

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G493	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/24/2015
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4160 N CAMPBELL AVE INDIANAPOLIS, IN 46226
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00175456.</p> <p>Complaint #IN00175456: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149 and W154.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 6/22/15, 6/23/15 and 6/24/15</p> <p>Facility Number: 001007 Provider Number: 15G493 AIMS Number: 100245090</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102  Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 3 of 4 sampled clients (A, B and D) plus 2</p>	W 0102	<p><b>CORRECTION:</b></p> <p><i>The facility must ensure that specific governing body and</i></p>	07/24/2015

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>additional clients (DC (Discharged Client) A and DC B. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures prevent neglect of DC A and client B, to complete thorough investigations regarding client B's broken ribs, DC A's medical needs, the alleged theft of DC B's television, an Injury of Unknown Origin (IUO) for client D and to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of DC A and client B, to complete thorough investigations regarding client B's broken ribs, DC A's medical needs, the alleged theft of DC B's television, an Injury of Unknown Origin (IUO) for client D and</li> </ol>		<p><i>management requirements are met. Specifically:</i></p> <p>With regard to the 5/26/15 investigation into Discharged Client A's abscess which resulted in hospitalization, surgeries and long-term skilled nursing care placement, the Nurse Manager will participate directly in all investigations in which medical neglect is suspected.</p> <p>Specifically for the investigation into Discharged Client B's missing television, Client B's fractured ribs and Client D's injury of unknown origin: The above referenced investigations were conducted prior to the governing body's implementation of enhanced systems to assure thorough investigations occur as required. These protocols are as follows. The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected</p>	

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	<p>to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days. Please see W104.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections. The governing body failed to ensure the facility implemented its policy and procedures prevent neglect of DC A and client B, to complete thorough investigations regarding client B's broken ribs, DC A's medical needs, the alleged theft of DC B's television, an Injury of Unknown Origin (IUO) for client D and to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days. Please see W122.</p> <p>This federal tag relates to complaint #IN00175456.</p> <p>9-3-1(a)</p>		<p>evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days.</p> <p>All participants in the investigatory process have been retrained regarding the need to notify the administrator of investigation results within five working days as well as the need to maintain documentation that the notification has occurred.</p> <p><b>PREVENTION:</b></p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with</p>	

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			<p>his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations.</p> <p>The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. .</p>	

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 2 of 4 sampled clients (B and D) plus 3 additional clients (E, DC (Discharged Client) A and DC B), the governing body</p>	W 0104	<p>Additionally, investigation results will be emailed directly to the administrator to provide an additional record that notification has occurred. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>The Executive Director will provide weekly updates to the Director of Operations – General Manager (area manager) regarding the status of all current investigations.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p> <p><b>CORRECTION:</b></p> <p><i>The governing body must exercise general policy, budget,</i></p>	07/24/2015

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	<p>failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of DC A and client B, to complete thorough investigations regarding client B's broken ribs, DC A's medical needs, the alleged theft of DC B's television, an Injury of Unknown Origin (IUO) for client D and to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures prevent neglect of DC A and client B, to complete thorough investigations regarding client B's broken ribs, DC A's medical needs, the alleged theft of DC B's television, an Injury of Unknown Origin (IUO) for client D and to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days. Please see W149.</p> <p>2. The governing body failed to exercise</p>		<p><i>and operating direction over the facility. Specifically, the governing body has facilitated the following:</i></p> <p>With regard to the 5/26/15 investigation into Discharged Client A's abscess which resulted in hospitalization, surgeries and long-term skilled nursing care placement, the Nurse Manager will participate directly in all investigations in which medical neglect is suspected.</p> <p>Specifically for the investigation into Discharged Client B's missing television, Client B's fractured ribs and Client D's injury of unknown origin: The above referenced investigations were conducted prior to the governing body's implementation of enhanced systems to assure thorough investigations occur as required. These protocols are as follows. The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed</p>	

