

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G244 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>10/16/2012 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA | STREET ADDRESS, CITY, STATE, ZIP CODE<br>9160 E 300 N<br>CHURUBUSCO, IN 46723 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| W0000              | <p>This visit was for the investigation of complaint #IN00116722.</p> <p>Complaint #IN00116722: Substantiated. Federal and state deficiencies related to the allegation are cited at W331 and W460.</p> <p>Dates of Survey: October 15 and 16, 2012.</p> <p>Facility number: 000767<br/>Provider number: 15G244<br/>AIM number: 100243300</p> <p>Surveyor:<br/>Susan Reichert, Medical Surveyor III,<br/>Team Leader</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 10/18/12 by Tim Shebel, 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.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G244 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                  |  | X3) DATE SURVEY COMPLETED<br><br>10/16/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>9160 E 300 N<br>CHURUBUSCO, IN 46723 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE  |  |   |  |
| W0331   | <p>483.460(c)<br/>NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 1 of 2 sampled clients (client A), to assess client A's chewing ability after an episode of choking, and failed to address hospital discharge instructions to monitor temperature after surgery.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 10/15/12 at 4:25 PM.</p> <p>1. A report dated 9/14/12 indicated client A had choked on food, requiring back blows to dislodge the food, taken to the ER for evaluation and released without findings. The report indicated client A's dining plan had been followed.</p> <p>Client A's records were reviewed at the group home on 10/15/12 at 6:03 PM. Hospital discharge instructions dated 9/14/12 indicated in part, "Risk Factors for choking episodes include the following:....The plate in upper dentures can block the ability to feel the size of the food that is bitten off, causing difficulty in swallowing...." A nutritional</p> | W0331   | <p>The facility will continue to provide clients with nursing services in accordance with their needs. The facility will assess clients after an episode of choking and address hospital discharge instructions to monitor temperature after surgery. A goal was developed for client A to take a drink between each bite and for staff to continue encouraging him to slow down while eating. All staff were trained on client A's dietary, risk for choke plan and post hospitalization procedures on 10/19/12. Post hospitalization will include a checklist that will address specific instruction post discharge. Client A saw his dentist on 10/22/12 and had his bottom dentures adjusted. A dietician has been contacted and scheduled to complete a meal observation on 11/2/12, for any further ways to assist client A. The house manager and QMRP will complete weekly observations to ensure that client A's diet and goal are being implemented.</p> | 11/02/2012  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G244 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>10/16/2012 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA | STREET ADDRESS, CITY, STATE, ZIP CODE<br>9160 E 300 N<br>CHURUBUSCO, IN 46723 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
|                    | <p>assessment (undated, but marked quarterly) indicated client A was to receive small, chopped/ground foods, straws for drinks and indicated "no reported swallowing deficits, but staff noted that [client A] has not been chewing foods well which has led to choking episodes. Had remaining teeth extracted and now uses dentures...." A nutritional assessment dated 8/8/12 indicated "No reported swallowing deficits, but staff noted that [client A] has not been chewing foods well which has led to choking episodes...A swallow study 8/8/12, results not reported at this time...." A swallow study dated 8/8/12 indicated client A was to receive a mechanical soft with chopped or ground meats, and "penetration of thin liquids, via straws, increases aspiration risk. Consider avoiding straws if possible...." A revised dining plan dated 10/8/12 indicated staff will monitor at all times with food and fluid intake by sitting beside him during all meals and snacks, staff will encourage slow intake of food and fluid by taking a drink between each bite.</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 10/15/12 at 6:03 PM. She indicated client A's dietitian was contacted and would be assessing him on 10/19/12. She indicated client A's dentures were going to be</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G244 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>10/16/2012 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA | STREET ADDRESS, CITY, STATE, ZIP CODE<br>9160 E 300 N<br>CHURUBUSCO, IN 46723 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
|                    | <p>examined, but he had not yet been seen. She indicated client A's interdisciplinary team (IDT) had revised his plan to include increased staff monitoring and sips of liquid between bites of food. She indicated client A had an episode of choking in June, 2012, and a swallow study had been completed after that episode. She indicated there had not been an evaluation of client A's swallowing ability by a speech pathologist or dietitian since the choking episode on 9/14/12 as the IDT had determined there would be no change in the evaluation results, but client A's physician was aware of the episode.</p> <p>The House Manager was interviewed on 10/15/12 at 6:15 PM. He indicated he was nearby when client A choked on 9/14/12 and client A's dining plan had been followed. He indicated client A had been monitored for signs and symptoms of aspiration after the choking episode.</p> <p>A BDDS report dated 6/6/12 was reviewed on 10/16/12 at 1:05 PM indicated client A had coughed while eating food, had expelled the food without staff assistance and had gone to the ER to be assessed with no findings listed in the report.</p> <p>Client A's record was reviewed again at</p> |               |   |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G244 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>10/16/2012 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA | STREET ADDRESS, CITY, STATE, ZIP CODE<br>9160 E 300 N<br>CHURUBUSCO, IN 46723 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
|                    | <p>the facility office on 10/16/12 at 1:30 PM. Dental Consult Report notes dated 1/10/12 indicated client A had received dentures and "to contact us for future needs...." There was no evidence in the record of client A's dentures having been assessed since January, 2012.</p> <p>The group home nurse was interviewed on 10/16/12 at 1:45 PM. She indicated she had observed client A during meals and had not noted swallowing problems, but had made the recommendation for client A's dentures to be evaluated by the dentist. She indicated client A had an appointment with the dentist on 10/22/12.</p> <p>2. A BDDS report dated 9/23/12 indicated client A was taken to the hospital after experiencing a seizure and was admitted. The report indicated client A was diagnosed with pneumonia and a bowel obstruction after his admission to the hospital, underwent surgery to address the bowel obstruction, and was discharged on 10/8/12.</p> <p>Client A's records in the group home were reviewed on 10/15/12 at 6:03 PM. Hospital discharge instructions for 10/8/12 indicated "Call your doctor if you have chills or fever of over 101 (by mouth). A follow up checklist for client</p> |               |   |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G244 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>10/16/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>9160 E 300 N<br>CHURUBUSCO, IN 46723                                   |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
|   | <p>A dated 10/8/12 did not indicate monitoring client A's temperature. A vital signs monitoring form indicated client A's temperature had been monitored on 9/20/12 and again on 10/11/12. There was no other evidence of client A's temperature having been monitored.</p> <p>The House Manager was interviewed on 10/15/12 at 6:15 PM. When asked if client A's temperature had been evaluated after his discharge on 10/8/12, he indicated it had been monitored weekly. When asked how staff were to determine if client A had a fever if it was monitored weekly, he stated, "Good question," and indicated there was no other evidence of client A's temperature was monitored after his discharge from the hospital on 10/8/12.</p> <p>This federal tag relates to complaint #IN00116722.</p> <p>9-3-6(a)</p> |   |   |                      |   |

