

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2013
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
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W000000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of Survey: 5/24/13, 5/28/13, 5/29/13, 5/30/13, 6/11/13 and 6/13/13.</p> <p>Facility Number: 001079 Provider Number: 15G565 AIMS Number: 100245500</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/21/13 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#2 and #3), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #2 did not pay for eyeglasses. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #3 did not pay for prescription insurance coverage.</p> <p>Findings include:</p> <p>1. Client #2's financial record was reviewed on 5/28/13 at 3:06 PM. Client #2's RFMSS (Resident Fund Management Service Statement) dated 2/1/13 through 5/29/13 indicated the following transaction:</p> <p>-3/14/13 description of debit activity indicated, "Eyeglasses, \$25.00."</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/28/13 at 3:28 PM. QIDP #1 indicated client #2 had broken her glasses and paid \$25.00 restitution for replacement of her eyeglasses. QIDP #1 indicated client #2 had restitution for</p>	W000104	<p>CORRECTION:</p> <p><i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the governing body will assure that the facility reimburses Client #2 for eyeglasses purchased with Client #2's personal funds and the governing body will begin paying Medicare rx premiums for Client #3 and client #3 will be reimbursed for past premiums for which they have paid for with personal funds.</i></p> <p>PREVENTION:</p> <p>The Business Manager has received additional training regarding the governing body's responsibility to utilize the daily Medicaid per diem to provide necessary services. The business manager will review all Resident Financial Management System disbursements to assure withdrawals are made for personal expenditures only. Additionally, at least two members of the administrative team will sign all RFMS checks before they are released to provide for additional budgetary oversight.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager,</p>	07/13/2013			

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	<p>destruction of her eyeglasses in her BSP (Behavior Support Plan) which was approved by client #2's guardian. QIDP did not provide documentation of restitution for eyeglasses as part of client #2's BSP and/or ISP (Individual Support Plan).</p> <p>Client #2's record was reviewed on 5/28/13 at 3:10 PM. Client #2's BSP dated 2/13/13 did not indicate client #2 would/should pay restitution for eyeglasses or adaptive equipment. Client #2's ISP dated 7/1/12 did not indicate client #2 would/should pay restitution for eyeglasses or adaptive equipment.</p> <p>2. Client #3's financial record was reviewed on 5/28/13 at 3:10 PM. Client #3's RFMSS dated 2/1/13 through 5/29/13 indicated the following transaction:</p> <p>-3/6/13 description of debit activity indicated, "Prescription Payment, \$18.10."</p> <p>AS (Administrative Staff) #1 was interviewed on 5/29/13 at 3:30 PM. AS #1 indicated client #3 should not be paying for her prescription coverage. AS #1 stated, "The charges were an oversight by the finance department. Clients in our waiver program pay for their own coverage and she assumed the clients in</p>		Business Manager, Office Coordinator, Quality Assurance Team, Operations Team	

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	this program did too." 9-3-1(a)			

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W000149	<p>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 13 of 62 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to implement its policy and procedures to immediately notify BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding four separate allegations of client to client aggression for clients #2 and #3. The facility failed to implement its policy and procedures to complete an investigation regarding two separate allegations of client to client aggression for clients #2 and #3 and two separate incidents of injuries of unknown origin for clients #1 and #2. The facility failed to implement its policy and procedures to report the results of an investigation of an injury of unknown origin for client #3 and an injury of unknown origin for client #6. The facility neglected to implement its policy and procedures to develop and implement preventative measures regarding client #3's physical aggression towards client #1.</p> <p>Findings include:</p> <p>1. The facility's IRs (Incident Reports),</p>	W000149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i></p> <ol style="list-style-type: none"> The facility will investigate an incident of client to client aggression regarding client #3, Former Client #1 and unspecified peers that occurred on 12/9/12. The facility will provide documentation showing the date of investigation completion and a listing of appropriately notified parties for an investigation of staff mistreatment of Client #2 and the discovery on 1/24/13 that Client #2 had fractured his left small finger. <p>PREVENTION:</p> <ol style="list-style-type: none"> Professional staff will receive additional training regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the 	07/13/2013			

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	<p>BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>-BDDS report dated 1/14/13 indicated on 1/11/13 client #3 was in the restroom while at day services with an unknown peer. The 1/14/13 BDDS report indicated client #3 exited the restroom and reported to day service staff an unknown peer had hit her while in the restroom. The 1/14/13 BDDS report indicated client #3 was examined by the day services nurse and "had a red hand mark on her shoulder." The review indicated the day services had knowledge of client #3's allegation on 1/11/13 and reported the incident to BDDS on 1/14/13. The review did not indicate documentation of an investigation regarding the 1/11/13 incident.</p> <p>-BDDS report dated 3/11/13 indicated on 3/7/13 client #2 was "upset when she arrived at [day services] to pick up [client #1]. [Staff #2] was trying to lift [client #1's] wheelchair on to van. [Client #2] was yelling profanities at [client #1] and grabbing at her legs while still on the lift. [Staff #2] did an one person assist as written in BSP (Behavior Support Plan) trying to prevent [client #2] from attacking housemate [client #1]. [DSS #1 (Day Service Staff)] assisted getting</p>		<p>Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p>2. Professional staff will receive additional training regarding the need to provide documentation of investigation result reporting to medical surveyors and other appropriate parties on request. Members of the Operations team will remain in communication with medical surveyors throughout the survey process to assure available documentation is provided upon request.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team Corrections completed by: 7/12/13</p>				

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	<p>[client #2] to a safe area until [client #1] calmed." The review indicated the 3/7/13 incident of client to client aggression was reported to BDDS on 3/11/13.</p> <p>-BDDS report dated 5/3/13 indicated on 4/29/13, "[Client #3] was upset, yelling and screaming and before staff could redirect hit housemate [client #1] on top of her helmet."</p> <p>-BDDS report dated 5/15/13 indicated on 5/13/13, "As staff was picking up [client #3] (sic) was yelling and screaming she did not want to go. Workshop staff assisted [client #3] onto the van, [client #3] became aggressive toward other housemates by swing (sic) at them but did not make actual contact. Staff attempted to drive off but [client #3] was still yelling and screaming, hitting on the van window, that staff (sic) stopped the van. For the safety of [client #3] shop staff assisted [client #3] off the van then called [CS #1] to transport [client #3] home." The 5/15/13 BDDS report indicated, "IDT will meet to review if modifications to BSP (Behavior Support Plan) is (sic) warranted to decrease physically and verbally aggressive behaviors."</p> <p>-BDDS report dated 3/12/13 indicated on 3/11/13, "[Client #2] was upset when [CS #1 (Clinical Supervisor)] picked her upon</p>			