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	<p>general policy, budget and operating direction over the facility to ensure the facility completed thorough investigations regarding client B's broken ribs, DC (Discharged Client) A's medical needs, the alleged theft of DC B's television and an IUO for client D. Please see W154.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility reported the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days. Please see W156.</p> <p>This federal tag relates to complaint #IN00175456.</p> <p>9-3-1(a)</p>		<p>that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days.</p> <p>All participants in the investigatory process have been retrained regarding the need to notify the administrator of investigation results within five working days as well as the need to maintain documentation that the notification has occurred.</p> <p><b>PREVENTION:</b></p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level</p>		

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			<p>management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations.</p> <p>The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of</p>	

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (B and D) plus 3 additional clients (E, DC (Discharged Client) A and DC B). The facility failed	W 0122	<p>investigation results. . Additionally, investigation results will be emailed directly to the administrator to provide an additional record that notification has occurred. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>The Executive Director will provide weekly updates to the Director of Operations – General Manager (area manager) regarding the status of all current investigations.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p> <p><b>CORRECTION:</b> <i>The facility must ensure that specific governing body and management requirements are met. Specifically, the governing</i></p>	07/24/2015

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	<p>to implement its policy and procedures to prevent neglect of DC A and client B, to complete thorough investigations regarding client B's broken ribs, DC A's medical needs, the alleged theft of DC B's television, an Injury of Unknown Origin (IUO) for client D and to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect of DC A and client B, to complete thorough investigations regarding client B's broken ribs, DC A's medical needs, the alleged theft of DC B's television, an Injury of Unknown Origin (IUO) for client D and to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days. Please see W149.</p> <p>2. The facility failed to complete thorough investigations regarding client B's broken ribs, DC (Discharged Client) A's medical needs, the alleged theft of DC B's television and an IUO for client</p>		<p>body has facilitated the following:</p> <p>With regard to the 5/26/15 investigation into Discharged Client A's abscess which resulted in hospitalization, surgeries and long-term skilled nursing care placement, the Nurse Manager will participate directly in all investigations in which medical neglect is suspected.</p> <p>Specifically for the investigation into Discharged Client B's missing television, Client B's fractured ribs and Client D's injury of unknown origin: The above referenced investigations were conducted prior to the governing body's implementation of enhanced systems to assure thorough investigations occur as required. These protocols are as follows. The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body</p>	

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	<p>D. Please see W154.</p> <p>3. The facility failed to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days. Please see W156.</p> <p>This federal tag relates to complaint #IN00175456.</p> <p>9-3-2(a)</p>		<p>will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days.</p> <p>All participants in the investigatory process have been retrained regarding the need to notify the administrator of investigation results within five working days as well as the need to maintain documentation that the notification has occurred.</p> <p><b>PREVENTION:</b></p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management</p>	

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			<p>teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations.</p> <p>The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. . Additionally, investigation results</p>	

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W 0149 Bldg. 00	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 for 2 of 4 sampled clients (B and D) plus 3 additional clients (E, DC (Discharged Client) A and DC B), the facility failed to implement its policy and procedures to	W 0149	will be emailed directly to the administrator to provide an additional record that notification has occurred. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.  The Executive Director will provide weekly updates to the Director of Operations – General Manager (area manager) regarding the status of all current investigations.  <b>RESPONSIBLE PARTIES:</b>  QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager  <b>CORRECTION:</b>  <i>The facility must develop and implement written policies and procedures that prohibit</i>	07/24/2015

