

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/01/2013
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 842 NATIONAL RD RICHMOND, IN 47374
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W0000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Survey Dates: January 23, 24, 25, 31 and February 1, 2013.</p> <p>Facility Number: 000841 Provider Number: 15G323 AIM Number: 100243670</p> <p>Surveyors: Vickie Kolb, RN, BSN, Public Health Nurse Surveyor III - Team Leader Steve Corya, Medical Surveyor Supervisor 5</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/11/13 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the client's IDT (Interdisciplinary Team) failed to assess and/or re-assess the client's ambulation needs while outside of the group home and when getting on and off the facility van.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/23/13 between 3:45 PM and 6:30 PM and again on 1/24/13 between 5:30 AM and 9:05 AM. During observations, the following was observed: __ Client #1's hearing was impaired and the client communicated via sign language, white board or paper and pencil. Client #1 walked with a shuffle, slightly dragging his left leg and holding his left arm close to his body at chest level. Client #1's bedroom was on the second floor of the home. __ A long ramp was attached to a wooden porch on the rear of the home. The porch wrapped around the back of the home to the front of the home with several steps leading off the front of the home onto a</p>	W0210	<p>CORRECTION: <i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Specifically, the team will have scheduled an additional Physical Therapy assessment to develop supports to assist Client #1 with ambulating safely outside of the home as well as getting in and out of the facility van.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the need to obtain appropriate assessments to facilitate the development of needed supports for all clients across environments. Members of the Operations, Quality Assurance and/or Health Services Teams will review assessment data and incident documentation to assure assessments occur as needed and required.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Operations Team, Quality Assurance Team</p>	03/01/2013			

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	<p>sidewalk leading to the street.</p> <p>__ On 1/23/13 at 3:45 PM after getting off the facility van, client #1 independently walked up the ramp in the rear of the home and entered the back door. After returning home, client #1 walked unsupervised outside to the side/front porch to smoke a cigarette.</p> <p>__ On the morning of 1/24/13, the ground was covered in ice and snow and the wind was blowing. The staff had shoveled a path through the snow from the ramp leading off the back door all the way around to the van. The van was a large full size van with 2 bench seats behind the driver's seat and a running board on the passenger side to step up onto to get into the van. Client #1 walked slowly down the ramp and waited at the van for a staff to come out of the house so he could get onto the van. Staff #5 came out of the house, opened the side door of the van and went around to the driver's side. Client #1 stepped up onto the running board of the van, reached into the van and grabbed the back of the passenger seat with his right hand to pull himself up. In doing so, client #1 swayed backwards and to the left, catching himself, pulling himself back up. Client #1 then sat down in the third row bench seat.</p> <p>Client #1's record was reviewed on 1/25/13 at 11 AM. The client's record</p>						

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	<p>indicated a diagnosis of, but not limited to, Cerebral Palsy and Bilateral Deafness.</p> <p>__ Client #1's physical therapy evaluation of 7/5/12 indicated client #1 could walk on even surfaces but required close supervision going up and down the stairs and on uneven surfaces.</p> <p>__ Client #1's physical therapy evaluation of 1/14/13 indicated the client was to wear a gait belt for stairs with hands on assistance from staff. The evaluation indicated client #1 required "supervision for all other mobility." The evaluation indicated staff #7 clarified with the physical therapist "supervision for all other mobility meant he [client #1] was not able to live independently."</p> <p>__ Client #1's Comprehensive High Risk Health Plan of 10/10/12 indicated "Hands on assist when navigating stairs or hazardous surfaces such as slippery areas, snow/ice and rocky uneven terrain and as needed." Client #1's Comprehensive High Risk Health Plan of 10/10/12 Addendum indicated staff were to have "Hands-On assist with all transfers and utilize gait belt for safety" and "Utilize wheelchair for mobility."</p> <p>Interview with the HM (House Manager) on 1/24/13 at 1 PM indicated the staff did not have to assist client #1 while ambulating outside the home or while getting on or off the facility van. When</p>				

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	<p>asked if client #1 stepped up onto the running board of the van to get inside, the HM stated, "Yes, I guess we didn't think about that."</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 1/24/13 at 3:15 PM indicated client #1 had been assessed to be able to ambulate on even terrain. The QMRP indicated client #1 was to use a gait belt when going up and down the stairs in the home. When asked how client #1 was to get up and down on the van, the QMRP indicated the client's physical therapy assessment had not included how the staff were to assist the client outside the home, going up and down ramps and/or getting in and out of the van in order to maintain the client's safety.</p> <p>9-3-4(a)</p>			