|   |   |   |  |   |   |   |                      |
|---|---|---|--|---|---|---|----------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G244 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                  |   | X3) DATE SURVEY COMPLETED<br><br>10/16/2012 |                      |
| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>9160 E 300 N<br>CHURUBUSCO, IN 46723 |   |   |                      |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   |  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |   | (X5) COMPLETION DATE |
| W0460   | <p>483.480(a)(1)<br/>FOOD AND NUTRITION SERVICES<br/>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based upon observation, record review, and interview for 1 of 4 sampled clients (client C), the facility failed to ensure his food was prepared to the consistency as specified in his diet plan.</p> <p>Findings include:</p> <p>Observation were completed in the group home on 10/15/12 from 5:00 PM until 6:03 PM. During the evening meal, client C was served a slice of pizza not less than 3 inches by 4 inches which he ate in 3 bites.</p> <p>The House Manager was interviewed on 10/15/12 at 7:06 PM. When asked if it was in keeping with client C's dining plan to eat his pizza slice in 3 bites, he indicated it was not consistent with client C's plan.</p> <p>Client C's record was reviewed on 10/15/12 at 7:05 PM in the group home. A 5/9/12 nutritional assessment indicated client C was to receive "cut foods, bread and sandwiches to small pieces...receives only half portions on his plate at one time which has helps (sic) the chugging and</p> |   |  | W0460   | <p>Each client will receive a nourishing well-balanced diet including modified and specially-prescribed diets. The facility will ensure that food is prepared to the consistency as specified in the diet plan. All staff were retrained on client C's diet plan on 10/19/12. The house manager and QMRP will complete weekly observations to ensure that client A's diet is being implemented.</p> |   | 10/30/2012           |

|   |   |   |   |   |  |   |  |
|---|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G244 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                  |  | X3) DATE SURVEY COMPLETED<br><br>10/16/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>9160 E 300 N<br>CHURUBUSCO, IN 46723 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE  |  |   |  |
|   | <p>stuffing of foods...."</p> <p>Client C's record in the office was reviewed on 10/16/12 at 2:30 PM. An 8/8/12 nutritional assessment indicated client C was receive "cut foods, bread and sandwiches to small pieces...receives only half portions on his plate at one time which has helps (sic) the chugging and stuffing of foods...." A dining plan dated 9/27/12 indicated client A was to receive "cut food, bread, sandwiches into small pieces...Give small bites at a time...1/2 portions at a time...Remind to slow down."</p> <p>The Director of Supported Group Living was interviewed on 10/16/12 at 2:35 PM. She indicated the Qualified Mental Retardation Professional (QMRP) had indicated staff had cut client C's pizza into half portion. The Director indicated client A's food should have been cut into smaller pieces.</p> <p>This federal tag relates to complaint #IN00116722.</p> <p>9-3-8 (a)</p> |   |   |   |  |   |  |