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	<p>prevent neglect of DC A and client B, to complete thorough investigations regarding client B's broken ribs, DC A's medical needs, the alleged theft of DC B's television, an Injury of Unknown Origin (IUO) for client D and to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/22/15 at 2:00 PM. The review indicated the following:</p> <p>1. BDDS report dated 5/26/15 indicated, "[DC A] was lethargic and did not eat throughout the day. Staff noted that she had an elevated temperature and pulse and that her blood pressure was lower than normal. The [agency] nurse directed staff to take her to the ER (Emergency Room) and when [DC A] appeared too weak to get out of bed, staff called 911. EMS (Emergency Medical Staff) transported [DC A] to the [hospital] ER via ambulance. ER personnel examined [DC A], diagnosed her with an abscess on her right inner thigh and admitted her</p>		<p><i>mistreatment, neglect or abuse of the client. Specifically:</i></p> <p>With regard to the 5/26/15 investigation into Discharged Client A's abscess which resulted in hospitalization, surgeries and long-term skilled nursing care placement, the Nurse Manager will participate directly in all investigations in which medical neglect is suspected.</p> <p>Specifically for the investigation into Discharged Client B's missing television, Client B's fractured ribs and Client D's injury of unknown origin: The above referenced investigations were conducted prior to the governing body's implementation of enhanced systems to assure thorough investigations occur as required. These protocols are as follows. The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected</p>	

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	<p>to the hospital for treatment. [Agency] nursing will remain in communication with the hospital and [agency] is investigating the circumstances that led to the infection."</p> <p>DC A's guardian was interviewed on 6/22/15 at 8:55 AM. DC A's guardian indicated DC A was hospitalized on 5/25/15. DC A's guardian indicated DC A's right leg was "swollen twice the size of the left thigh with a 3 to 4 inch band from near the hip joint and an 8 inch strip all the way around the leg and all the way down the back of the leg." DC A's guardian indicated DC A's skin was "dry, scaly, hot and reddened." DC A's guardian indicated DC A was diagnosed with Cellulitis (bacterial infection) "of weeks duration". DC A's guardian stated DC A "endured an initial lancing and three additional surgeries. [DC A] also became septic, despite IV (intravenous) antibiotics." DC A's guardian indicated DC A was currently admitted to a long term care facility and required further treatment with a wound vacuum.</p> <p>DC A's ER notes dated 5/25/15 at 8:57 PM were reviewed on 6/23/15 at 2:00 PM. DC A's ER notes indicated, "[DC A] is a 71 year old female with history of severe mental retardation, seizures... who presents to the ED (Emergency</p>		<p>evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days.</p> <p>All participants in the investigatory process have been retrained regarding the need to notify the administrator of investigation results within five working days as well as the need to maintain documentation that the notification has occurred.</p> <p><b>PREVENTION:</b></p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with</p>	

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	<p>Department) via EMS with fever (102 at home), change in activity and appetite since yesterday. Caregiver states she was going to bring the patient in but the patient had decreased balance and became diaphoretic (heavy sweating/perspiration) so called for an ambulance. Caregiver states the patient eats and ambulates at baseline. [DC A] is non-verbal at baseline. When trying to Cath (insert catheter) the patient, caregiver and nurse noticed right thigh redness and warmth. Caregiver states [DC A] sat down for (her) shower today and didn't notice the redness until ED arrival."</p> <p>-Investigation Final Report form dated 5/28/15 indicated the following:</p> <p>-Written Narrative Statement (WNS) from staff #1 regarding DC A's 5/25/15 hospitalization indicated, "When I gave [DC A] a shower I did not see the abscess because I had her sit down in the shower chair because she could not stand, I gave her a shower right before the ambulance got here because she was hot and clammy (sic). If she could have stood while I gave her a shower I would have noticed it, but since she was sitting down you could not see it because her thighs are big and they touch while sitting. Thank God I took her to the ER and it was discovered because</p>		<p>his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p>	