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the client's ISP (Individualized Support Plan) failed to address how the staff were to ensure client #1's safety while in the home in regards to the level of supervision needed while ambulating, the use of a gait belt when going up and down the stairs and how the staff were to assist client #1 with his ambulation needs outside the home.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/23/13 between 3:45 PM and 6:30 PM and again on 1/24/13 between 5:30 AM and 9:05 AM. During observations, the following was observed: __ Client #1's hearing was impaired and the client communicated via sign language, white board or paper and pencil. Client #1 walked with a shuffle, slightly dragging his left leg and holding his left arm close to his body at chest level. Client #1's bedroom was on the second floor of the home. __ The home had two levels with a winding large staircase between the levels. At the top of the stair case, a gait</p>	W0240	<p>CORRECTION: <i>The individual program plan must describe relevant interventions to support the individual toward independence.</i> Specifically, the team will has scheduled an additional Physical Therapy assessment to develop supports to assist Client #1 with ambulating safely outside of the home as well as getting in and out of the facility van. The team will revise Client #1's Comprehensive High Risk Plans based on the results of the PT Evaluation.</p> <p>PREVENTION: Professional staff will be retrained regarding the need to develop supports to assure the safety of all clients across environments. Members of the Operations, Quality Assurance and/or Health Services Teams will review assessment data and incident documentation and will make recommendations for modifications to client support plans as appropriate. These reviews will take place as part of an ongoing process in which members of the Quality Assurance and/or operations team will conduct on-site audits no less than monthly.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential</p>	03/01/2013			

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	<p>belt was draped over the railing and a plastic box was hung on the wall next to the stairs. Interview with the QMRP (Qualified Mental Retardation Professional) on 1/23/13 at 4:30 PM indicated the plastic box at the top of the stairs was for client #1 to alert the staff of client #1's need for assistance to come down the stairs. The QMRP picked up a receiver lying on the hutch in the dining room and indicated when client #1 would make a sound in the box at the top of the stairs, the staff would hear him in the receiver in the dining room and go to help client #1 down the stairs. The QMRP indicated the receiver was turned off at the time of the interview, but was supposed to be on at all times for client #1 to communicate his need for help in going down the stairs.</p> <p>__A long ramp was attached to a wooden porch on the rear of the home. The porch wrapped around the back of the home to the front of the home with several steps leading off the front of the home onto a sidewalk leading to the street.</p> <p>__On 1/23/13 at 3:45 PM after getting off the facility van, client #1 independently walked up the ramp in the rear of the home and entered the back door. After returning home, client #1 walked unsupervised outside to the side/front porch to smoke a cigarette.</p> <p>__On the morning of 1/24/13, the ground</p>		<p>Manager, Direct Support Staff, Operations Team, Quality Assurance Team</p>				

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	<p>was covered in ice and snow and the wind was blowing. The staff had shoveled a path through the snow from the ramp leading off the back door all the way around to the van. The van was a large full size van with 2 bench seats behind the driver's seat and a running board on the passenger side to step up onto to get into the van. Client #1 walked slowly down the ramp and waited at the van for a staff to come out of the house so he could get onto the van. Staff #5 came out of the house, opened the side door of the van and went around to the driver's side. Client #1 stepped up onto the running board of the van, reached into the van and grabbed the back of the passenger seat with his right hand to pull himself up. In doing so, client #1 swayed backwards and to the left, catching himself, pulling himself back up. Client #1 then sat down in the third row bench seat.</p> <p>__During observations, the staff were not observed to directly supervise or assist client #1 whenever ambulating outside of the home or while getting onto the van.</p> <p>The facility's records were reviewed on 1/23/13 at 11:30 AM. The BDDS (Bureau of Developmental Disabilities Services) reports indicated on 7/29/12 at 6:20 PM client #1 stood up in front of the chair he was sitting in at the group home and tripped. Client #1 yelled for the staff and</p>				

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	"landed on the couch." Client #1 complained of his left knee, ankle and toe hurting and said he could not walk. No redness, bruising and/or swelling was noted. The staff notified the facility nurse and was instructed to elevate and ice client #1's lower leg. On 7/31/12 client #1 continued to complain of pain in his lower extremity and was taken to a walk in clinic. Client #1 was diagnosed with a "non-displaced fracture at the proximal base of the left fifth metatarsal (one of the bones in the foot)." The report indicated client #1 had sustained a similar injury prior to his current residential placement. The report indicated an investigation was conducted and none of the staff "actually witnessed the cause of [client #1] tripping in the living room, but two staff saw him (client #1) stumbling from the chair where he was sitting toward the couch. It is unknown if he (client #1) tripped over the edge of the area rug or if he (client #1) did not fully pick up his (client #1's) left foot and possibly drag the toe of his (client #1's) shoe on the rug when he (client #1) started walking after getting up from the chair in which he (client #1) was sitting. His (client #1's) left leg is shorter than his (client #1's) right leg due to Cerebral Palsy on his (client #1's) left side." "It was determined through x-ray of his (client #1's) left foot that he (client #1) has had previous left foot surgeries due to			

