

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/05/2013
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 428 S 15TH ST RICHMOND, IN 47374		
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Survey Dates: January 30, 31, February 1 and 5, 2013</p> <p>Facility Number: 000857 Provider Number: 15G341 AIMS Number: 100243690</p> <p>Surveyor: Vickie Kolb, RN, BSN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/11/13 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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W0120	<p><b>483.410(d)(3)</b> <b>SERVICES PROVIDED WITH OUTSIDE SOURCES</b> The facility must assure that outside services meet the needs of each client. Based on observation, record review, and interview, for 1 of 4 sample clients (client #3), the facility failed to ensure the outside services followed client #3's dining plan and provided client #3 with the identified adaptive dining equipment while dining.</p> <p>Findings include:</p> <p>During observations at the group home on 1/30/13 between 3:45 PM and 7 PM and on 1/31/13 between 5:30 AM and 8 AM client #3 was observed eating his evening and morning meals. Client #3 used a high sided dish, a large weighted spoon, a straw and a domed plate cover while eating. The staff sat next to client #3 and placed a domed plate cover over client #3's plate and/or bowl between bites to prevent client #3 from eating too fast. The staff prompted client #3 to take small bites and to slow his pace of eating while eating.</p> <p>Observations were conducted at the day service program on 2/1/13 between 11:30 AM and 12:30 PM. Client #3 was observed eating his afternoon meal with DPS (Day Program Staff) #5 assisting</p>	W0120	<p><b>CORRECTION:</b> <i>The facility must assure that outside services meet the needs of each client. Specifically, The facility has provided day service staff with a new set of Client #3's adaptive eating equipment and has provided day service with retraining on proper implementation of Client #3's dining plan.</i></p> <p><b>PREVENTION:</b> Facility Professional staff have observed day service staff at meal and provided on-site coaching to assure ongoing implementation of clients' dining plans. Day service staff have been instructed to inform the Clinical Supervisor directly of any adaptive equipment repair or replacement needs. Facility Supervisory staff will conduct day service observations as needed but no less than monthly to assure proper implementation of formal supports.</p> <p><b>RESPONSIBLE PARTIES:</b> Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	03/01/2013	

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	<p>client #3. Client #3 used a high sided plate, a plastic spoon and a straw. DPS #5 handed client #3 the plastic spoon and client #3 picked up a large spoon full of food and placed it into his mouth. DPS #5 stated, "No you don't, not on my watch" and prompted client #3 to take smaller bites. While eating, client #3 was not using a weighted large handled spoon. While assisting client #3 to eat, DPS #5 did not use a domed plate cover to prompt client #3 to slow his pace of eating.</p> <p>Client #3's record was reviewed on 2/1/13 at 1 PM. Client #3's ISP (Individualized Support Plan) of 3/22/12 indicated whenever client #3 had more than 1/2 inch of food on his adaptive spoon, the staff were to prompt client #3 to shake some of it off and to take smaller bites. The ISP indicated the staff were to cover client #3's plate/bowl with a dome lid after each portion of food to prevent client #3 from eating too fast.</p> <p>Interview with DPS #5 on 2/1/13 at 12:30 PM indicated she was aware client #3 used a dome plate cover to slow his pace of eating. DPS #5 indicated it was used occasionally at the Day Program. DPS #5 indicated client #5's adaptive spoon had broken and she thought another one had been ordered for the client.</p>			

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	<p>Interview with DSPC (Day Services Program Coordinator) on 2/1/13 at 12:35 PM stated the use of a dome plate cover was not in client #3's ISP and she "just thought" it was used because the QMRP (Qualified Mental Retardation Professional) preferred the staff use it.</p> <p>Interview with the QMRP on 2/1/13 at 4 PM indicated she was not aware client #3's adaptive spoon used at the day program had broken and was in need of being replaced. The QMRP indicated client #3 was to use an adaptive spoon and a dome plate cover to slow his pace of eating at every meal due to his risk of choking and lack of a gag reflex.</p> <p>9-3-1(a)</p>				

