

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  05/22/2012
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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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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Date of Survey: May 14, 15, 16 and 22, 2012</p> <p>Provider Number: 15G565 Aims Number: 100245500 Facility Number: 001079</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on May 25, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sample clients (#4) to ensure the facility and client #4's outside services had communication/coordinated client #4's behavior interventions with the facility.</p> <p>Findings include:</p> <p>Record review for client #4 was done on 5/15/12 at 1:54p.m. Client #4 had an individual support plan (ISP) dated 12/21/11. Client #4's ISP indicated client #4 (due to history of falls) was to remain in her wheelchair and ask staff for transfer assistance. The ISP indicated client #4 had a program for staff to be in line of sight at all times when out of her bedroom and in activities outside the group home. The ISP indicated staff were to provide "frequent" safety cues to client #4.</p> <p>Day service staff #1 was interviewed on 5/15/12 at 8:28a.m. Day staff #1 indicated they were not aware of client #4's need of staff to be in line of sight at all times. Day staff #1 reviewed the program documentation they had for client #4 and the documentation did not indicate the need for constant line of sight staffing.</p>	W0120	<p><b>CORRECTION:</b> <i>The facility must assure that outside services meet the needs of each client.</i> Specifically, the facility has provided day service staff with client #4's current support plan and has provided day service personnel with in service training to assure proper implementation of Client #4's plan.</p> <p><b>PREVENTION:</b> Professional staff will be retrained on the need to provide day service providers with amended support plans and accompanying inservice training prior to implementation. The QDDPD will maintain records of inservice training with day service personnel as well as receipt acknowledgements for support documents supplied to day service providers. <b>Responsible Parties:</b>QDDPD, Home Manager, Support Associates, Quality Assurance Team, Operations Team</p>	06/21/2012			

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	<p>Staff #1 (program director) was interviewed on 5/16/12 at 11:02a.m. Staff #1 indicated client #4 was to be kept in line of staff at all times to provide assistance if she attempted to get out of her wheelchair. Staff #1 was not aware client #4's day service provider was not aware of this and did not have program documentation regarding line of sight supervision for client #4.</p> <p>9-3-1(a)</p>			

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W0149	<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.</p> <p>Based on record review and interview, the facility failed for 3 of 10 reportable incidents reviewed (client #5, #6, #7) to implement policy and procedures in regard to completing an investigation in 5 working days and completing an incident report for an observed client injury.</p> <p>Findings include:</p> <p>Record review of the facility's reportable incident reports was done on 5/15/12 at 10:02a.m. The following incidents were documented: 1) Client #5 had a 1/12/12 incident report that alleged staff had used restrictive techniques to wake up client #5. The investigation was documented to have been completed on 1/30/12. 2) Client #6 was documented in her 1/22/12 "Routine Body Assessment" to have a bruise on her right hip. There had not been an incident report completed for the found bruise. The facility professional staff became aware of the found bruise on 2/1/12 during a monthly record review for client #6 and the bruise was reported and investigated. 3) Client #7 was documented in her 1/22/12 "Routine Body Assessment" to have a bruise on the left side of her abdomen. There had not been</p>	W0149	<p><b>CORRECTION:</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, abuse or neglect of the client. Specifically, Direct Support Staff will be retrained regarding immediate reporting of incidents to supervisory personnel and the agency's Operations and Quality Assurance Teams.</p> <p><b>PREVENTION:</b> The agency has added an additional level of supervision at the facility to supplement staff training and oversight. The facility's management will review documentation and maintain contact with staff on all shifts to assure timely incident reporting occurs. Quality Assurance and Operations Team members will review staff training documentation and meet face to face with facility management on an ongoing basis to assure supervisors and direct support staff maintain an understanding of incident reporting requirements. <b>Responsible Parties:</b> QDDPD, Home Manager, Support Associates, Quality Assurance Team, Operations Team</p>	06/21/2012			

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	<p>an incident report completed for the found bruise. The facility professional staff became aware of the found bruise on 2/1/12 during a monthly record review for client #7 and the bruise was reported and investigated.</p> <p>The facility's policy and procedures were reviewed on 5/16/12 t 10:45a.m. The policy titled "Investigations" (dated 9/14/07) indicated: "Ensure alleged incidents of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date the allegation was made and investigation was initiated." The facility policy titled "Incident Management Adept Incident Reports and BDDS Reportables" dated 9/14/07 indicated: "All Adept employees are required to complete a written incident report when encountering any incident involving changes in an individual's physical condition, mental status, or any unusual event. This includes but is not limited to possible injury to an individual."</p> <p>Interview on 5/16/12 at 11:02a.m. of professional staff #1 indicated the facility did not have documentation of incident reports for the 1/22/12 found bruises for clients #6 and #7. Staff #1 indicated incident reports should have been written</p>				

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	<p>on 1/22/12 for the observed injuries. Staff #1 indicated the 1/12/12 incident investigation for client #5 had not been completed in five working days.</p> <p>9-3-2(a)</p>			