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	<p>(sic) from [day service #1], [client #2] started yelling and screaming on the van. Upon arrival at [day service #2] [client #2] started yelling again. Housemate [client #1] got on the van [client #2] started yelling at [client #1] (sic) [CS #1] observed [client #2] hit and kick [client #1] on the left leg. [CS #1] immediately pulled the van over and rearrange (sic) [client #2's] seat away from [client #1]. [Client #2] became upset again trying to kick and hit [client #1] (sic) [CS #1] gentle (sic) blocked the kick from [client #2] trying to kick [client #1]. [CS #1] attempted to drive but [client #2] kept getting out of her seating (sic) trying to hit and kick [client #1]. [CS #1] called another staff from another group home for assistant (sic) to get consumers home safe. [Client #2] and one other consumer got on the van with the other staff." The review did not indicate documentation of an investigation regarding the 3/11/13 incident of client to client aggression.</p> <p>-BDDS report dated 3/24/13 indicated on 3/23/13 staff #3 was assisting client #2 in the shower. The 3/24/13 BDDS report indicated staff #3 "... noticed a 6 inch circular black, red and purple bruise on left upper thigh. [Client #2] complained of pain." The 3/24/13 BDDS report indicated client #2 was sent to the emergency room for evaluation and</p>			

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	<p>released with the diagnosis of a contusion. The review did not indicate documentation of an investigation regarding the 3/23/13 injury of unknown origin.</p> <p>-BDDS report dated 3/14/13 indicated on 3/14/13 while in class at her day service location, "[DSS #2] noticed that [client #1] had a small bruise in the corner of her eye when [client #1] looked up at [DSS #2]. [DSS #2] asked [client #1] what happened to her eye. [Client #1] stated that she fell this morning in her bedroom trying to get into her chair. [Client #1] stated she was trying to get out of bed by herself. [Client #1] also stated that [staff #4] at her home assisted her up from the fall in the bedroom. [DSS #2] informed [DSC #1 (Day Service Coordinator)]. [DSC #1] went to the class room to look at the eye. [DSC #1] had to tilt [client #1's] head back to see the bruise. The bruise was over her right eye lid, small, red and bluish in color in the corner of her eye not noticeable at first glance. [Client #1] also has a red mark above the eye." The 3/14/13 BDDS report indicated, "[DSC #1] contacted the [HM #1 (Home Manager)] to inform her. [HM #1] stated that none of her staff had reported anything to her this morning...." The review did not indicate documentation of an investigation regarding the 3/14/13</p>				

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	<p>injury of unknown origin for client #1.</p> <p>-IR dated 5/15/13 indicated, "When [staff #6] arrived on shift [client #3] had a 2 centimeter size bruise on the side of her forearm and her left arm seemed to be swollen and a size 2 centimeter bruise on her left arm."</p> <p>-Follow up BDDS report dated 5/23/13 regarding the 5/15/13 injury of unknown origin for client #3 indicated the team had investigated the injury of unknown origin. The review did not indicate the date the team completed the investigation. The review did not indicate if and when the administrator had been notified of the results of the investigation.</p> <p>-BDDS report dated 5/16/13 indicated on 5/15/13, "Staff noticed that [client #6] had two 2 inch red scratches on the back of her neck and one 2 inch scratch on her right forearm. Staff cleaned the area and applied Bacitracin on the area." The 5/16/13 BDDS report indicated, "Investigation will be done to determine the origin of the scratches."</p> <p>-Follow up BDDS report dated 5/22/13 indicated the team had investigated the 5/15/13 injuries of unknown origin for client #6. The review did not indicate documentation regarding if and when the</p>						

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	<p>administrator had been notified of the results of the investigation.</p> <p>2. The facility's IRs, BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>BDDS report dated 3/12/13 indicated on 3/11/13, "[Client #3] was upset when [CS #1 (Clinical Supervisor)] picked her upon (sic) from [client #3's] [day service provider], [client #3] started yelling and screaming on the van. Upon arrival at [client #1's] [day service provider] [client #3] started yelling again. Housemate [client #1] got on the van [client #3] started yelling at [client #1] (sic) [CS #1] observed [client #3] hit and kick [client #1] on the left leg. [CS #1] immediately pulled the van over and rearranged [client #3] seat (sic) away from [client #1]. [Client #3] became upset again trying to kick and hit [client #1] (sic) [CS #1] gentle blocked (sic) the kick from [client #3] trying to kick [client #1]. [CS #1] attempted to drive but [client #3] kept getting out of her seating trying to hit and kick [client #1]."</p> <p>BDDS report dated 4/17/13 indicated on 4/16/13, "[Client #3] got upset while riding on the van to day program because one of her housemate was not going to the</p>						

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	<p>day program. [Client #3] started yelling and screaming then took her frustration out on [client #1] by hitting her on top of her helmet."</p> <p>BDDS report dated 5/3/13 indicated on 4/29/13, "[Client #3] was upset yelling and screaming and before staff could redirect hit housemate [client #1] on top of her helmet."</p> <p>BDDS report dated 5/8/13 indicated on 5/7/13, "Staff was assisting [client #1] onto the van. [Client #3] without displaying precursor behavior starting (sic) yelling, screaming and calling housemate [client #1] unprofessional names then hit her on the top of her helmet."</p> <p>IR dated 5/17/13 indicated, "As [staff #7] was assisting [client #1] onto the van at [day services] [client #3] reached up and hit [client #1] on top of her head."</p> <p>Client #3's record was reviewed on 5/28/13 at 12:14 PM. Client #3's PN's dated 3/1/13 through 5/28/13 indicated the following:</p> <p>PN dated 3/27/13 indicated, "[Client #3] keep (sic) beating on the medication room door today because staff was taking another consumers vitals and giving them</p>						

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	<p>medication. [Client #3] wanted it to be her turn. [Client #3] hit [client #1] on the head twice."</p> <p>PN dated 5/16/13 indicated, "[Client #3] began to have a behavior when staff came to pick her up from day service to go to [doctor's] office. [Client #3] got on the van in an uproar. Staff tried redirecting her but she continued to be loud and hitting on consumers and staff. When [client #3] got to [doctor's] office [client #3] was still loud and trying to hit [client #1]. Staff could not calm her down. The [doctor] then refused to see her and denied her of being seen in the near future. When [client #3] and staff returned to the van [client #3] was still in an uproar."</p> <p>Client #3's record did not indicate documentation of an IDT or team discussion regarding her behavioral episodes. Client #3's record did not indicate documentation of discussion or development of preventative measures to address client #3's aggression towards client #1.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated the results of investigations of allegations of abuse, neglect,</p>			

