.</p> <p>An investigation into the incident dated 4/28/15 was reviewed on 6/25/15 at 10:30 AM and indicated day services #1</p>		<p>observations (for 30 days) at the outside agency to assure that there are no rights violations or mistreatment of our clients while at the outside agency. If there are no issues after the 30 days the QIDP will do weekly observations at the outside agency. The Clinical Supervisor will initially do weekly observations that will fade to one per month if there are no issues observed.</p>				

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	<p>"did not follow [client #2's] behavior plan and chose to put her hands down into [client #2's] pants in front of others to retrieve items which were not a threat to [client #2's] health and safety. She continued to do so in spite of the fact that [client #2] was struggling and screaming 'no' and other staff members were asking her to stop. The team concluded that the actions taken taken by [day services #1] during this incident were emotionally abusive due to intimidation and the violation of [client #2's] rights."</p> <p>The Creative Learning Program Manager (CLPM)/QDDP (Qualified Developmental Disabilities Professional) was interviewed on 6/25/15 at 10:50 AM and indicated day services staff #1 had been terminated after the investigation had determined her actions were substantiated as abuse. The CLPM/QDDP indicated day services staff #1 had been investigated in the past for misuse of physical restraint, but the allegation was not substantiated.</p> <p>The facility's 6/2011 Operations Standard Reporting Abuse, Neglect, Exploitation, and/or Mistreatment was reviewed on 6/24/15 at 2:30 PM and indicated in part, "ResCare strictly prohibits abuse/neglect/exploitation/mistreatment." All incident reports are used as a basis for</p>				

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W 0240 Bldg. 00	<p>examining individual safety, are tracked through a database and reviewed by ResCare Northern Region Indiana management team, support team and safety committee. The database allows for examination of trends in incidents per home, individual, location, type of injury, etc. The safety committee will make recommendations to the management team to improve the quality of services provided to individual (sic)....." The policy indicated administrative staff were to report any incidents of potential abuse, neglect, exploitation, and mistreatment to BDDS within 24 hours.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based upon observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #4) to ensure her</p>	W 0240	W240: The individual program plan must describe relevant interventions	07/30/2015

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	<p>Individual Support Plan (ISP) included guidelines for the use of her walker.</p> <p>Findings include:</p> <p>Observations were completed on 6/25/15 from 6:40 AM until 8:44 AM. A walker sat unused in a corner of the dining room. Client #4 went to her bedroom after completing her breakfast without using the walker. At 7:40 AM, the QIDP (Qualified Intellectual Disabilities Professional) noticed client #4 had left the dining room without her walker and brought it to her.</p> <p>Client #4's record was reviewed on 6/25/15 at 1:25 PM. Client #4's ISP dated 8/16/14 failed to include the use of client #4's walker. There was no other evidence of the use of client #4's walker in the record to indicate how often, where, when or under what conditions client #4 was to use her walker.</p> <p>The group home nurse was interviewed on 6/26/15 at 11:20 AM and indicated there was no evidence in client #4's plans of client #4's walker use. She stated, "That should be part of her plan."</p> <p>9-3-4(a)</p>		to support the individual toward independence. The use of the walker has been added to client # 4's ISP and to her risk plans. The nurse and the QIDP have been trained on including adaptive equipment in the ISP and on health risk plans. The staff have been trained on when Client # 4 is to use the walker and to prompt her to use it if she is not. The QIDP will do twice weekly observations to assure that all adaptive equipment is being utilized as stated in the ISP and/or health care plan. The nurse manager and Clinical Supervisor will audit charts on a quarterly basis to assure that adaptive equipment is included in the ISP and risk plans.	

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W 9999 Bldg. 00	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-2(c)(3) Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime.</p> <p>The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p>	W 9999	<p>W9999 Resident protections. All managerial staff who are responsible for contacting and getting references have been trained that there needs to be 3 complete references and that mere dates of employment by previous employers does not constitute a reference in compliance with the state rule. The HR department will review each reference submitted to assure that it is a complete reference. References with dates only will not be included as one of the 3 references needed and the applicant will be contacted to give additional names for reference checks before starting employment.</p>	07/30/2015

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	<p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 1 of 3 staff (staff #2) personnel files, the facility failed to ensure three references were obtained prior to employment.</p> <p>Findings include:</p> <p>The facility's personnel files were reviewed on 6/26/15 at 10:30 AM. Records for staff #2 indicated 2 complete references. A third reference indicated employment dates only.</p> <p>The Human Resources Coordinator was interviewed on 6/26/15 at 10:40 AM and indicated she had been unable to obtain more information from staff #2's previous employer.</p> <p>9-3-2(c)(3)</p>			