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	<p>all the plates and screws in his (client #1's) left foot. The orthopedic physician does not want to do surgery to put another screw in his (client #1's) foot due to all the hardware that already exists." The report indicated "it would not take much force for him (client #1) to injure the left foot."</p> <p>Client #1's record was reviewed on 1/25/13 at 11 AM. The client's record indicated a diagnosis of, but not limited to, Cerebral Palsy and Bilateral Deafness. __ Client #1's physical therapy evaluation of 7/5/12 indicated client #1 could walk on even surfaces but required close supervision going up and down the stairs and on uneven surfaces. __ Client #1's physical therapy evaluation of 1/14/13 indicated the client was to wear a gait belt for stairs with hands on assistance from staff. The evaluation indicated client #1 required "supervision for all other mobility." The evaluation indicated staff #7 clarified with the physical therapist "supervision for all other mobility meant he [client #1] was not able to live independently." __ Client #1's Comprehensive High Risk Health Plan of 10/10/12 indicated "Hands on assist when navigating stairs or hazardous surfaces such as slippery areas, snow/ice and rocky uneven terrain and as needed." Client #1's Comprehensive High</p>						

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	<p>Risk Health Plan of 10/10/12 Addendum indicated staff were to have "Hands-On assist with all transfers and utilize gait belt for safety" and "Utilize wheelchair for mobility."</p> <p>__ Client #1's ISP (Individualized Support Plan) of 7/24/12 did not indicate how the staff were to assist and supervise client #1 inside and outside of the home while ambulating over uneven terrain, going up and down steps and while getting on and off the facility van. The ISP did not specify when client #1 was to use a gait belt and when/how the intercom system at the top of the stairs was to be used in regards to client #1.</p> <p>Interview with client #1 on 1/23/13 at 5:20 PM indicated client #1 did not like going up and down steps because he did not feel safe and it was hard to maintain his balance.</p> <p>Interview with the HM (House Manager) on 1/24/13 at 1 PM indicated whenever client #1 went up and down the stairs in the home the staff were to put the gait belt on client #1 and assist him up and down the steps. The HM indicated client #1 ambulated independently and the staff did not supervise or assist client #1 while ambulating outside the home or while getting on or off the facility van. When asked if client #1 had to take a step up</p>						

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	<p>into the van, the HM stated, "Yes."</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 1/24/13 at 3:15 PM indicated client #1 was to wear a gait belt for safety when going up and down the steps inside the group home. The QMRP indicated the staff did not assist client #1 with ambulation outside of the home and client #1 did not use a wheelchair. The QMRP indicated client #1's ISP was not specific on how the staff were to supervise and assist client #1 when ambulating inside and outside of the group home, maneuvering steps and uneven terrain outside of the group home and how the staff were to assist and supervise client #1 while getting on and off the facility van. The QMRP indicated client #1's ISP was not clear on when client #1 was to wear a gait belt and did not include the use of an intercom system for the stairs.</p> <p>9-3-4(a)</p>				

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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 2 of 46 medications observed being administered, the facility failed to ensure all medications were administered without error to clients #1 and #6.</p> <p>Findings include:</p> <p>During observation of the medication pass on 1/24/13 between 7 AM and 8:40 AM, the following was observed: Client #1 returned home at 7:17 AM after having blood drawn. At 7:42 AM, staff #5 gave client #1 Synthroid 75 mg (milligrams) for low thyroid levels. At 8:20 AM staff #5 gave client #6 30 ml (milliliters) of Fiber Therapy for constipation.</p> <p>Review of the January 2013 MARs (Medication Administration Records) on 1/24/13 at 8:45 AM for clients #1 and #6 indicated client #1's Synthroid was to be given 1 hour prior to all meals and client #6 was to have 15 ml of Fiber Therapy in water every morning.</p> <p>Staff #5 and the HM (House Manager) were interviewed on 1/24/13 at 8:50 AM.</p>	W0369	<p>CORRECTION: <i>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Specifically Staff number 5 will be retrained regarding the need to assure all medications –including liquid medications and suspensions— are administered as ordered and that physician's directives regarding post medication administration food consumption are followed.</i></p> <p>PREVENTION: All staff will be retrained regarding the parameters for eating after Client #1 receives Synthroid. The facility will conduct supervised medication administration sessions for all staff no less than quarterly. Additionally, members of the Operations Team will conduct periodic observations of medication administration sessions on an ongoing basis to assure staff administer medications without error.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Direct Support Staff, Operations Team, Quality Assurance Team</p>	03/01/2013	

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	<p>Staff #5 indicated she had given client #6 30 ml of Fiber Therapy and not 15 ml as instructed on client #6's MAR. The HM indicated client #1 ate his breakfast after returning home from having his blood drawn and prior to getting his Synthroid. Both staff #5 and the HM indicated client #1 was to get his Synthroid 1 hour prior to meals. The HM indicated it was the responsibility of the staff giving the medication to ensure client #1 had eaten prior to receiving his Synthroid.</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 1/24/13 at 3:15 PM indicated all medications were to be given as the physician had prescribed as indicated on the MAR without error.</p> <p>9-3-6(a)</p>			