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	<p>mistreatment, exploitation and injuries of unknown origin should be completed and reported to the administrator within 5 business days of the incident. QIDP #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be investigated. QIDP #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to BDDS within 24 hours of the time of knowledge. QIDP #1 indicated the facility's policy and procedures should be implemented. QIDP #1 stated, "The IDT meets to discuss incidents." QIDP #1 stated, "The IDT replaced the old behavior review committee. We do IDT's when there are patterns or significant events." QIDP #1 indicated the IDT meets to review client events and develop supports to address behaviors or incidents from re-occurring. QIDP #1 indicated client #3's behaviors should have been discussed by the IDT to assess current programming, medical and/or staffing supports. QIDP #1 indicated record of IDTs should be documented in the clients' records. QIDP #1 indicated there was not additional documentation of IDTs for client #3 available for review.</p> <p>The facility's policy and procedures were reviewed on 6/11/13 at 9:00 AM. The facility's 9/14/07 policy and procedure</p>			

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	<p>entitled, "Investigations" indicated, "Practices: 3. (b) Ensure alleged incident of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date the allegations were made and investigation was initiated." The facility's 9/14/07 policy and procedure entitled "Abuse, Neglect, Exploitation operating standard 1.26" indicated, "Following ResCare protocol for the exact process to report incidents, once the suspicion has been reported to the supervisor and/or PD (Program Director), the PD will report, within 24 hours, the suspected abuse, neglect or exploitation as follows:</p> <p>G. "To the BDDS central office...."</p> <p>The facilities 2/26/11 policy and procedure entitled, "Abuse, Neglect, Exploitation, Mistreatment" indicated, "Intimidation/emotional abuse: the act or failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation. Discouraging or inhibiting behavior by threatening both actual or implied. Attitude or acts that interfere with the psychological and social well being of an individual." The 2/26/11 policy indicated,</p>			

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	"Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, drink, shelter, clothing and to provide a safe environment." 9-3-2(a)			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 4 of 62 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding four separate allegations of client to client aggression for clients #2 and #3.</p> <p>Findings include:</p> <p>The facility's IRs (Incident Reports), BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>1. BDDS report dated 1/14/13 indicated on 1/11/13 client #3 was in the restroom while at day services with an unknown peer. The 1/14/13 BDDS report indicated client #3 exited the restroom and reported to day service staff an unknown peer had hit her while in the restroom. The 1/14/13 BDDS report indicated client #3 was examined by the day services nurse and</p>	W000153	<p>CORRECTION: <i>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, the facility will retrain direct support regarding the need to immediately report all incidents of client to client aggression to supervisory staff and to complete appropriate documentation. Facility and day service supervisory staff will receive additional training regarding the need to report all incidents of client to client aggression to appropriate state entities within 24 hours.</i></p> <p>PREVENTION: Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Program Manager and Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate reporting to required state agencies occurs.</p>	07/13/2013
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	<p>"had a red hand mark on her shoulder." The review indicated the day services had knowledge of client #3's allegation on 1/11/13 and reported the incident to BDDS on 1/14/13.</p> <p>2. BDDS report dated 3/11/13 indicated on 3/7/13 client #2 was "upset when she arrived at [day services] to pick up [client #1]. [Staff #2] was trying to lift [client #1's] wheelchair on to van. [Client #2] was yelling profanities at [client #1] and grabbing at her legs while still on the lift. [Staff #2] did an one person assist as written in BSP (Behavior Support Plan) trying to prevent [client #2] from attacking housemate [client #1]. [DSS #1 (Day Service Staff)] assisted getting [client #2] to a safe area until [client #1] calmed." The review indicated the 3/7/13 incident of client to client aggression was reported to BDDS on 3/11/13.</p> <p>3. BDDS report dated 5/3/13 indicated on 4/29/13, "[Client #3] was upset yelling and screaming and before staff could redirect hit housemate [client #1] on top of her helmet."</p> <p>4. BDDS report dated 5/15/13 indicated on 5/13/13, "As staff was picking up [client #3] (sic) was yelling and screaming she did not want to go. Workshop staff assisted [client #3] onto</p>		<p>RESPONSIBLE PARTIES: Clinical Supervisor, day service supervisory staff, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

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	<p>the van, [client #3] became aggressive toward other housemates by swing at them but did not make actual contact. Staff attempted to drive off but [client #3] was still yelling and screaming, hitting on the van window, that staff (sic) stopped the van. For the safety of [client #3] workshop staff assisted [client #3] off the van then called [CS #1 (clinical supervisor)] to transport [client #3] home." The 5/15/13 BDDS report indicated, "IDT will meet review if modifications to BSP (Behavior Support Plan) is (sic) warranted to decrease physically and verbally aggressive behaviors."</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to BDDS within 24 hours of the time of knowledge.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>				

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W000154	<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 62 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to complete an investigation regarding two separate allegations of client to client aggression for clients #2 and #3 and two separate incidents of injuries of unknown origin for clients #1 and #2.</p> <p>Findings include:</p> <p>The facility's IRs (Incident Reports), BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>1. BDDS report dated 1/14/13 indicated on 1/11/13 client #3 was in the restroom while at day services with an unknown peer. The 1/14/13 BDDS report indicated client #3 exited the restroom and reported to day service staff an unknown peer had hit her while in the restroom. The 1/14/13 BDDS report indicated client #3 was examined by the day services nurse and "had a red hand mark on her shoulder." The review did not indicate documentation of an investigation</p>	W000154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the facility will investigate an incident of client to client aggression regarding client #3 at day service on 1/11/13, an incident of client to client aggression between Client #1 and Client #2 on 3/11/13, Client #1's injury of unknown origin on 3/14/13 and Client #2's injury of unknown origin on 3/23/13.</p> <p>PREVENTION: Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely</p>	07/13/2013			

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	<p>regarding the 1/11/13 incident.</p> <p>2. BDDS report dated 3/12/13 indicated on 3/11/13, "[Client #2] was upset when [CS #1 (Clinical Supervisor)] picked her upon (sic) from [day service #1], [client #2] started yelling and screaming on the van. Upon arrival at [day service #2] [client #2] started yelling again. Housemate [client #1] got on the van [client #2] started yelling at [client #1] (sic) [CS #1] observed [client #2] hit and kick [client #1] on the left leg. [CS #1] immediately pulled the van over and rearrange (sic) [client #2] seat away from [client #1]. [Client #2] became upset again trying to kick and hit [client #1] (sic) [CS #1] gentle (sic) blocked the kick from [client #2] trying to kick [client #1]. [CS #1] attempted to drive but [client #2] kept getting out of her seating (sic) trying to hit and kick [client #1]. [CS #1] called another staff from another group home for assistant (sic) to get consumers home safe. [Client #2] and one other consumer got on the van with the other staff." The review did not indicate documentation of an investigation regarding the 3/11/13 incident of client to client aggression.</p> <p>3. BDDS report dated 3/24/13 indicated on 3/23/13 staff #3 was assisting client #2 in the shower. The 3/24/13 BDDS report indicated staff #3 "... noticed a 6 inch</p>		<p>completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

