

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G397	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/21/2012
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250
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W0000	<p>This visit was for the investigation of complaint #IN00110047.</p> <p>Complaint #IN00110047-Unsubstantiated, due to lack of evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 6/20 and 6/21/12</p> <p>Facility Number: 000911 Provider Number: 15G397 Aim Number: 100244420</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/28/12 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, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the governing body failed to exercise general policy, operating direction and budget over the facility to replace the carpet in the main areas of the group home (living room, hallway and dining room).</p> <p>Findings include:</p> <p>During the 6/20/12 observation period between 6:00 AM and 7:55 AM, at the group home, the carpet in the dining room/living room areas had multiple large black stains on the off white carpet. There were dark stains going down the carpet in the hallway to the kitchen. There were multiple small stains located all over the carpeted areas.</p> <p>Interview with administrative staff #2 on 6/20/12 at 1:55 PM indicated the carpet in the group home could not be cleaned. Administrative staff #2 indicated the carpet needed to be replaced. Administrative staff #2 indicated the group home was in the process of trying to get the carpet replaced.</p>	W0104	<p>CORRECTION: <i>The governing body must exercise general policy, budget, and operating direction over the facility.</i> Specifically, the torn and worn out carpet will be replaced.</p> <p>PREVENTION: Professional staff will be retrained regarding the need to follow-up with representatives of the agency's business department after submitting requests for repairs, maintenance and replacement of facility furnishings including but not limited to flooring and floor coverings. Members of the Quality Assurance and Operations Teams will periodically perform home environment audits and on ongoing basis to assure appropriate upkeep occurs at the facility and to assist with expediting purchases as appropriate. RESPONSIBLE PARTIES: QDDPD, Home Manager, Support Associates, Operations Team, Quality Assurance Team</p>	07/21/2012			

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	9-3-1(a)			

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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 interview and record review for 1 of 4 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation in regard to injury of unknown origin which resulted in a fractured finger for client E.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 6/20/12 at 11:06 AM. The facility's reportable incident reports indicated the following:</p> <p>-4/17/12 "[Client E's] (individual supported by ResCare) guardian, [name of guardian], contacted the Director of Supervised Group Living and reported that [client E] told her he had injured his hand while working at [name of workshop] on Friday, 4/13/12. The QMRP (Qualified Mental Retardation Professional took) [client E] to the [name of hospital] Emergency Department where X-Rays indicated [client E] had sustained a fracture of his 4th (fourth) metacarpal of his left hand. ER (emergency room) personnel applied a</p>	W0154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, an investigation will be completed for Client E's injury of unknown origin on 4/17/12, which resulted in a fractured finger. PREVENTION: Facility professional staff will receive be provided with clear expectations regarding investigation of incidents. Facility supervisory staff will be retrained regarding agency investigation procedures, with emphasis on timely completion. Retraining will focus on the need to follow-up with Day Service staff to assure investigations take place as needed and to request assistance from the Operations Team as needed. Additionally, training will stress the importance of prioritizing facility support tasks to assure that alleged violations are investigated without delay. The Quality Assurance and Operations Teams will monitor compliance with investigation timelines and coordinate corrective measures as needed. Once completed, the facility will turn in investigation packets to the Quality Assurance Team for review and filing. Additionally, the QDDPD will maintain a copy of each investigation at the facility.</p> <p>RESPONSIBLE PARTIES:</p>	07/21/2012	

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	<p>splint and released [client E]...." The reportable incident report indicated "... [Client E] has a history of injuring himself at work and not telling anyone to avoid accountability...[Name of workshop] will investigate the circumstances of the injury."</p> <p>-4/13/12 On 4/18/12 [client E] arrived at work with his hand bandaged. Staff began an investigation...[Client E] reported to [name of workshop staff] at that time that he had hit his hand on something metal at home but could not give a time or what he hit. On 4/19/12 [name of workshop] received a call from [client E's] residential staff stating that [client E] had hit something at work on Friday, 4/13 causing the injury...."</p> <p>Review of the above mentioned 4/17/12 and/or 4/13/12 reportable incident reports indicated the facility did not conduct/document a thorough investigation in regard to client E's fracture.</p> <p>Interview with administrative staff #1 on 6/20/12 at 2:05 PM indicated the facility did not have a documented investigation in regard to client E's injury of unknown origin. Administrative staff #1 indicated the QMRP-D (Qualified Mental Retardation Professional-Designee) did not conduct an investigation in regard to</p>		QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team				

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	the incident. 9-3-2(a)			

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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 observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to address the client's identified behavioral needs.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 6/20/12 at 11:06 AM. The facility's 6/13/12 reportable incident report indicated client A reported client H "...engaged in a pattern of unwanted sexual contact..." with client A. The 6/20/12 reportable incident report indicated client A reported client H allegedly touched client A in his private parts over clothing, exposed himself to client A and made verbal statements.</p> <p>The facility's undated Investigative Report indicated clients and facility staff were interviewed. The undated investigation indicated client H had not made statements/remarks toward others and/or approached client A in a sexual manner/way. The 6/20/12 investigation indicated another client saw client A go</p>	W0227	<p>CORRECTION: <i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. Specifically, the team will develop appropriate behavior supports to address Client A's sexually inappropriate behavior and taking others' personal items</i></p> <p>PREVENTION: Facility professional staff will be retrained regarding the need to develop comprehensive behavior supports across environments for all clients. Members of the Operations and Quality Assurance Teams will periodically review incident documentation and support documents, on an ongoing basis to assure the team addresses client behavioral support needs as appropriate. Members of the Operations and/or Quality Assurance Teams will conduct on site reviews at the facility as needed but no less than monthly. RESPONSIBLE PARTIES: QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team</p>	07/21/2012			