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W0154	<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 1 of 10 allegations of abuse/neglect and/or mistreatment reviewed, the facility failed to conduct an investigation in regard to allegations of client to client abuse/aggression for client #5.</p> <p>Findings include:</p> <p>The facility records were reviewed on 1/30/13 at 1 PM. The facility BDDS (Bureau of Developmental Disabilities Services) reports indicated on 8/8/12 at 9:30 AM while at the day program, another consumer threw a 3 inch piece of aluminum metal at client #5, striking client #5 in the chest. The facility records did not indicate an investigation had been conducted.</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 2/1/13 at 4 PM indicated the QMRP was unable to provide evidence of an investigation in regards to the client to client abuse for client #5.</p> <p>9-3-2(a)</p>	W0154	<p><b>CORRECTION:</b> <i>The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, the day service administrative staff have provided the facility with a copy of the investigation into an incident of client to client aggression involving Client #4 that occurred on 8/8/12.</i></p> <p><b>PREVENTION:</b> Facility professional staff have provided day service administrative staff with specific expectations regarding the criteria for conducting investigations for incidents that occur in the day service and workshop setting. The QDDP will turn in copies of completed day service investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will participate in a weekly teleconference with the Quality Assurance Manager to review incidents that require follow-up and investigation to assure timely completion.</p> <p><b>RESPONSIBLE PARTIES:</b> Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	03/01/2013

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W0156	<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 interview and record review for 6 of 7 investigations reviewed, the facility failed to report the results of the investigations to the administrator in accordance with State law within five working days of the date of the incident for clients #1, #2, #3, #4, #6 and #8.</p> <p>Findings include:</p> <p>The facility records were reviewed on 1/30/13 at 1 PM. The facility BDDS (Bureau of Developmental Disabilities Services) reports indicated the following: __ On 1/30/12 at 1:45 PM while at the day program, client #3 was hit in the right hand by another consumer. The report indicated an investigation would be conducted. The follow up BDDS report of 2/4/12 indicated the outcome of the investigation regarding another consumer at the day program hitting client #3 in the hand was substantiated. The facility records did not indicate an investigative report with the outcome of the investigation and/or when the administrator was notified of the investigative results.</p>	W0156	<p><b>CORRECTION:</b> <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, the administrator has been informed of the results of the following investigations:</i></p> <ol style="list-style-type: none"> <li>1. Client to client aggression involving Client #3 on 1/30/13</li> <li>2. Medication error involving Client #1 on 2/6/12</li> <li>3. Injury of unknown origin discovered on Client #8 on 4/22/12</li> <li>4. Injury of unknown origin discovered on Client #4 on 8/27/12</li> <li>5. Medication error involving Client #3 on 9/12/12</li> <li>6. Allegation of verbal abuse toward Client #6 on 11/20/12</li> </ol> <p><b>PREVENTION:</b> The Clinical Supervisor will complete follow-up reports to the Indiana Division of Disability and Rehabilitation Services within five working days of all incidents requiring investigation. Copies of all follow-up reports will be emailed to the administrator or designee at the time of the</p>	03/01/2013			

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	<p>__ On 2/6/12 at 7:45 AM client #1 did not receive his scheduled medications of Baclofen 10 mg (milligrams) for muscle spasms and spasticity, Zyrtec 10 mg for allergies, Keppra 500 mg for seizures, OsCal 500 mg with Vitamin D for a dietary supplement, KDur 20 milli-equilivents for treating low blood levels of potassium, Vimpat 300 mg for seizures and Dilantin 100 mg for seizures. Due to a staff error, client #1 received instead Acyclovir 400 mg for viral infections, Baclofen 15 mg. Doxycycline 100 mg for infections, Claritin 10 mg for allergies, Trileptal 900 mg for mood stabilization &amp; seizures, Phenobarbital 60 mg for seizures, Topamax 200 mg for seizures and OsCal 500 mg. The report indicated client #1 started experiencing body jerks and was taken to the hospital for evaluation. The report indicated staff #1 was suspended pending investigation of the incident. The follow up report of 2/17/12 indicated staff #1 received disciplinary action and retraining per agency policy. The team determined that if current protocols had been followed, the error would not have occurred and therefore procedural changes are not indicated at this time. The investigative record did not indicate when the administrator was notified of the outcome of the investigation.</p>		<p>reports' submission. The administrator will be notified via email of the results of all other investigations that do not require reports to DDRS. Additionally, the facility's Clinical Supervisor will participate in a weekly teleconference with the Quality Assurance Manager to review incidents that require follow-up and investigation to assure timely reporting of results.</p> <p><b>RESPONSIBLE PARTIES:</b> Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>				

