

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2015
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00177824.</p> <p>Complaint #IN00177824: Substantiated, Federal and state deficiency related to the allegation(s) is cited at W227.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: July 22 and July 31, 2015.</p> <p>Facility Number: 000685 Provider Number: 15G666 AIM Number: 100474600A</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0227  Bldg. 00	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on interview and record review for 1 of 4 sampled clients (A), the client's Individual Support Plan (ISP) failed to address the client's needs in regard to vulnerability.</p>	W 0227	<p><b>CORRECTION:</b></p> <p><i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.</i></p>	08/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 7/22/15 at 11:35 AM. The facility's 7/11/15 reportable incident report indicated "[Client A] (individual supported by ResCare) told the overnight staff that she was going to go outside and make a phone call. Staff asked her to wait until she finished administering medications. 10 minutes later, [client A] was no longer in the house and not in line of sight of the house. A supervisor initiated a search of the neighborhood and a missing persons report was filed with the [name of city] Police. [Client A] remains missing at this time. She possesses good pedestrian skills and reasonably good judgment. She has, however, been assessed as requiring 24-hour protective oversight. At the time of her elopement, one staff was on duty on the overnight shift supervising eight individuals. [Client A] has a history of elopement and has made one previous unsuccessful attempt since her admission on 2/19/15. Elopement is addressed in her current Behavior Support Plan. ResCare supervisory and administrative staff have remained in contact with her family and known associates throughout the day and will continue to do so until she is located. The team has continued to</p>		<p>Specifically for Client A, the interdisciplinary team has developed additional protective approaches to prevent elopement and train her toward making safe decisions in community settings. A review of incident documentation and current supports indicated this deficient practice did not affect any additional clisnets.</p> <p><b>PERVENTION:</b></p> <p>The agency will retrain QIDP and facility nurse regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility weekly for the next 30 days and twice monthly visits for an additional 60 days to assure appropriate supports are included in each client's support plan. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p>	
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	<p>search the area and have been in contact with local hospitals. The interdisciplinary team is currently developing immediate protective measures that will include enhanced supervision, outside door alarms and double staffing on the overnight shift."</p> <p>The facility's 7/13/15 follow-up report to the 7/11/15 reportable incident report indicated "Through a cooperative effort between ResCare and the [name of city] Police, [client A] was located at 8:30 PM on 7/12/15 at the home of a friend, at [street address], in [name of city]. She was unharmed and returned to her SGL (Supported Group Living) residence without resistance. The team has modified [client A's] Behavior Support Plan (BSP) to include enhanced supervision- line of sight while in common areas of the home and 15 minute checks when she is in the bedroom or bathroom. Alarms are being installed on doors, and her bedroom windows with appropriate informed consent from all appropriate parties...Additionally, all overnight shifts will have at least two staff on duty."</p> <p>Interview with client A on 7/22/15 at 7:30 AM stated she had eloped from the group home due to "peer pressure" from her ex-boyfriend. Client A indicated her</p>		<p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>ex-boyfriend told her he would kill himself if she did not come and see him. Client A indicated she went because she did not want her ex-boyfriend to do anything to himself. Client A indicated she eloped to her ex-boyfriend's brother's house. Client A indicated it took her 2 1/2 hours to walk there. Client A indicated she had sexual intercourse with her ex-boyfriend while she was there. Client A indicated they had unprotected sex. Client A stated "That was not smart." Client A indicated the police found her after her and the ex-boyfriend had been walking in the woods. Client A indicated her ex-boyfriend and/or his brother took some of her personal belongings while she was there. Client A stated she was glad she was back at the group home as the way her ex-boyfriend and brother lived "was not my lifestyle."</p> <p>Client A's record was reviewed on 7/22/15 at 1:49 PM. Client A's 7/13/15 Record Of Visit indicated client A was evaluated for Sexually Transmitted Diseases, Urinary tract Infection and an ankle sprain.</p> <p>Client A's 3/18/15 ISP indicated client A's identified need in regards to vulnerability had not been addressed to ensure the client would not be taken advantage of.</p>			

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W 0252 Bldg. 00	<p>Interview with Clinical Supervisor (CS) #1 on 7/22/15 at 2:25 PM indicated client A had a history of elopement prior to coming to them. CS #1 indicated CS #1, the home manager along with the Police devised a plan to get client A back. CS #1 indicated client A's ex-boyfriend's brother had attempted to get money from client A's family. CS #1 indicated client A was located at the ex-boyfriend's brother house as client A had called her family. CS #1 indicated client A had some personal items taken by the ex-boyfriend and his brother. CS #1 indicated client A was willing to come back to the group home. CS #1 indicated the group home was not double staffed on the overnight shift, alarms had been placed on the doors and windows and 15 minute checks had been initiated. CS #1 indicated client A could be taken advantage of by others. CS #1 indicated client A's vulnerability had not been addressed.</p> <p>This federal tag relates to complaint #IN00177824.</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the</p>			

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	<p>criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (B), the facility failed to collect behavioral data in regard to the client's self-injurious behavior.</p> <p>Findings include:</p> <p>During the 7/22/15 observation period between 5:40 AM and 8:30 AM, at the group home, client B was observed to have a swollen face. The client's eyes were swollen shut with discolored areas around his forehead.</p> <p>Interview with staff #3 on 7/22/15 at 8:00 AM indicated client B was taken to the hospital on 7/22/15 after the swelling was noted to one side of his face. Staff #3 indicated the swelling had increased since the client was first sent to the hospital. Staff #3 indicated the doctor at the hospital was not able to determine why client B's face was swollen. Staff #3 indicated client B would hit the side of his face as the client demonstrated self-injurious behavior (SIB). Staff #3 indicated client B wore a helmet due to his SIB.</p> <p>Client B's record was reviewed on</p>	W 0252	<p><b>CORRECTION:</b></p> <p><i>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Specifically, facility direct support staff will be trained toward proper implementation and documentation of Client #B's behavior supports. An audit of facility documentation indicated that this deficient practice did not affect any additional clients.</i></p> <p><b>PREVENTION:</b></p> <p>The QIDP has been trained regarding the need to assure data collection grids are in place at the facility to give direct support staff the opportunity to collect data on prioritized learning objectives as required, as well as the need to track and monitor progress on all client learning objectives. Along with the QIDP, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, will conduct documentation reviews to assure</p>	08/30/2015