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	<p>no one else seem (sic) to be doing anything about her changes in behavior do (sic) to the infection that was found, (sic) and 5/25/15 was my first day back on second shift since 5/19/15."</p> <p>-WNS from staff #2 regarding DC A's 5/25/15 hospitalization indicated, "I came to work and saw how [DC A] was acting. [DC A] was really hot and sweating. We called on call and the nurse, they did not answer after two calls each (sic) we called [TL (Team Leader) #1]. [TL #1] told us (to) leave a message on their voice mail, and take [DC A] to the hospital. Then the on call called back first and told us try calling the on call nurse back. They called back and said take vitals. We did, then they said take her to the hospital."</p> <p>-WNS from TL #1 regarding DC A's 5/25/15 hospitalization indicated, "[Staff #2] called me at 6:45 PM, she said, [DC A] isn't acting herself. They said, they tried to call both on-call phones and no answer. I told [staff #2] to take [DC A] to the hospital and keep trying to call on-call phones to let them know what's going on. At 11:45 PM, [staff #1] called me to let me know [DC A] had got (sic) admitted in the hospital. [Staff #1] said, she was trying to call on-call and nobody (was) answering. I told her to keep</p>		<p>The Executive Director will provide weekly updates to the Director of Operations – General Manager (area manager) regarding the status of all current investigations.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

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	<p>calling until somebody answers the phone to let them know that [DC A] has been admitted so, she can leave without getting in trouble. [Staff #1] told me that [DC A] had an abscess on her thigh, that's the reason why she is being admitted to the hospital. I didn't know anything about the abscess until [staff #1] called me at 11:45 PM."</p> <p>-WNS from RM (Residential Manager) #1 regarding DC A's 5/25/15 hospitalization indicated, "On one of my visits to [DC A] at the hospital, I asked the nurse what could be responsible for the infection and what is the prevention. All she said was that [DC A] had Cellulitis, which was probably caused by a scratch that got infected. [Hospital Nurse] said, the best prevention is to always keep her finger nails clipped and clean and... staff should be more observant and keep more (sic) watch on her."</p> <p>The Investigation Final Report dated 5/28/15 did not indicate documentation of analysis of staff #1's WNS to determine if behavioral changes or other signs/symptoms were present prior to 5/25/15 and on-call nursing and on-call supervisory responsiveness to staff #1 and #2's attempts to contact them. The Investigation Final Report dated 5/28/15</p>			

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	<p>did not indicate documentation of a description and chronology of what happened, analysis of the evidence or finding of fact and determination as to whether or not staff neglected DC A's medical needs.</p> <p>DC A's record was reviewed on 6/23/15 at 10:25 AM. DC A's Progress Notes from 5/24/15 through 3/1/15 did not indicate documentation of staff observing behavioral changes or signs/symptoms of health issues for DC A.</p> <p>DC A's weekly body check forms dated 5/20/15, 5/13/15, 5/6/15 and 4/22/15 did not indicate documentation of staff observing signs/symptoms of skin issues for DC A.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 6/22/15 at 10:35 AM. LPN #1 indicated staff completed body checks on all clients in the group home every Wednesday. LPN #1 indicated a body check should be done during shower time when the client is undressed and all areas of the body can be observed for issues. LPN #1 indicated staff had not reported any issues/concerns regarding DC A's body checks or behavioral changes prior to 5/25/15. LPN #1 indicated DC A would have exhibited signs/symptoms prior to 5/25/15. LPN #1 indicated staff completing DC A's body</p>			

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	<p>checks and bathing DC A should have noticed DC A's left leg being swollen, redness or other changes.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 6/22/15 at 11:56 AM. QIDP #1 indicated staff had not reported any concerns regarding DC A's behavioral changes or other signs/symptoms of medical needs prior to 5/25/15. QIDP #1 indicated staff should have noticed and reported DC A's swollen leg or other signs prior to 5/25/15.</p> <p>AS (Administrative Staff) #1 was interviewed on 6/22/15 at 12:00 PM. AS #1 indicated staff should have noticed and reported DC A's change in behavior or signs of DC A's medical needs prior to 5/25/15.</p> <p>2. BDDS report dated 10/18/14 indicated, "[Client B] complained to staff that he fell on his left side on 10/18/14 at day program. [Client B] was complaining of pain when he laugh (sic) or move. Staff called the nurse and nurse advice (sic) to take [client B] to [medical clinic]. [Medical clinic] found that [client B] had 2 broken ribs."</p> <p>The Investigation Final Report dated 10/24/14 did not indicate documentation</p>			