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	<p>__ On 4/22/12 at 12 PM, while on a home visit, client #8's family noticed a small dime size area, yellowish in color on client #8's left temple. The report indicated statements were obtained and an investigation conducted. The facility records did not indicate an investigative report with the outcome of the investigation and/or when the administrator was notified of the investigative results.</p> <p>__ On 8/27/12 at 7 AM while assisting client #4 with morning hygiene, staff noted a red scratch on the top of client #4 's left foot 2 cm (centimeters) x 1 cm. Client #4 could not explain the origin of the injury. The report indicated an investigation will be initiated. The facility records did not indicate an investigative report with the outcome of the investigation and/or when the administrator was notified of the investigative results.</p> <p>__ On 9/12/12 at 8:30 PM, client #3 "received an incorrect dose of Trileptal (a medication used to treat seizures). On 9/6/12, [client #3's] neurologist increased the medication from 300 mg (milligrams) in the mornings to 600 mg. The neurologist kept his [client #3's] bedtime dose at 600 mg. The medication change</p>			

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	<p>was entered correctly on the Medication Administration Record (MAR). An unidentified person changed the evening dose entry in the MAR to [2] tablets which was not correct for the bedtime dose. Therefore, when staff administered the bedtime dose [client #3] received 600 mg of Trileptal instead of the prescribed dose. It was not the fault of the staff administering medication because she was following the written instructions in the MAR." The follow up BDDS report of 9/21/12 indicated "Through investigation no one knew who changed the instruction in the Medication Administration Record regarding [client #3's] Trileptal medication change." The facility records did not indicate an investigative report with the outcome of the investigation and/or when the administrator was notified of the investigative results.</p> <p>__The 11/20/12 report indicated a staff reported to the RM (Residential Manager) an allegation of verbal abuse made on 11/19/12 toward client #6. The report indicated during the evening meal client #6 asked staff #10 to get something for him and staff #10 told client #6 "to get off his lazy butt" and get the item himself. "Additionally, on 11/21/12 it was reported by [client #6's] housemate to the Residential Manager that while out grocery shopping with staff and two of his</p>			

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	<p>housemates on 11/20/12, staff (staff #10) left the housemate (client #2) to watch [client #6] and another housemate [client #4] in the check out line of [name of department store], while she (staff #10) went to get her personal items out of the store's lay away." The follow up BDDS report of 12/7/12 indicated the outcome of the investigation, including interviewing client #6 who could not recall anything negative being stated to him by the alleged staff #10 at the dinner table, as well as other individuals and staff at the table the night of the alleged inappropriate comment could not substantiate inappropriate verbal comments made toward client #6. The facility records did not indicate an investigative report with the outcome of the investigation and/or when the administrator was notified of the investigative results.</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 2/1/13 at 4 PM indicated she had provided all investigative reports for review. The QMRP indicated she notified the administrator of the investigative results via e-mail. The QMRP indicated the date of the follow up BDDS reports would have been when the administrator was notified of the investigative results.</p>						

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W0242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on interview and record review for 1 of 4 sample clients (#1), the client's ISP (Individual Support Plan) failed to address client #1's identified training need in regards to dental hygiene.</p> <p>Findings include:</p> <p>Interview with staff #1 on 1/31/13 at 3 PM indicated client #1 required verbal and physical assistance to complete his dental hygiene.</p> <p>Client #1's record was reviewed on 1/31/13 at 1 PM. Client #1's Dental Summary Progress Report of 1/31/12 indicated client #1 had "heavy amount of plaque and tartar." The report indicated client #1 needed assistance with dental hygiene home care. "He is not brushing well at all. May need to do more than assist. Focus on brushing gum line." Client #1's ISP of 7/26/12 did not indicate any objectives or training goals to assist</p>	W0242	<p><b>CORRECTION:</b></p> <p><i>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Specifically, the team has initiated a learning objective that addresses Client #1's dental hygiene needs.</i></p> <p><b>PREVENTION:</b></p> <p>The Clinical Supervisor will be retrained regarding the need to review the comprehensive functional assessment, medical assessments, incident documentation and progress notes to assure each client receives training in needed personal skills. Members of the Quality Assurance and Operations Teams will</p>	03/01/2013			

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	<p>client #1 with his dental hygiene.</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 2/1/13 at 4 PM indicated client #1's ISP did not include any training objectives in regards to dental hygiene.</p> <p>9-3-4(a)</p>		<p>periodically compare current support documents to assessment data to assure training needs are addressed in each client's individual support plan.</p> <p><b>RESPONSIBLE PARTIES:</b> Clinical Supervisor, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