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	<p>circular black, red and purple bruise on left upper thigh. [Client #2] complained of pain." The 3/24/13 BDDS report indicated client #2 was sent to the emergency room for evaluation and released with the diagnosis of a contusion. The review did not indicate documentation of an investigation regarding the 3/23/13 injury of unknown origin.</p> <p>4. BDDS report dated 3/14/13 indicated on 3/14/13 while in class at her day service location, "[DSS #2] noticed that [client #1] had a small bruise in the corner of her eye when [client #1] looked up at [DSS #2]. [DSS #2] asked [client #1] what happened to her eye. [Client #1] stated that she fell this morning in her bedroom trying to get into her chair. [Client #1] stated she was trying to get out of bed by herself. [Client #1] also stated that [staff #4] at her home assisted her up from the fall in the bedroom. [DSS #2] informed [DSC #1 (Day Service Coordinator)]. [DSC #1] went to the class room to look at the eye. [DSC #1] had to tilt [client #1's] head back to see the bruise. The bruise was over her right eye lid, small, red and bluish in color in the corner of her eye not noticeable at first glance. [Client #1] also has a red mark above the eye." The 3/14/13 BDDS report indicated, "[DSC #1] contacted the [HM</p>						

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	<p>#1 (Home Manager)] to inform her. [HM #1] stated that none of her staff had reported anything to her this morning...."</p> <p>The review did not indicate documentation of an investigation regarding the 3/14/13 injury of unknown origin for client #1.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be investigated.</p> <p>9-3-2(a)</p>			

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W000156	<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 62 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to report the results of an investigation of an injury of unknown origin for client #3 and an injury of unknown origin for client #6.</p> <p>Findings include:</p> <p>The facility's IRs (Incident Reports), BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>1. IR dated 5/15/13 indicated, "When [staff #6] arrived on shift [client #3] had a 2 centimeter size bruise on the side of her forearm and her left arm seemed to be swollen and a size 2 centimeter bruise on her left arm."</p> <p>-Follow up BDDS report dated 5/23/13 regarding the 5/15/13 injury of unknown origin for client #3 indicated the team had investigated the injury of unknown origin. The review did not indicate the date the</p>	W000156	<p>CORRECTION: <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 facility will provide documentation showing the date of investigation completion and a listing of appropriately notified parties for investigations for the sources of Client #3's and Client #6's injuries discovered on 5/15/13.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the need to provide documentation of investigation result reporting to medical surveyors and other appropriate parties on request. Members of the Operations team will remain in communication with medical surveyors throughout the survey process to assure available documentation is provided upon request.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Quality Assurance Team, Operations Team</p> <p>Corrections completed by: 7/13/13</p>	07/13/2013			

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	<p>team completed the investigation. The review did not indicate if and when the administrator had been notified of the results of the investigation.</p> <p>2. BDDS report dated 5/16/13 indicated on 5/15/13, "Staff noticed that [client #6] had two 2 inch red scratches on the back of her neck and one 2 inch scratch on her right forearm. Staff cleaned the area and applied Bacitracin on the area." The 5/16/13 BDDS report indicated, "Investigation will be done to determine the origin of the scratches."</p> <p>-Follow up BDDS report dated 5/22/13 indicated the team had investigated the 5/15/13 injuries of unknown origin for client #6. The review did not indicate documentation regarding if and when the administrator had been notified of the results of the investigation.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated the results of investigations of allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be completed and reported to the administrator within 5 business days of the incident.</p> <p>9-3-2(a)</p>						

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 7 of 62 allegations of abuse, neglect, exploitation, mistreatment and/or injuries of unknown origin reviewed, the facility failed to develop and implement preventative measures regarding client #3's physical aggression towards client #1.</p> <p>Findings include:</p> <p>The facility's IRs, BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>1. BDDS report dated 3/12/13 indicated on 3/11/13, "[Client #3] was upset when [CS #1 (Clinical Supervisor)] picked her upon (sic) from [client #3's] [day service provider], [client #3] started yelling and screaming on the van. Upon arrival at [client #1's] [day service provider] [client #3] started yelling again. Housemate [client #1] got on the van [client #3] started yelling at [client #1] (sic) [CS #1] observed [client #3] hit and kick [client #1] on the left leg. [CS #1] immediately pulled the van over and rearranged [client #3] seat (sic) away from [client #1]. [Client #3] became upset again trying to</p>	W000157	<p>CORRECTION: <i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, the interdisciplinary team will evaluate current assessment and incident data and meet to develop revised strategies to increase personal safety the following individuals in response to the incidents listed below:</i></p> <ol style="list-style-type: none"> Aggression that occurred during transport on the facility van from Client #3 toward Client #1 on 3/11/13. Aggression from Client #3 toward Client #1 on 3/27/13 Aggression that occurred during transport on the facility van from Client #3 toward Client #1 on 4/16/13. Aggression from Client #3 toward Client #1 on 4/29/13 Aggression that occurred during transport on the facility van from Client #3 toward Client #1 on 5/11/13. Aggression from Client #3 toward Client #1 on 5/28/13 Attempted aggression that occurred during transport on the facility van from Client #3 toward Client #1 on 5/16/13. <p>PREVENTION: The QIDP will bring all relevant elements of the interdisciplinary team together after incidents of resulting in significant injury to review current supports and to</p>	07/13/2013			

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	<p>kick and hit [client #1] (sic) [CS #1] gentle blocked (sic) the kick from [client #3] trying to kick [client #1]. [CS #1] attempted to drive but [client #3] kept getting out of her seating trying to hit and kick [client #1]."</p> <p>2. BDDS report dated 4/17/13 indicated on 4/16/13, "[Client #3] got upset while riding on the van to day program because one of her housemates was not going to the day program. [Client #3] started yelling and screaming then took her frustration out on [client #1] by hitting her on top of her helmet."</p> <p>3. BDDS report dated 5/3/13 indicated on 4/29/13, "[Client #3] was upset yelling and screaming and before staff could redirect hit housemate [client #1] on top of her helmet."</p> <p>4. BDDS report dated 5/8/13 indicated on 5/7/13, "Staff was assisting [client #1] onto the van. [Client #3] without displaying precursor behavior starting (sic) yelling, screaming and calling housemate [client #1] unprofessional names then hit her on the top of her helmet."</p> <p>5. IR dated 5/17/13 indicated, "As [staff #7] was assisting [client #1] onto the van at [day services] [client #3] reached up</p>		<p>make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. The Quality Assurance Manager will meet weekly with the QIDP to review incidents which require interdisciplinary team action.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