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	<p>of a conclusion, finding of fact/determination and did not indicate day service staff were interviewed as potential witnesses to client B's broken ribs.</p> <p>3. BDDS report dated 8/13/14 indicated, "Staff went to [DC B's] room to get his clothes to give him a shower and noticed that his television was missing. Staff notified the on-call team and the administrative team. Administrative team doing (sic) investigation."</p> <p>The review did not indicate documentation of an investigation regarding the alleged theft of DC B's television.</p> <p>4. BDDS report dated 12/6/14 indicated, "Staff was assisting [client D] with getting out of the bed when staff discovered [client D] had a bruise across his nose 1.5 inches long. Staff was instructed by site nurse to start a (sic) injury flow chart. Staff will monitor the bruise for proper healing until the bruise is completely healed. As this is an IUO an investigation will be conducted of how he sustained the bruise across his nose."</p> <p>The review did not indicate documentation of an investigation regarding client D's IUO.</p>			

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	<p>5. BDDS report dated 9/9/14 indicated an allegation of staff mistreatment of client A while at a medical facility for an assessment following a agency van accident.</p> <p>The investigation summary form dated 9/16/14 regarding the investigation of alleged staff mistreatment of client A did not indicate documentation of the facility administrator being notified of the conclusion/results of the investigation.</p> <p>6. BDDS report dated 5/30/15 indicated client E had an IUO on her right foot. The 5/30/15 BDDS report indicated an investigation would be completed to determine the cause of the IUO.</p> <p>The Investigation Final Report dated 5/22/15 indicated the IUO was discovered on 5/14/15 and the investigation was completed on 5/22/15. The review indicated the investigation conclusion of client E's IUO was not reported to the facility administrator within 5 business days.</p> <p>AS (Administrative Staff) #1 was interviewed on 6/22/15 at 12:00 PM. AS #1 indicated there was not documentation available for review regarding the alleged theft of DC B's television or the IUO for</p>			

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	<p>client D. AS #1 indicated the abuse and neglect policy should be implemented. AS #1 indicated a final investigation report should include a summary of information and findings, description of what happened, analysis of the evidence, documentation of all witnesses and potential witnesses being interviewed and a finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive. AS #1 indicated the results of investigations should be reported to the facility administrator within 5 business days of the alleged incident.</p> <p>The facility's policies and procedures were reviewed on 6/24/15 at 11:04 AM. The facility's policy entitled, "Abuse, Neglect, Exploitation, Mistreatment" dated 2/26/11 indicated the following:</p> <p>- "Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, or mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, ResCare and local and state and federal guidelines."</p> <p>- "All staff will be trained on the</p>			

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	<p>detection, reporting and prevention of abuse, neglect, exploitation and mistreatment at time of hire and at least annually thereafter."</p> <p>- "Exploitation: an act that deprives an individual of real or personal property by fraudulent or illegal means."</p> <p>- "Mistreatment: to treat badly or wrongly, hurt, harm, misuse or injure any of the individuals we serve/support."</p> <p>- "Program intervention neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan, inappropriate application of intervention without a qualified person notification/review."</p> <p>- "Medical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide necessary medical attention, proper nutritional support or administering medications as prescribed."</p> <p>- In order to ensure the health, safety and welfare of the people we support, events or collections of circumstances that are outside of what is normally expected, cannot by (sic) explained and understood by the existence of the event and result in</p>			

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	<p>or have the potential to result in injury or abuse, neglect or exploitation to the consume must be investigated. Investigations will be conducted per the protocols listed in the incident management best practices manual. The primary purpose of an investigation is to describe and explain factors contributing to an incident and/or to prevent (sic) recurrence. The investigation should include the following: (8.) Witnesses: anyone who directly observed an incident or was affected by the incident, or who was directly or indirectly involved in the process i.e., injured parties, eyewitnesses or other participants; ... ; (10.) A thorough investigation final report will be written at the completion of the investigation. The report shall include but is not limited to the following:... summary of information and findings (evidence collected, witnesses interviewed), date of the investigation, names of the investigators; description and chronology of what happened; analysis of the evidence; finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive...."</p> <p>This federal tag relates to complaint #IN00175456.</p> <p>9-3-2(a)</p>			