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W0322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on observation, interview and record review for 2 of 4 sample clients (clients #1 and #4), the facility failed to ensure the clients returned for follow up therapy assessments as recommended by their therapists.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/30/13 between 3:45 PM and 7 PM. Client #1 was observed walking with a slow unsteady gait, using a walker while wearing a gait belt and assisted by the staff.</p> <p>Client #1's record was reviewed on 1/31/13 at 1 PM. Client #1's Record of Visit of 2/16/12 indicated client #1 was evaluated by a PT (Physical Therapist) with the recommendation for client #1 to return for a follow up appointment in 3 months so the physical therapist could evaluate client #1's progress. Client #1's record did not indicate client #1 returned for a follow up assessment after the visit on 2/16/12.</p> <p>Client #4's record was reviewed on 1/31/13 at 4 PM. Client #4's Record of Visit of 6/2/11 indicated client #4 was</p>	W0322	<p><b>CORRECTION:</b> <i>The facility must provide or obtain preventive and general medical care. Specifically, the facility has scheduled follow-up physical therapy evaluations for Client #1 and Client #4.</i></p> <p><b>PREVENTION:</b> The facility nurse will maintain a tracking grid for all clients to assure that routine and recommended medical assessments, including but not limited to follow-up evaluations, occur within required time frames. Members of the Operations and Quality Assurance Teams will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure appropriate medical follow-up takes place as required.</p> <p><b>RESPONSIBLE PARTIES:</b> Clinical Supervisor, Residential Manager, Direct Support Staff, Nursing Team, Quality Assurance Team, Operations Team</p>	03/01/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G341	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/05/2013
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	<p>evaluated by an OT (Occupational Therapist) with the recommendation for client #4 to return for a follow up appointment in 1 year. Client #4's record did not indicate client #4 returned for a follow up assessment after the visit on 6/2/11.</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 2/1/13 at 4 PM indicated the facility nurse did not make the follow up appointments. The QMRP stated the facility med coach was the person who was responsible for making follow up appointments and the med coach "must have missed it" in regards to ensuring client #1 returned for a follow up physical therapy assessment as recommended. The QMRP stated, "That he (client #1) had a lot of seizures and things going on in that 3 month period and I don't know why he didn't get rescheduled." The QMRP stated, "To my knowledge" client #4 did not return in 1 year for a follow up visit to OT.</p> <p>9-3-6(a)</p>				

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W0323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #1), the facility failed to ensure client #1's hearing was assessed annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 1/31/13 at 1 PM.</p> <p>__ Client #1's History and Physical Examination of 8/7/12 did not indicate the physician evaluated client #1's hearing. Client #1's record indicated client #1's most recent hearing evaluation was conducted in 6/10.</p> <p>__ Client #1's Visual Care Progress Report of 10/4/11 indicated client #1 had Myopia/Astigmatism and optic nerve pallor (disorders of the eye) due to a stroke. The report indicated client #1 was to have a follow up in 1 year. Client #1's record did not indicate client #1 had a follow up visit within 1 year of the visit on 10/4/11.</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 2/1/13 at 4 PM indicated client #1's most current hearing evaluation was 6/10. The</p>	W0323	<p><b>CORRECTION:</b></p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Specifically, the team has assisted Client #1 one with obtaining the services of a new primary care physician and Client #1 has received a physical examination that included a hearing evaluation.</p> <p><b>PREVENTION:</b></p> <p>Facility staff will be retrained to assure that client's physicians complete all sections of the annual physical form. Facility nursing and professional staff will review records of medical procedures upon completion to assure that all required assessments and evaluations occur with appropriate accompanying documentation and will make arrangements for corrections and/or additional evaluations as needed.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>Clinical Supervisor, Residential Manager, Direct Support Staff, Nursing Team, Quality Assurance Team, Operations Team</p>	03/01/2013			

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	<p>QMRP indicated client #1's annual physical report did not indicate the physician had examined client #1's ears when the client had his annual physical. The QMRP stated the facility med coach was the person who was responsible for making follow up appointments and the med coach "must have missed it" in regards to ensuring client #1 returned for a vision exam in one year from 10/4/11.</p> <p>9-3-6(a)</p>			