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	<p>and hit [client #1] on top of her head."</p> <p>Client #3's record was reviewed on 5/28/13 at 12:14 PM. Client #3's PN's dated 3/1/13 through 5/28/13 indicated the following:</p> <p>6. PN dated 3/27/13 indicated, "[Client #3] keep (sic) beating on the medication room door today because staff was taking another consumers vitals and giving them medication. [Client #3] wanted it to be her turn. [Client #3] hit [client #1] on the head twice."</p> <p>7. PN dated 5/16/13 indicated, "[Client #3] began to have a behavior when staff came to pick her up from day service to go to [doctor's] office. [Client #3] got on the van in an uproar. Staff tried redirecting her but she continued to be loud and hitting on consumers and staff. When [client #3] got to [doctor's] office [client #3] was still loud and trying to hit [client #1]. Staff could not calm her down. The [doctor] then refused to see her and denied her of being seen in the near future. When [client #3] and staff returned to the van [client #3] was still in an uproar."</p> <p>Client #3's record did not indicate documentation of an IDT or team discussion regarding her behavioral</p>						

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	<p>episodes. Client #3's record did not indicate documentation of discussion or development of preventative measures to address client #3's aggression towards client #1.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 stated, "The IDT meets to discuss incidents." QIDP #1 stated, "The IDT replaced the old behavior review committee. We do IDTs when there are patterns or significant events." QIDP #1 indicated the IDT meets to review client events and develop supports to address behaviors or incidents from re-occurring. QIDP #1 indicated client #3's behaviors should have been discussed by the IDT to assess current programming, medical and/or staffing supports. QIDP #1 indicated record of IDTs should be documented in the clients' records. QIDP #1 indicated there was not additional documentation of IDTs for client #3 available for review.</p> <p>9-3-2(a)</p>				

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #3), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure the IDT (Interdisciplinary Team) convened to develop and assess client #2's supports following behavioral episodes. The QIDP failed to ensure the IDT convened to develop and assess client #3's supports following behavioral episodes. The QIDP failed to ensure clients #2 and #3's ISP (Individual Support Plan)/ BSP (Behavior Support Plan) included the needed supports and services regarding how staff was to assist the clients during transportation. The QIDP failed to ensure clients #1 and #3's training objectives were monitored and revised on a routine basis.</p> <p>Findings include:</p> <p>1. The facility's IRs (Incident Reports), BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>-BDDS report dated 1/4/13 indicated on 1/3/13, "[Client #2] had an outburst while</p>	W000159	<p>CORRECTION: Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, the QIDP will receive additional training to improve integration, coordination, and monitoring of Client #1 - #6's active treatment programs. The training will focus on: 1. Timely review and modification of learning objectives and other supports. 2. Assuring that the interdisciplinary team meets to assess supports after episodes of aggressive behavior. 3. Assuring the development of supports to enable staff to keep clients safe during transportation. .</p> <p>PREVENTION: Members of the Operations and Quality Assurance Teams will conduct twice monthly audits of facility support documents and conduct active treatment observations for the next 90 days. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly observations designed to assure that the QIDP integrates, coordinates and monitors, the</p>	07/13/2013	

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	<p>on the van. [Client #2] pinched [FC #1's (Former Client)] thumb, took her fist and was pounding on [client #3's] feet and also hit [client #4's] left leg."</p> <p>-BDDS report dated 3/11/13 indicated on 3/7/13 client #2 was, "... upset when she arrived at [day services] to pick up [client #1]. [Staff #2] was trying to lift [client #1's] wheelchair on to van. [Client #2] was yelling profanities at [client #1] and grabbing at her legs while still on the lift. [Staff #2] did an one person assist as written in BSP (Behavior Support Plan) trying to prevent [client #2] from attacking housemate [client #1]."</p> <p>-BDDS report dated 3/13/13 indicated on 3/12/13, "While riding home from day service without displaying precursor behavior, [client #2] began yelling, using profanity and opening and closing the van door. Staff pulled over and [client #2] exited the vehicle. A passing police car pulled over to assist. [Client #2] attempted to walk into traffic and the police prevented her from doing so. Additional staff arrived to assist but [client #2] remained non-cooperative and refused to get into either vehicle. The police handcuffed [client #2] and she transported via (sic) to emergency room for psychiatric evaluation. [Client #2] was evaluated and released to residential staff</p>		<p>active treatment program effectively. Administrative staff will provide guidance, mentorship and corrective measures as needed. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>				

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	<p>with no recommendations. [Client #2] remained agitated but agreed to leave and return home with no further problems."</p> <p>-IR dated 3/22/13 indicated while CS (Clinical Supervisor) #1 was transporting clients #1 and #2, "[Client #2] was upset from missing a doctor appointment (sic) was screaming and hitting (sic) dashboard. When [CS #1] to on (sic) interstate driving [client #2] was grabbing at steering wheel and attempting to change gears. As soon as possible [CS #1] pulled over on shoulder for safety. [CS #1] finally got [client #2] calmed down and finished transport."</p> <p>-IR dated 5/23/13 indicated, "[Client #2] was upset because she didn't want to go on the PM transport. [Client #2] began coloring on herself with her markers and when staff tried to take her markers she began throwing them. [Client #7] asked [client #2] to stop throwing her markers and [client #2] threw the markers at [client #7's] face. [Client #7] then threw her phone at (sic) back at [client #2]."</p> <p>Client #2's record was reviewed on 5/28/13 at 3:10 PM. Client #2's PN's (Progress Note) from 5/1/13 through 5/28/13 were reviewed. Client #2's PN's indicated the following:</p>			

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	<p>-5/13/13, "[Client #2] had behavior on the van during morning transportation. [Client #2] began saying [client #1] was looking (sic) staring at her and [client #1's] head was turned in the opposite direction. [Client #2] then began to kick and pull on [client #1's] wheelchair. [Staff #8] called [CS #1 (Clinical Supervisor)] and was able to calm [client #2] down."</p> <p>-5/13/13, "[Client #2] had another behavior today when [staff #8] took [client #1] another consumer to dental appointment. For no apparent reason [client #2] fell out on the floor in the middle of the doctor office. [Client #2] wouldn't tell staff what was wrong. [Client #2] just continued to kick, scream and bang her head on the wall. Doctor's office employee helped out to calm [client #2] down but the issue wasn't resolved until security came."</p> <p>-5/21/13, "[Client #2] began to have a behavior about her boyfriend. [Boyfriend] and [client #2] have broken up and she just happened to see him in passing at [day service] when [boyfriend] walked by the van without speaking to her she fell out of her seat and began to have a behavior saying [expletive] this and [expletive] him."</p> <p>-5/21/13, "[Client #2] went on the PM</p>						