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W 0154  Bldg. 00	<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 for 4 of 26 allegations of abuse, neglect, mistreatment, exploitation and Injury of Unknown Origin (IUO) reviewed, the facility failed to complete thorough investigations regarding client B's broken ribs, DC (Discharged Client) A's medical needs, the alleged theft of DC B's television and an IUO for client D.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/22/15 at 2:00 PM. The review indicated the following:</p> <p>1. BDDS report dated 5/26/15 indicated, "[DC A] was lethargic and did not eat throughout the day. Staff noted that she had an elevated temperature and pulse and that her blood pressure was lower than normal. The [agency] nurse directed staff to take her to the ER (Emergency</p>	W 0154	<p><b>CORRECTION:</b></p> <p><i>The facility must have evidence that all alleged violations are thoroughly investigated.</i></p> <p>With regard to the 5/26/15 investigation into Discharged Client A's abscess which resulted in hospitalization, surgeries and long-term skilled nursing care placement, the Nurse Manager will participate directly in all investigations in which medical neglect is suspected.</p> <p>Specifically for the investigation into Discharged Client B's missing television, Client B's fractured ribs and Client D's injury of unknown origin: The above referenced investigations were conducted prior to the governing body's implementation of enhanced systems to assure thorough</p>	07/24/2015
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	<p>Room) and when [DC A] appeared too weak to get out of bed, staff called 911. EMS (Emergency Medical Staff) transported [DC A] to the [hospital] ER via ambulance. ER personnel examined [DC A], diagnosed her with an abscess on her right inner thigh and admitted her to the hospital for treatment. [Agency] nursing will remain in communication with the hospital and [agency] is investigating the circumstances that led to the infection."</p> <p>DC A's guardian was interviewed on 6/22/15 at 8:55 AM. DC A's guardian indicated DC A was hospitalized on 5/25/15. DC A's guardian indicated DC A's right leg was "swollen twice the size of the left thigh with a 3 to 4 inch band from near the hip joint and an 8 inch strip all the way around the leg and all the way down the back of the leg." DC A's guardian indicated DC A's skin was "dry, scaly, hot and reddened." DC A's guardian indicated DC A was diagnosed with Cellulitis (bacterial infection) "of weeks duration". DC A's guardian stated DC A "endured an initial lancing and three additional surgeries. [DC A] also became septic, despite IV (intravenous) antibiotics." DC A's guardian indicated DC A was currently admitted to a long term care facility and required further treatment with a wound vacuum.</p>		<p>investigations occur as required. These protocols are as follows.</p> <p>The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days.</p> <p><b>PREVENTION:</b></p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and</p>	

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	<p>DC A's ER notes dated 5/25/15 at 8:57 PM were reviewed on 6/23/15 at 2:00 PM. DC A's ER notes indicated, "[DC A] is a 71 year old female with history of severe mental retardation, seizures... who presents to the ED (Emergency Department) via EMS with fever (102 at home), change in activity and appetite since yesterday. Caregiver states she was going to bring the patient in but the patient had decreased balance and became diaphoretic (heavy sweating/perspiration) so called for an ambulance. Caregiver states the patient eats and ambulates at baseline. [DC A] is non-verbal at baseline. When trying to Cath (insert catheter) the patient, caregiver and nurse noticed right thigh redness and warmth. Caregiver states [DC A] sat down for (her) shower today and didn't notice the redness until ED arrival."</p> <p>-Investigation Final Report form dated 5/28/15 indicated the following:</p> <p>-Written Narrative Statement (WNS) from staff #1 regarding DC A's 5/25/15 hospitalization indicated, "When I gave [DC A] a shower I did not see the abscess because I had her sit down in the shower chair because she could not stand, I gave her a shower right before the ambulance</p>		<p>corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations.</p>	

