

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G633	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2012
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 153 WHITE OAK WAY NORTH VERNON, IN 47265
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of survey: February 6, 7, 8, 10 and 17, 2012</p> <p>Facility Number: 001206 Provider Number: 15G633 AIM Number: 100240180</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>The following deficiencies reflect findings in accordance with 460 IAC 9. Quality Review completed 2/28/12 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 observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the Governing Body failed to exercise general operating direction over the facility by failing to implement policies and procedures which included/addressed the Elder Justice Act; which requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility; (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act.)</p> <p>Findings include:</p> <p>According to review of the agency's Operational Policy "Reporting Suspected Crimes Against Individuals" dated of 1/13/12 on 2/08/12 at 1:30 PM, the Governing Body failed to exercise general policy and operating direction over the facility in that the governing body failed to train their staff and failed to ensure notification regarding the Elder Justice Act (as defined above) was exhibited in</p>	W0104	<p><b>Corrective action:</b> · Staff have been inserviced on the Elder Justice Act and notice has been posted in home (Attachment A).</p> <p><b>How we will identify others:</b> Director of Supervised Group Living, Quality Assurance Director will implement EJA training to all staff.</p> <p><b>Measures to be put in place:</b> EJA training will be implemented for all staff and new hires will receive in their initial training (Attachment B).</p> <p><b>Monitoring of Corrective Action:</b> Quality Assurance Director, Training Coordinator will review staff training to ensure that all staff have received training</p>	03/09/2012			

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	<p>the facility.</p> <p>During observations at the facility on 2/06/2012 from 4:30 PM until 7:30 PM and on 2/07/2012 from 5:45 AM until 8:00 AM clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed to be living in the facility. Environmental tours of the facility during the observation times failed to indicate posted documentation regarding the Elder Justice Act and the rights/responsibilities thereof.</p> <p>The Program Coordinator (staff #1) was interviewed on 2/07/12 at 12:00 PM regarding the required implementation of the Elder Justice Act.</p> <p>The interview indicated the agency was aware of the Elder Justice Act, had commenced policy changes; but had not yet implemented staff training or posted information regarding the Act at the time of survey.</p> <p>9-3-1(a)</p>				<p>on the Elder Justice Act.</p> <p><b>Completion Date:</b> <b>3-9-2012</b></p>		

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), the facility failed to provide each current employee with initial training regarding the Elder Justice Act and failed to ensure each employee understood their rights and responsibilities pertaining to the Act.</p> <p>Findings include:</p> <p>During observations at the facility on 2/06/2012 from 4:30 PM until 7:30 PM and on 2/07/2012 from 5:45 AM until 8:00 AM, clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed to be living in the facility. During the various times of the observation periods, Program Coordinator #1, LPN #2, Home Manager #3 and direct contact staff #4, #5, #6, #7, # 8, and #9 worked with the clients.</p> <p>Environmental tours of the facility during the observation times indicated no posted documentation regarding the Elder Justice Act and the staff's rights/responsibilities thereof.</p> <p>A list of employees, who worked at the</p>	W0189	<p><b>Corrective action:</b></p> <ul style="list-style-type: none"> <li>Staff have been inserviced on the Elder Justice Act and notice has been posted in home (Attachment A).</li> </ul> <p><b>How we will identify others:</b></p> <p>Director of Supervised Group Living, Quality Assurance Director will implement EJA training to all staff.</p> <p><b>Measures to be put in place:</b></p> <p>EJA training will be implemented for all staff and new hires will receive in their initial training (Attachment B).</p> <p><b>Monitoring of Corrective Action:</b></p> <p>Quality Assurance Director, Training Coordinator will review staff training to ensure that all</p>	03/09/2012

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	<p>facility with clients #1, #2, #3, #4, #5, #6, #7 and #8 was compiled by Residential Director staff #14 on 2/06/12 at 1:15 PM. The list was reviewed on 2/06/2012 at 1:30 PM and contained the following direct contact and administrative staff: Program Coordinator/PC #1, LPN #2, House Manager/HM #3 and Direct Contact staff #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13.</p> <p>Employee files for PC #1 and Direct Contact staff #9 and #12 were reviewed on 2/06/2012 at 1:55 PM. The review indicated no training regarding the Elder Justice Act.</p> <p>PC #1 and HM #3 were interviewed on 2/07/2012 at 12:30 PM and indicated they had not yet been trained by the agency regarding the required implementation of the Elder Justice Act.</p> <p>Interview with the Residential Director (staff #14) on 2/06/2012 at 1:55 PM indicated the agency was aware of the Elder Justice Act and had added information concerning it into their policies and procedures but had not yet implemented training about it. The interview indicated current staff had not been trained regarding the Elder Justice Act.</p>		<p>staff have received training on the Elder Justice Act.</p> <p><b>Completion Date: 3-9-2012</b></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, record review and interview for 1 of 4 sampled clients (#1), and 1 additional client (#5), the facility's nursing services failed to ensure the clients' medical issues were addressed/included in their Individual Service Plans/ISPs.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on the afternoon/evening of 2/06/12 from 4:30 PM until 7:30 PM. Client #5 was resting in her bed from 4:30 PM until House Manager #3 assisted her into a wheelchair and assisted her into the dining room at 5:30 PM. Client #5's feet were not elevated for the remainder of the observation period (from 5:30 PM until 7:30 PM). Staff #8 thickened client #1's beverages (water and kool-aid in 12 ounce sip type cups) with 2 tablespoons of thickening agent on 2/06/12 at 6:25 PM. Staff #8 stated client #1 was to have "nectar thick" liquids. Client #1 ate the evening meal from 6:30 PM until 7:00 PM without one on one staff supervision.</p> <p>During observations on 2/07/12 from 6:59 AM until 7:15 AM, staff #6 gave client</p>	W0331	<p><b>Corrective action:</b></p> <ul style="list-style-type: none"> <li>· Client #5's High Risk plan has been revised and staff, both group home and workshop, have been inserviced (Attachment C).</li> <li>· Client #1's Dining plan has been revised and staff inserviced (Attachment C).</li> <li>· Staff #6 received LIC training (Attachment D).</li> <li>· Staff have been inserviced on use of Thickett (Attachment E).</li> <li>· Nursing Coordinator has been inserviced on reviewing new orders and revising HRP's, dining plans, medications, per new orders (Attachment F).</li> <li>· Staff have been inserviced on crushing medications (Attachment G).</li> <li>· Client #5 has seen podiatrist and is requested to wear soft shoes (Attachment H) and WS staff have been inserviced on positioning times</li> </ul>	03/09/2012			