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	<p>transport and had a behavior because she wanted to call her mom. [Client #2] took her seatbelt off and laid on the floor of the van. [Staff #8] had to pull over until the [RM #1 (Resident Manager)] came and removed [client #2] from the van."</p> <p>Client #2's record indicated client #2's most recent IDT meeting was on 6/12/12. Client #2's ISP dated 7/1/12 indicated the following formal training objectives: will clean her room, will speak in a pleasant tone, will state the effect of her medication, will prepare a dish for dinner from the menu, will stay on task with an activity of her choice, will dress appropriately according to the weather, will exercise daily and will express her wants and emotions. Client #2's record indicated the QIDP (Qualified Intellectual Disabilities Professional) had not monitored client #2's objectives as there were no monthly summaries and/or quarterly reviews from 7/1/12 through 5/30/13 to review to determine if client #2 had achieved the objectives since client #2's objectives were started on 7/1/12.</p> <p>2. The facility's IRs (Incident Reports), BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>--BDDS report dated 3/12/13 indicated on</p>						

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	<p>3/11/13, "[Client #3] was upset when [CS #1 (Clinical Supervisor)] picked her upon (sic) from [client #3's] [day service provider], [client #3] started yelling and screaming on the van. Upon arrival at [client #1's] [day service provider] [client #3] started yelling again. Housemate [client #1] got on the van [client #3] started yelling at [client #1] (sic) [CS #1] observed [client #3] hit and kick [client #1] on the left leg. [CS #1] immediately pulled the van over and rearranged [client #3] seat (sic) away from [client #1]. [Client #3] became upset again trying to kick and hit [client #1] (sic) [CS #1] gentle blocked (sic) the kick from [client #3] trying to kick [client #1]. [CS #1] attempted to drive but [client #3] kept getting out of her seating trying to hit and kick [client #1]."</p> <p>-BDDS report dated 4/17/13 indicated on 4/16/13, "[Client #3] got upset while riding on the van to day program because one of her housemate was not going to the day program. [Client #3] started yelling and screaming then took her frustration out on [client #1] by hitting her on top of her helmet."</p> <p>-BDDS report dated 5/3/13 indicated on 4/29/13, "[Client #3] was upset yelling and screaming and before staff could redirect hit housemate [client #1] on top</p>						

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	<p>of her helmet."</p> <p>-BDDS report dated 5/8/13 indicated on 5/7/13, "Staff was assisting [client #1] onto the van. [Client #3] without displaying precursor behavior starting (sic) yelling, screaming and calling housemate [client #1] unprofessional names then hit her on the top of her helmet."</p> <p>-BDDS report dated 5/15/13 indicated on 5/13/13, "As staff was picking up [client #3] (sic) was yelling and screaming she did not want to go. Workshop staff assisted [client #3] onto the van, [client #3] became aggressive toward other housemates by swing (sic) at them but did not make actual contact. Staff attempted to drive off but [client #3] was still yelling and screaming hitting on the van window, that staff (sic) stopped the van. For the safety of [client #3] workshop staff assisted [client #3] off the van then called [CS #1] to transport [client #3] home." The 5/15/13 BDDS report indicated, "IDT will meet to review if modifications to BSP (Behavior Support Plan) is (sic) warranted to decrease physically and verbally aggressive behaviors."</p> <p>-IR dated 5/17/13 indicated, "As [staff #7] was assisting [client #1] onto the van at</p>				

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	<p>[day services] [client #3] reached up and hit [client #1] on top of her head."</p> <p>Client #3's record was reviewed on 5/28/13 at 12:14 PM. Client #3's PN's dated 3/1/13 through 5/28/13 indicated the following:</p> <p>-PN dated 3/27/13 indicated, "[Client #3] keep (sic) beating on the medication room door today because staff was taking another consumers vitals and giving them medication. [Client #3] wanted it to be her turn. [Client #3] hit [client #1] on the head twice."</p> <p>-PN dated 3/31/13 indicated, "[Client #3] also went over to the [group home] to have dinner. On our way going [client #3] tried to jump out of the van and staff immediately pull (sic) over and talk to her."</p> <p>-PN dated 4/16/13 indicated, "[Client #3] went on the van ride for transport. [Client #3] hit another housemate, she didn't go to work."</p> <p>-PN dated 5/16/13 indicated, "[Client #3] began to have a behavior when staff came to pick her up from day service to go to [doctor's] office. [Client #3] got on the van in an uproar. Staff tried redirecting her but she continued to be loud and</p>						

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	<p>hitting on consumers and staff. When [client #3] got to [doctor's] office [client #3] was still loud and trying to hit [client #1]. Staff could not calm her down. The [doctor] then refused to see her and denied her of being seen in the near future. When [client #3] and staff returned to the van [client #3] was still in an uproar. [Client #3] then got on the van and reached back and tried to hit [client #7]."</p> <p>Client #3's record did not indicate documentation of an IDT or team discussion regarding her behavioral episodes. Client #3's ISP dated 10/27/12 indicated the following formal training objectives: will participate in a physical activity, will state the reasons why she is taking a medication, will select an outfit for the day that is weather appropriate and matches, will brush her teeth, will choose a leisure time activity, will wash her hands after using the toilet, will identify and state the values of four basic coins and will consume no more than one spoonful of food at a time. Client #3's record indicated the QIDP had not monitored client #3's objectives as there were no monthly summaries and/or quarterly reviews from 1/27/13 through 5/30/13 to review to determine if client #3 had achieved the objectives since client #3's objectives were started on 10/17/12.</p>			

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	<p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 stated, "The IDT meets to discuss incidents." QIDP #1 stated, "The IDT replaced the old behavior review committee. We do IDT's when there are patterns or significant events." QIDP #1 indicated the IDT meets to review client events and develop supports to address behaviors or incidents from re-occurring. QIDP #1 indicated clients #2 and #3's behaviors should have been discussed by the IDT to assess current programming, medical and/or staffing supports. QIDP #1 indicated record of IDT's should be documented in the clients' records. QIDP #1 indicated there was not additional documentation of IDT's for clients #2 and/or #3 available for review. QIDP #1 indicated clients #2 and #3's objectives should be monitored on a monthly basis to determine if revisions were needed. QIDP indicated the QIDP monthly and/or quarterly summaries should be completed and utilized to track and determine client's goals, progress and revisions.</p> <p>3. The QIDP failed to ensure clients #2 and #3's ISP/ BSP (Behavior Support Plan) included the needed supports and services regarding how staff was to assist the clients during transportation. Please</p>						