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed for 1 of 3 reportable incident investigations reviewed (client #5) to ensure reportable incident investigation results were completed and reported to the administrator within five working days.</p> <p>Findings include:</p> <p>Record review of facility reportable incidents was done on 5/15/12 at 10:02a.m. Client #5 had a reportable incident report on 1/12/12 that indicated staff had used restrictive techniques to wake up client #5. An investigation had begun on the reportable event on 1/12/12. The investigation summary had not been completed and reported to the administrator until 1/30/12.</p> <p>Staff #1 (program director) was interviewed on 5/16/12 at 11:02a.m. Staff #1 indicated the investigation of client #5's 1/12/12 was not completed until 1/30/12. Staff #1 indicated the investigation had not been completed in five working days.</p>	W0156	<p><b>CORRECTION:</b> <i>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Specifically the agency has established a separate Quality Assurance Department to assist with prompt completion of investigations. The Quality Assurance Manager will oversee investigations into allegations of abuse, neglect and mistreatment and will report the results of investigations to the Executive Director within 5 working days.</i></p> <p><b>PREVENTION:</b> The Quality Assurance Team will conduct informal daily investigation status meetings to assure the investigation process remains on track for timely completion. The Quality Assurance Manager will delegate specific investigation tasks in order to streamline the investigative process. The Quality Assurance Team will periodically audit completed investigations to amend the investigation process as needed to assure compliance. Responsible Parties: QDDPD, Home Manager, Support Associates, Quality Assurance Team, Operations Team</p>	06/21/2012			

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W0473	<p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature.</p> <p>Based on observation and interview, the facility failed for 7 of 7 clients (#1, #2, #3, #4, #5, #6, #7) who reside in the group home, to ensure the clients received milk (supper) at an appropriate temperature, within 15 minutes upon removal from the temperature control device.</p> <p>Findings include:</p> <p>An observation was done at the group home on 5/14/12 from 4:24p.m. to 6:48p.m. At 5:03p.m. client #5 put a gallon of milk on the dining room table for supper. The milk remained on the dining room table until 6:20p.m. when clients #1, #2, #3, #4, #5, #6 and #7 came to the ding room table for supper. The milk was on the table for 77 minutes before clients were to be served the milk.</p> <p>Interview of professional staff #2 on 5/14/12 at 6:21p.m. indicated the milk should not have been left out at room temperature when not in use.</p> <p>9-3-8(a)</p>	W0473	<p><b>CORRECTION:</b> <i>Food must be served at appropriate temperature.</i> Direct support staff have been retrained regarding the need to serve food in a manner that prevents the spread of infection by serving it at an appropriate temperature and specifically that milk must be served within 15 minutes of removal from the refrigerator.</p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to provide ongoing supervision during meal preparation and during family style dining to assure foods are served at an appropriate temperature. Additionally, members of the Operations and Quality Assurance Teams will periodically observe active treatment sessions at the facility, on an ongoing basis, to assure food is served at an appropriate temperature. <b>Responsible Parties:</b> QDDPD, Home Manager, Support Associates, Quality Assurance Team, Operations Team</p>	06/21/2012			

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W0474	<p>483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 4 sampled clients (#1, #2) to ensure the clients' received chopped meat as prescribed by the physician's order.</p> <p>Findings include:</p> <p>An observation was done at the group home on 5/14/12 from 4:24p.m. to 6:48p.m. Clients #1 and #2 received regular style (on the bone) chicken wings at supper.</p> <p>The record for client #1 was reviewed on 5/15/12 at 12:40p.m. Client #1 had physician's orders on 4/20/12 to receive a mechanical soft diet with chopped meat. The Dietician had ordered a mechanical soft diet with chopped meat on 3/10/12.</p> <p>The record for client #2 was reviewed on 5/15/12 at 1:25p.m. Client #2 had physician's orders on 4/20/12 to receive a chopped consistency diet. The Dietician had ordered a chopped consistency diet on 3/15/12.</p> <p>Interview of staff #1 on 5/16/12 at 11:02a.m. indicated clients #1 and #2</p>	W0474	<p><b>CORRECTION:</b> <i>Food must be served in a form consistent with the developmental level of the client.</i> Specifically, Staff have been retrained on dining plans for Clients #1 and #2, and their diets are being prepared and served as prescribed. <b>PREVENTION:</b> Professional staff will be retrained regarding the need to provide ongoing supervision during meal preparation and during family style dining to assure foods are prepared and served in an appropriate texture. Additionally, members of the Operations and Quality Assurance Teams will periodically observe active treatment sessions at the facility, on an ongoing basis, to assure food is prepared and served per prescribed diets. <b>Responsible Parties:</b> QDDPD, Home Manager, Support Associates, Health Services Team, Quality Assurance Team, Operations Team</p>	06/21/2012	

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	<p>should have been served their chicken chopped up as per their physician ordered diets.</p> <p>9-3-8(a)</p>			