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	<p>got here because she was hot and clammy (sic). If she could have stood while I gave her a shower I would have noticed it, but since she was sitting down you could not see it because her thighs are big and they touch while sitting. Thank God I took her to the ER and it was discovered because no one else seem (sic) to be doing anything about her changes in behavior do (sic) to the infection that was found, (sic) and 5/25/15 was my first day back on second shift since 5/19/15."</p> <p>-WNS from staff #2 regarding DC A's 5/25/15 hospitalization indicated, "I came to work and saw how [DC A] was acting. [DC A] was really hot and sweating. We called on call and the nurse, they did not answer after two calls each (sic) we called [TL (Team Leader) #1]. [TL #1] told us (to) leave a message on their voice mail, and take [DC A] to the hospital. Then the on call called back first and told us try calling the on call nurse back. They called back and said take vitals. We did, then they said take her to the hospital."</p> <p>-WNS from TL #1 regarding DC A's 5/25/15 hospitalization indicated, "[Staff #2] called me at 6:45 PM, she said, [DC A] isn't acting herself. They said, they tried to call both on-call phones and no answer. I told [staff #2] to take [DC A] to</p>		<p>The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. . Additionally, investigation results will be emailed directly to the administrator to provide an additional record that notification has occurred. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>The Executive Director will provide weekly updates to the Director of Operations – General Manager (area manager) regarding the status of all current investigations.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

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	<p>the hospital and keep trying to call on-call phones to let them know what's going on. At 11:45 PM, [staff #1] called me to let me know [DC A] had got (sic) admitted in the hospital. [Staff #1] said, she was trying to call on-call and nobody (was) answering. I told her to keep calling until somebody answers the phone to let them know that [DC A] has been admitted so, she can leave without getting in trouble. [Staff #1] told me that [DC A] had an abscess on her thigh, that's the reason why she is being admitted to the hospital. I didn't know anything about the abscess until [staff #1] called me at 11:45 PM."</p> <p>-WNS from RM (Residential Manager) #1 regarding DC A's 5/25/15 hospitalization indicated, "On one of my visits to [DC A] at the hospital, I asked the nurse what could be responsible for the infection and what is the prevention. All she said was that [DC A] had Cellulitis, which was probably caused by a scratch that got infected. [Hospital Nurse] said, the best prevention is to always keep her finger nails clipped and clean and... staff should be more observant and keep more (sic) watch on her."</p> <p>The Investigation Final Report dated 5/28/15 did not indicate documentation</p>			

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	<p>of analysis of staff #1's WNS to determine if behavioral changes or other signs/symptoms were present prior to 5/25/15 and on-call nursing and on-call supervisory responsiveness to staffs #1 and #2's attempts to contact them. The Investigation Final Report dated 5/28/15 did not indicate documentation of a description and chronology of what happened, analysis of the evidence or finding of fact and determination as to whether or not staff neglected DC A's medical needs.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 6/22/15 at 10:35 AM. LPN #1 indicated staff completed body checks on all clients in the group home every Wednesday. LPN #1 indicated a body check should be done during shower time when the client is undressed and all areas of the body can be observed for issues. LPN #1 indicated staff had not reported any issues/concerns regarding DC A's body checks or behavioral changes prior to 5/25/15. LPN #1 indicated DC A would have exhibited signs/symptoms prior to 5/25/15. LPN #1 indicated staff completing DC A's body checks and bathing DC A should have noticed DC A's left leg being swollen, redness or other changes.</p> <p>QIDP (Qualified Intellectual Disabilities</p>			