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	see W240. 9-3-3(a)			

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205			
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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM 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 1 of 4 sampled clients (#1), the facility failed to ensure staff were trained regarding client #1's adaptive equipment.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 5/28/13 from 4:40 PM through 6:40 PM. Client #1 was observed throughout the observation period. Client #1 utilized a wheelchair for ambulation. Client #1's wheelchair had a wheelchair alarm device attached to the back of the wheelchair with a pull cord sensor. Client #1's pull chord sensor mechanism was attached to the back of her wheelchair. Client #1's wheelchair alarm/sensor was not attached to her body/clothing. At 5:40 PM CS #1 (Clinical Supervisor) approached client #1 and asked if her wheelchair alarm was turned on. CS #1 then stated, "This needs to be adjusted." CS #1 untangled the wheelchair alarm cords and attached the pull cord sensor on the back of the wheelchair. CS #1 did not reattach the sensor to client #1's body or</p>	W000189	<p>CORRECTION: <i>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. Specifically, the facility has completed retraining of all staff toward supporting Client #1's use of adaptive equipment.</i></p> <p>PREVENTION: All new staff will be trained on the facility's need to furnish maintain in good repair and teach clients to make informed choices about the use of adaptive equipment upon hire and annually thereafter. Any temporary staff assigned to cover shifts in the home will be trained on client specific adaptive equipment needs prior to working in the home. Facility supervisory staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training toward proper use of adaptive equipment. Additionally members of the Operations and Quality Assurance Teams will periodically monitor active</p>	07/13/2013			

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	<p>clothing.</p> <p>CS #1 was interviewed on 5/28/13 at 5:40 PM. CS #1 indicated client #1's wheelchair alarm/sensor was used due to client #1's history of falling out of the wheelchair. CS #1 indicated the pull cord sensor was attached to the back of the wheelchair.</p> <p>Client #1's record was reviewed on 5/28/13 at 2:13 PM. Client #1's Healthcare Addendum form dated 3/29/13 indicated, "[Client #1] also has a personal alarm that is attached to her when she is up out of bed." Client #1's ISP (Individual Support Plan) dated 3/29/13 indicated client #1 utilized an alarm on her wheelchair to alert staff of falls.</p> <p>Interview with QIDP #1 (Qualified Intellectual Disabilities Professional) on 5/28/13 at 3:04 PM indicated client #1's wheelchair alarm should be attached to her body or clothing. When asked if staff should be trained to use client #1's adaptive equipment, QIDP stated, "Yes."</p> <p>Interview with CS #1 on 5/28/13 at 3:05 PM indicated client #1's wheelchair alarm should be attached to her body or clothing. When asked if she had any training regarding client #1's adaptive equipment and/or wheelchair alarm, CS</p>		<p>treatment on an ongoing basis to assure quality service delivery.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Quality Assurance Team, Operations Team</p>		

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	#1 stated, "Nothing specific on the alarm." 9-3-3(a)			

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 2 of 4 sampled clients (#2 and #3), the facility failed to ensure clients #2 and #3's ISP (Individual Support Plan)/ BSP (Behavior Support Plan) included the needed supports and services regarding how staff was to assist the clients during transportation.</p> <p>Findings include:</p> <p>1. The facility's IRs (Incident Reports), BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>-BDDS report dated 1/4/13 indicated on 1/3/13, "[Client #2] had an outburst while on the van. [Client #2] pinched [FC #1's (Former Client)] thumb, took her fist and was pounding on [client #3's] feet and also hit [client #4's] left leg."</p> <p>-BDDS report dated 3/11/13 indicated on 3/7/13 client #2 was "... upset when she arrived at [day services] to pick up [client #1]. [Staff #2] was trying to lift [client #1's] wheelchair on to van. [Client #2] was yelling profanities at [client #1] and grabbing at her legs while still on the lift.</p>	W000240	<p>CORRECTION: <i>The individual program plan must describe relevant interventions to support the individual toward independence. Specifically, the team will enlist the assistance of the agency's behavior therapist to develop appropriate supports for staff to assist Client #2 and Client #3 during transportation. Staff will be trained on proper implementation of these strategies.</i></p> <p>PREVENTION: The QIDP and will receive training regarding the need to develop specific supports to address safety and behavioral issues as assessed by the interdisciplinary team. Members of the Operations and Quality Assurance Teams will conduct active treatment observations, including spot checks at the onset and end of daily transport from various locations for the next 60 days and twice monthly for an additional 30 days. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly observations designed to assure that assure training programs and</p>	07/13/2013			

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	<p>[Staff #2] did an one person assist as written in BSP (Behavior Support Plan) trying to prevent [client #2] from attacking housemate [client #1]."</p> <p>-BDDS report dated 3/13/13 indicated on 3/12/13, "While riding home from day service without displaying precursor behavior, [client #2] began yelling, using profanity and opening and closing the van door. Staff pulled over and [client #2] exited the vehicle. A passing police car pulled over to assist. [Client #2] attempted to walk into traffic and the police prevented her from doing so. Additional staff arrived to assist but [client #2] remained non-cooperative and refused to get into either vehicle. The police handcuffed [client #2] and she transported via (sic) to emergency room for psychiatric evaluation. [Client #2] was evaluated and released to residential staff with no recommendations. [Client #2] remained agitated but agreed to leave and return home with no further problems."</p> <p>-IR dated 3/22/13 indicated while CS #1 was transporting clients #1 and #2, "[Client #2] was upset from missing a doctor appointment (sic) was screaming and hitting (sic) dashboard. When [CS #1] to on (sic) interstate driving [client #2] was grabbing at steering wheel and attempting to change gears. As soon as</p>		<p>interventions are in place to support health, safety and dignity. These observations will include interviews with direct support staff to assess and address as needed competency and knowledge of updated behavior supports.</p> <p>RESPONSIBLE PARTIES: QIDP, Behavior Therapist, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	