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	<p>into client H's bedroom and touch client H's genitals over his clothing. The facility's investigation indicated "...[Staff #5] said [client A] has asked [client H] to masturbate in front of him and to watch him masturbate. She (staff #5) said [client H] has declined these requests. [Staff #5] said that [client A] asks [client H] to spend the night in his room and that when she (staff #5) reported it to [Qualified Mental Retardation Professional-Designee (QMRP-D)], [QMRP-D] told her not to permit it...."</p> <p>The facility's undated investigation indicated the facility staff were not aware of and/or did not see client H be inappropriate with client A. The undated investigative report indicated "...8. All staff said they have never seen any sexual contact between [clients H and A]. 9. All staff said [client A] makes frequent sexual remarks-particularly about masturbation. 10. [Client A's] ISP (Individual Support Plan) Progress Notes confirm a pattern of using profanity and derogatory language...."</p> <p>Client A's record was reviewed on 6/20/12 at 11:56 AM. Client A's Progress Notes indicated the following (not all inclusive):</p> <p>-4/11/12 "[Client A] cussing a lot this evening during general conversation w/</p>						

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	<p>(with) housemates. Using derogatory & (and) unacceptable terms as well. Prompted several times to stop it. He did not...."</p> <p>-5/20/12 "[Client A and client H] were up till after 1 AM. [Client A] slept on the floor & [client H] slept in [client A's] bed. Staff checked on them through the night-all went well."</p> <p>-6/14/12 "[Client A] was very inappropriate during van runs today talking about...in the...and so on he said that he's been telling jokes all day... [Client A] seen one of the staff and start (sic) talking about what he wanted to do to her. Inappropriate very nasty, not nice...."</p> <p>-6/19/12 "...He has a nasty mouth. It seems like he can't go one day without being inappropriate...."</p> <p>Client A's 10/12/11 Behavior Support Plan (BSP) indicated client A's identified behavior of making inappropriate sexual comments/remarks and/or inappropriate sexual behavior had not been addressed.</p> <p>Interview with staff #2 on 6/20/12 at 7:35 AM indicated she had not seen client H demonstrate inappropriate sexual behavior toward others. Staff #2</p>						

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	<p>indicated client A demonstrated inappropriate sexual behavior in that client A made inappropriate sexual comments/remarks toward others. Staff #2 stated client A "Has a bad mouth with saying sexual things." Staff #2 indicated client A would state what he would do to others but had not demonstrated the behaviors.</p> <p>Interview with staff #3 on 6/20/12 at 7:43 AM indicated client A would make inappropriate verbal remarks.</p> <p>Interview with administrative staff #1 on 6/20/12 at 12:10 PM indicated the facility was not able to substantiate client A's allegation of sexual abuse. Administrative staff #1 indicated client A had demonstrated inappropriate sexual comments/behavior toward others. Administrative staff #1 indicated client A's identified behavioral need had not been addressed.</p> <p>Interview with administrative staff #2 on 6/20/12 at 1:55 PM indicated client A's interdisciplinary team would need to meet to address client A's identified behavioral need in regard to making inappropriate sexual comments to others.</p> <p>2. During the 6/20/12 observation period between 6:00 AM and 7:55 AM, at the</p>						

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	<p>group home, client A took client F's head phones out of his room and refused to return the head phones when staff #1 asked client A to give them back to client F. Client A ignored staff #1 until client A went to the dining room table and threw them at client F. Once client A finished breakfast, client A had client C's headphones on. When staff #2 verbally prompted client A to return the headphones to client C, client A indicated client C had told him it was ok for him to use them.</p> <p>Interview with staff #3 on 6/20/12 at 7:43 AM indicated client A would go into other client's bedrooms and take their personal items.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 6/20/12 at 11:06 AM. The facility's undated investigation in regard to a 6/13/12 allegation of sexual abuse indicated client A had been seen going into client H's bedroom. The undated investigation indicated "...4. [Client H] said that he is afraid of [client A] and [client A] talks him into things like using his computer...."</p> <p>Client A's record was reviewed on 6/20/12 at 11:56 AM. Client A's 5/16/12 Progress Note indicated "[Client A] was</p>						

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	<p>playing w/ (with) roommates [client H's] computer when [client A] told [client H] that the screen was broke (sic) (Not connected to PC (personal computer). [Client A] was flipping the screen back and forth until it came apart. [Client A] and [client H] had a little argument about who broke it..." Client A's 4/20/12 Progress Note indicated client A had taken a housemate's disc player and did not want to return it.</p> <p>Client A's 10/12/11 BSP indicated client A's identified behavioral need of taking others' personal items had not been addressed.</p> <p>Interview with administrative staff #2 on 6/20/12 at 1:55 PM indicated client A's BSP had not addressed client A's taking other's items.</p> <p>9-3-4(a)</p>						