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	<p>Professional) #1 was interviewed on 6/22/15 at 11:56 AM. QIDP #1 indicated staff had not reported any concerns regarding DC A's behavioral changes or other signs/symptoms of medical needs prior to 5/25/15. QIDP #1 indicated staff should have noticed and reported DC A's swollen leg or other signs prior to 5/25/15.</p> <p>AS (Administrative Staff) #1 was interviewed on 6/22/15 at 12:00 PM. AS #1 indicated staff should have noticed and reported DC A's change in behavior or signs of DC A's medical needs prior to 5/25/15.</p> <p>2. BDDS report dated 10/18/14 indicated, "[Client B] complained to staff that he fell on his left side on 10/18/14 at day program. [Client B] was complaining of pain when he laugh (sic) or move. Staff called the nurse and nurse advice (sic) to take [client B] to [medical clinic]. [Medical clinic] found that [client B] had 2 broken ribs."</p> <p>The Investigation Final Report dated 10/24/14 did not indicate documentation of a conclusion, finding of fact/determination and did not indicate day service staff were interviewed as potential witnesses to client B's broken ribs.</p>			

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	<p>3. BDDS report dated 8/13/14 indicated, "Staff went to [DC B's] room to get his clothes to give him a shower and noticed that his television was missing. Staff notified the on-call team and the administrative team. Administrative team doing (sic) investigation."</p> <p>The review did not indicate documentation of an investigation regarding the alleged theft of DC B's television.</p> <p>4. BDDS report dated 12/6/14 indicated, "Staff was assisting [client D] with getting out of the bed when staff discovered [client D] had a bruise across his nose 1.5 inches long. Staff was instructed by site nurse to start a (sic) injury flow chart. Staff will monitor the bruise for proper healing until the bruise is completely healed. As this is an IUO an investigation will be conducted of how he sustained the bruise across his nose."</p> <p>The review did not indicate documentation of an investigation regarding client D's IUO.</p> <p>AS (Administrative Staff) #1 was interviewed on 6/22/15 at 12:00 PM. AS #1 indicated there was not documentation available for review regarding the alleged</p>			

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W 0156 Bldg. 00	<p>theft of DC B's television or the IUO for client D. AS #1 indicated a final investigation report should include a summary of information and findings, description of what happened, analysis of the evidence, documentation of all witnesses and potential witnesses being interviewed and a finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive.</p> <p>This federal tag relates to complaint #IN00175456.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 2 of 26 allegations of abuse, neglect, mistreatment, exploitation and Injury of Unknown Origin (IUO) reviewed, the facility failed to ensure the results of the investigation of an allegation of staff mistreatment of client A and an IUO regarding client E were reported to the administrator within 5 business days.</p>	W 0156	<p><b>CORRECTION:</b></p> <p><i>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Specifically, all participants in the investigatory</i></p>	07/24/2015

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	<p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/22/15 at 2:00 PM. The review indicated the following:</p> <p>1. BDDS report dated 9/9/14 indicated an allegation of staff mistreatment of client A while at a medical facility for an assessment following a agency van accident.</p> <p>The investigation summary form dated 9/16/14 regarding the investigation of alleged staff mistreatment of client A did not indicate documentation of the facility administrator being notified of the conclusion/results of the investigation.</p> <p>2. BDDS report dated 5/30/15 indicated client E had an IUO on her right foot. The 5/30/15 BDDS report indicated an investigation would be completed to determine the cause of the IUO.</p> <p>The Investigation Final Report dated 5/22/15 indicated the IUO was discovered on 5/14/15 and the investigation was completed on 5/22/15. The review indicated the investigation conclusion of client E's IUO was not</p>		<p>process have been retrained regarding the need to notify the administrator of investigation results within five working days as well as the need to maintain documentation that the notification has occurred.</p> <p><b>PREVENTION:</b></p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of</p>	

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	<p>reported to the facility administrator within 5 business days.</p> <p>AS (Administrative Staff) #1 was interviewed on 6/22/15 at 12:00 PM. AS #1 indicated the results of investigations should be reported to the facility administrator within 5 business days of the alleged incident.</p> <p>9-3-2(a)</p>				<p>investigation results. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Additionally, investigation results will be emailed directly to the administrator to provide an additional record that notification has occurred. Failure to report the results of investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Operations Team</p>		