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	<p>possible [CS #1] pulled over on shoulder for safety. [CS #1] finally got [client #2] calmed down and finished transport."</p> <p>-IR dated 5/23/13 indicated, "[Client #2] was upset because she didn't want to go on the PM transport. [Client #2] began coloring on herself with her markers and when staff tried to take her markers she began throwing them. [Client #7] asked [client #2] to stop throwing her markers and [client #2] threw the markers at [client #7's] face. [Client #7] then threw her phone at (sic) back at [client #2]."</p> <p>Client #2's record was reviewed on 5/28/13 at 3:10 PM. Client #2's PN's (Progress Note) from 5/1/13 through 5/28/13 were reviewed. Client #2's PN's indicated the following:</p> <p>-5/13/13, "[Client #2] had behavior on the van during morning transportation. [Client #2] began saying [client #1] was looking (sic) staring at her and [client #1's] head was turned in the opposite direction. [Client #2] then began to kick and pull on [client #1's] wheelchair. [Staff #8] called [CS #1 (Clinical Supervisor)] and was able to calm [client #2] down."</p> <p>-5/13/13, "[Client #2] had another behavior today when [staff #8] took [client #1] another consumer to dental</p>						

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	<p>appointment. For no apparent reason [client #2] fell out on the floor in the middle of the doctor office. [Client #2] wouldn't tell staff what was wrong. [Client #2] just continued to kick, scream and bang her head on the wall. Doctor's office employee helped out to calm [client #2] down but the issue wasn't resolved until security came."</p> <p>-5/21/13, "[Client #2] began to have a behavior about her boyfriend. [Boyfriend] and [client #2] have broken up and she just happened to see him in passing at [day service] when [boyfriend] walked by the van without speaking to her she fell out of her seat and began to have a behavior saying [expletive] this and [expletive] him."</p> <p>-5/21/13, "[Client #2] went on the PM transport and had a behavior because she wanted to call her mom. [Client #2] took her seatbelt off and laid on the floor of the van. [Staff #8] had to pull over until the [RM #1 (Resident Manager)] came and removed [client #2] from the van."</p> <p>Client #2's ISP dated 7/1/12 did not indicate how staff were to address client #2's attempts to vacate the facility van while in motion. The 7/1/12 ISP did not indicate how staff were to arrange client #2's environment while on the facility van</p>			

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	<p>during transportation to ensure client #2 did not attack the driver of the van or peers. Client #2's BSP dated 7/1/12 did not indicate how staff were to address client #2's attempts to vacate the facility van while in motion. The 7/1/12 BSP did not indicate how staff were to arrange client #2's environment while on the facility van during transportation to ensure client #2 did not attack the driver of the van or peers.</p> <p>2. The facility's IRs (Incident Reports), BDDS reports and investigations were reviewed on 5/24/13 at 8:55 AM. The review indicated the following:</p> <p>--BDDS report dated 3/12/13 indicated on 3/11/13, "[Client #3] was upset when [CS #1 (Clinical Supervisor)] picked her upon (sic) from [client #3's] [day service provider], [client #3] started yelling and screaming on the van. Upon arrival at [client #1's] [day service provider] [client #3] started yelling again. Housemate [client #1] got on the van [client #3] started yelling at [client #1] (sic) [CS #1] observed [client #3] hit and kick [client #1] on the left leg. [CS #1] immediately pulled the van over and rearranged [client #3] seat (sic) away from [client #1]. [Client #3] became upset again trying to kick and hit [client #1] (sic) [CS #1] gentle blocked (sic) the kick from [client</p>						

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	<p>#3] trying to kick [client #1]. [CS #1] attempted to drive but [client #3] kept getting out of her seating (sic) trying to hit and kick [client #1]."</p> <p>-BDDS report dated 4/17/13 indicated on 4/16/13, "[Client #3] got upset while riding on the van to day program because one of her housemate was not going to the day program. [Client #3] started yelling and screaming then took her frustration out on [client #1] by hitting her on top of her helmet."</p> <p>-BDDS report dated 5/3/13 indicated on 4/29/13, "[Client #3] was upset, yelling and screaming and before staff could redirect hit housemate [client #1] on top of her helmet."</p> <p>-BDDS report dated 5/8/13 indicated on 5/7/13, "Staff was assisting [client #1] onto the van. [Client #3] without displaying precursor behavior starting (sic) yelling, screaming and calling housemate [client #1] unprofessional names then hit her on the top of her helmet."</p> <p>-BDDS report dated 5/15/13 indicated on 5/13/13, "As staff was picking up [client #3] (sic) was yelling and screaming she did not want to go. Workshop staff assisted [client #3] onto the van, [client</p>						

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	<p>#3] became aggressive toward other housemates by swinging at them but did not make actual contact. Staff attempted to drive off but [client #3] was still yelling and screaming and hitting on the van window, that staff (sic) stopped the van. For the safety of [client #3] day service staff assisted [client #3] off the van then called [CS #1] to transport [client #3] home."</p> <p>-IR dated 5/17/13 indicated, "As [staff #7] was assisting [client #1] onto the van at [day services] [client #3] reached up and hit [client #1] on top of her head."</p> <p>Client #3's record was reviewed on 5/28/13 at 12:14 PM. Client #3's PN's dated 3/1/13 through 5/28/13 indicated the following:</p> <p>-PN dated 3/31/13 indicated, "[Client #3] also went over to the [group home] to have dinner. On our way going [client #3] tried to jump out of the van and staff immediately pull over and talk to her."</p> <p>-PN dated 4/16/13 indicated, "[Client #3] went on the van ride for transport. [Client #3] hit another housemate, she didn't go to work."</p> <p>-PN dated 5/16/13 indicated, "[Client #3] began to have a behavior when staff came</p>				

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	<p>to pick her up from day service to go to [doctor's] office. [Client #3] got on the van in an uproar. Staff tried redirecting her but she continued to be loud and hitting on consumers and staff. When [client #3] got to [doctor's] office [client #3] was still loud and trying to hit [client #1]. Staff could not calm her down. The [doctor] then refused to see her and denied her of being seen in the near future. When [client #3] and staff returned to the van [client #3] was still in an uproar. [Client #3] then got on the van and reached back and tried to hit [client #7]."</p> <p>Client #3's ISP dated 10/27/12 did not indicate how staff were to address client #3's attempts to vacate the facility van while in motion. Client #3's 10/27/12 ISP did not indicate how staff were to arrange client #3's environment while on the facility van during transportation to ensure client #3 did not physically aggress toward the driver of the van or peers. Client #3's BSP dated 7/27/12 did not indicate how staff were to address client #3's attempts to vacate the facility van while in motion. The 7/27/12 BSP did not indicate how staff were to arrange client #3's environment while on the facility van during transportation to ensure client #3 did not physically aggress toward the driver of the van or peers.</p>				

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	<p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated clients #2 and #3's ISP/BSPs should address the clients' elopement and physical aggression during transportation.</p> <p>9-3-4(a)</p>			