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	<p>7/22/15 at 1:00 PM. Client B's Record Of Visits (ROV) indicated the following (not all inclusive):</p> <p>-7/22/15 Client B's emergency room doctor indicated "facial swelling &amp; (and) bruising. extensive (sic) swelling and contusions of face. Diagnosis: Facial injury swelling of face...."</p> <p>-7/22/15 Client B was taken to a third hospital for evaluation and diagnosed with Periorbital Cellulitis (infection of the skin and/or eyelids around the eyes).</p> <p>Client B's 2/28/15 Behavior Support Plan (BSP) indicated client B demonstrated self-injurious behavior defined as "Any time [client B] is hitting his head."</p> <p>Client B's record and/or blank behavior data sheets from May to July 2015 indicated the facility staff did not document when client B demonstrated SIB.</p> <p>Interview with Clinical Supervisor (CS) #1 and staff #1 on 7/22/15 at 2:25 PM indicated client B demonstrated SIB. CS #1 stated client B would hit his head/side of his face with his hand "often." CS #1 and staff #1 indicated facility staff was not collecting and/or documenting data in regard to client B's SIB behavior.</p>		<p>data is collected as required at the facility no less than weekly for the next 30 days, and no less than twice monthly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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W 0331  Bldg. 00	<p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 4 sampled clients (B), the facility's nursing services failed to develop a risk plan in regard to the client's shunt, and failed to ensure client B's shunt was being monitored for potential malfunction/problems.</p> <p>Findings include:</p> <p>During the 7/22/15 observation period between 5:40 AM and 8:30 AM, at the group home, client B was observed to have a swollen face. The client's eyes were swollen shut with discolored areas around his forehead.</p> <p>Interview with staff #3 on 7/22/15 at 8:00 AM indicated client B was taken to the hospital on 7/22/15 after the swelling was noted to one side of his face. Staff #3 indicated the swelling had increased since the client was first sent to the hospital.</p> <p>Interview with staff #2 on 7/22/15 at 8:30 AM and at 3:30 PM, indicated she</p>	W 0331	<p><b>CORRECTION:</b></p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically: The facility nurse will be retrained regarding the need to develop risk plans for all relevant medical conditions. Specifically, based on recommendations from Client B's doctors, the facility nurse has developed a comprehensive high risk plan for Client B's shunt which includes protocols for staff monitoring for problems with the shunt. All facility staff have been trained on implementation of the plan.</i></p> <p>A review of current diagnostic information and risk plans indicated this deficient practice did not affect additional clients.</p> <p><b>PERVENTION:</b></p>	08/30/2015	

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	<p>thought client B was having an allergic reaction. Staff #2 indicated the hospital's emergency room doctor indicated client B's swelling was not due to any trauma/injury. Staff #2 indicated client B was taken to a second hospital for an evaluation. Staff #2 indicated client B did not have an allergic reaction. Staff #2 indicated she asked the hospital to check client B's shunt. Staff #2 indicated the hospital confirmed client B had a shunt and the shunt was fine.</p> <p>Client B's record was reviewed on 7/22/15 at 1:00 PM. Client B's Record Of Visits (ROV) indicated the following (not all inclusive):</p> <p>-7/22/15 Client B was taken to a third hospital for evaluation and diagnosed with Periorbital Cellulitis (infection of the skin and/or eyelids around the eyes).</p> <p>-3/20/15 Client B was seen by a neurologist for "eval (evaluation) shunt &amp; (and) behavior." The ROV indicated "Diagnosis: Autism, H2O (water) cephelus."</p> <p>Client B's 2/18/15 faxed order indicated "May have Neurologist assessment. new (sic) admission and shunt evaluation."</p> <p>Client B's Nursing Monthly Summaries</p>		<p>The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis.</p> <p>Members of the Operations Team (including Clinical Supervisors, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility weekly for the next 30 days and twice monthly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p>	

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	<p>from 2/2015 to 6/2015 indicated the facility's nurse did not indicate client B had a shunt and/or indicate client B's shunt was being monitored.</p> <p>Client B's 7/6/15 Comprehensive High Risk Plans indicated the facility's nursing services failed to develop a risk plan in regard to client B's shunt.</p> <p>Client B's 2/28/15 Individual Support Plan did not indicate client B had a shunt, and/or indicate how facility staff were to monitor for signs and symptoms of potential problems with the shunt.</p> <p>Interview with LPN #2 on 7/22/15 at 4:10 PM indicated she was not the nurse for the group home as the LPN for the group home was on vacation. LPN #2 stated when client B was admitted to the group home, "It was told by the family" client B had a shunt. LPN #2 indicated the group home's nurse was waiting for the neurologist to confirm client B had a shunt. LPN #2 stated client B "should have a nursing plan for reported shunt until it was confirmed."</p> <p>9-3-6(a)</p>		<p>These administrative documentation reviews will include review of healthcare records and incident documentation to assure appropriate risk plans and nursing supports are in place.</p>		