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	<p>#1 her morning medications. Client #1's medications consisted of pills, gel caps, aerosols, and liquids. Client #1 was given 30 ml/milliliters of liquid lactulose (for constipation) and coughed and spit out some of the liquid medication. Client #1 was offered a second 30 ml amount of the lactulose (she was prescribed 60 ml total morning dosage) and she turned her head away. Staff #6 was able to prompt client #1 to take the second amount of the lactulose. Staff #6 gave client #1 unthickened water after the medications.</p> <p>During observations of the facility owned day program on 2/08/12 from 11:35 AM until 1:00 PM, client #5 was observed to wear fur lined soft boots. Client #5 was seated in her wheelchair without with her legs/feet being elevated. An environmental tour of the day program site indicated no reclining type chairs for clients to use for repositioning or elevating feet/legs.</p> <p>Review of client #1's record on 2/07/12 at 1:00 PM indicated the client's diagnoses included, but were not limited to, GERD (gastro esophageal reflux disease) and dysphagia. The record review indicated the client had a speech consultation dated 10/10/11 with the following recommendations: pureed diet consistency with honey thick liquids in</p>		<p>(Attachment C).</p> <p><b>How we will identify others:</b> Director of Health Services will review Nursing Coordinators High Risk plans, dining plans, to ensure that adequate and appropriate measures are in place, including proper documentation, assessments and timely interventions.</p> <p><b>Measures to be put in place:</b> A weekly Nursing Coordinator checklist has been implemented (Attachment I) and Director of Health Services will review weekly to ensure that care is adequate and timely, including physician recommendations, and treatments. Nursing coordinators will perform weekly observations at group home and workshop to ensure that dining plans, HRPs, positioning schedules are being</p>				

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	<p>small sips without using straws. Medications were to be crushed and in pudding. The client was to sit up at a 90 degree angle during meals. All by mouth intake was to be with "100% supervision." Verbal and tactile cues were to be used to ensure client #1 took small bites of food and small sips of honey thickened liquids. The record review indicated no revision of the client's mealtime programming to ensure "100% supervision" by staff. The record review indicated no input by nursing staff to ascertain if some of her pill type medications could be crushed nor had the liquid medications been evaluated to see if they should be added to pudding or in some fashion be thickened for safe consumption by client #1.</p> <p>Client #5's record review (2/08/12 at 7:00 PM) indicated she had a podiatry consultation on 11/03/11 which indicated " observation [of] ulceration R/F (right foot) is nearly healed." The podiatrist recommended the client's right foot be cleansed with soap and water, treated with a medicated ointment and wrapped in gauze. The record review indicated client #5's right foot was not healed at the time of the survey and her treatment continued. The client had not been fitted for an adaptive type foot covering (soft booties) at the time of the survey. Nor had nursing</p>		<p>implemented.</p> <p><b>Monitoring of Corrective Action:</b> Director of Health Services, Director of Supervised Group Living, and Quality Assurance will perform periodic service reviews to ensure that all nursing standards, including documentation, medical interventions, treatments are being performed per policy and procedure and per physician orders.</p> <p><b>Completion Date:</b> <b>3-9-2012</b></p>				

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	<p>staff implemented a positioning schedule for the client's lower extremities during her day program (8:00 AM to 3:00 PM).</p> <p>Interview with day program staff #15 and #5 on 2/08/12 at 12:30 PM indicated client #5 kept her feet in the fur lined winter boots all day at day program The interviews indicated client #5 had no foot rests on her wheelchair to elevate her legs and she had no recliner to use for repositioning.</p> <p>Interview with LPN #2 on 2/07/12 at 1:15 PM indicated the previous nurse should have followed up on the mealtime/medication recommendations regarding client #1.</p> <p>Interview with staff #3 (2/07/12 12:30 PM) indicated client #1 was to have honey thick liquids. The interview indicated client #5 wore fur lined boots to the day program but she should not wear them all day but should be changing into slippers before putting on her boots for the return trip home.</p> <p>9-3-6(a)</p>				