

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G303		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/18/2013	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 12736 EVAN LN AURORA, IN 47001			
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 9, 10, 11 and 18, 2013.</p> <p>Facility Number: 000822 Provider Number: 15G303 AIM Number: 100243630</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 10/28/13 by W. Chris Greeney, 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><b>483.410(a)(1) GOVERNING BODY</b></p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure: ___ Client #1's, #2's, #3's, #4's, #5's, #6's, #7's and #8's home had enough furniture to be comfortable and provided a home like atmosphere for the clients.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/9/13 between 5 PM and 6 PM. The group home is a newly built home with a large main open room and cathedral ceiling. The one room consists of the living area, dining area and the kitchen. The floors throughout the home were wood, no area rugs and sounds/voices echoed throughout the home. The walls were white and bare, nothing hanging on the walls. In the living area there was a small television on a table in the corner of the room. In the same area was one small recliner, a love seat and a wooden rocker. Client #4 lay on a small bean bag on the floor and nearby the TV. There was only one living area in the home and it contained enough seating for 4 people. There were 8 clients in the group home.</p> <p>Telephone interview with client #4's legal guardian/mother on 10/18/13 at 1 PM indicated the recliner belonged to her daughter (client #4). Client #4's mother indicated she was not aware there was a bean bag in the group home and she did not want her daughter laying on one. Client #4's mother indicated her daughter was to be</p>	W000104	<p>W104: The governing body must exercise general policy, budget, and operating direction over facility. Corrective action:· Couch has arrived and is in home, pictures, plant, area rug, have been purchased for placement in home (Attachment A).· Bean bag has been removed form home. NOTE: See W125</p> <p>W130 W148 W149                      W154 How we will identify others: Clinical Supervisors will ensure that common areas have enough seating for the number of clients in the home. Measures to be put in place: EDOM Site Visit Checklist will be implemented to check that furniture is sufficient and in good repair (Attachment B).. Monitoring of Corrective Action: Periodic Service reviews, including BIC, will be performed periodically by Quality Assurance, Operations Manager, and Program Manager to ensure that homes have furniture, home like atmosphere, policies, procedures, and active treatment protocols are being implemented, and unknown injuries are being investigated per policy. Completion Date: 11-8-201311-19-2013-Addendum</p>	11/08/2013			

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	<p>sitting and/or laying in her recliner. Client #4's mother stated the home was "stark and institution like." Client #4's mother stated, "There's not enough seating for all of them (clients #1, #2, #3, #4, #5, #6, #7 and #8) to sit down in the living room and I don't understand why they don't get more furniture. They have the room."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the GHM (Group Home Manager) on 10/18/13 at 4 PM indicated the facility had ordered a couch for the living room. The GIDP and GHM did not know where the bean bag came from and how client #4 ended up with it.</p> <p>2. Please see W125. The governing body failed to exercise general policy and operating direction over the facility to ensure the clients' rights in regard to restricting clients #1, #2, #3, #4, #5, #6, #7 and #8 from access to the sharps.</p> <p>3. Please see W130. The governing body failed to exercise general policy and operating direction over the facility to ensure client #3 was provided personal privacy while showering/bathing.</p> <p>4. Please see W148. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility notified client #1's, #2's, #3's, #4's, #5's, #6's, #7's and #8's families and legally appointed representatives of two infestations of bed bugs in the group home.</p> <p>5. Please see W149. The governing body failed to exercise general policy and operating direction over the facility to ensure the all injuries of unknown origin were investigated in regard to client #4.</p> <p>6. Please see W154. The governing body failed to</p>		: Clinical Supervisors will perform weekly Active Treatment observations. Operations Manager will perform bi-monthly EDOM checklist. Program Manager will perform bi-annually.				

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	exercise general policy and operating direction over the facility to ensure all injuries of unknown origin were investigated in regard to client #4.  9-3-1(a)				

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W000120	<p><b>483.410(d)(3)</b> <b>SERVICES PROVIDED WITH OUTSIDE SOURCES</b></p> <p>The facility must assure that outside services meet the needs of each client. Based on observations, record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure the DP (Day Program) followed client #4's ISP/BSP (Individual Support Plan/Behavior Support Plan) and provided client #4 a sanitary environment while at the DP.</p> <p>Findings include:</p> <p>Observations were conducted at the DP on 10/10/13 between 8:45 AM and 10:30 AM. At 8:45 AM client #4 was in a small room with 6 other consumers and 2 staff. Client #4 was laying on a twin size bed in the corner of the room, sucking her thumb and mouthing at the palms of her hands. At 9:15 AM client #4 got up from the bed and walked over to the small couch and lay down. Staff #1 asked client #4 "Do you want to come color a pumpkin with us?" Client #4 did not respond to DP staff #1. Client #4 began waving her hands in the air and then began mouthing the palms of her hands. During this observations the staff did not offer client #4 a choice of alternate sensory items and/or activities when displaying SIB (self injurious behaviors). The staff was not observed to clean the bed and/or change the sheets on the bed after client #4 got up from the bed.</p> <p>Client #4's record was reviewed on 10/10/13 at 12 PM. Client #4's ISP dated 9/23/13 indicated client #4 had diagnoses of, but not limited to, Autism, Severe MR (Mental Retardation) and hearing impaired. The ISP indicated client #4 "requires a consistent routine to maximize her potential. She enjoys her vibrating toys, recliner, sitting outside in the sun, and engages in various forms of self</p>	W000120	<p>W120: The facility must assure that outside services meet the needs of each client. Corrective action: New Horizons staff have been inserviced on Client #4's ISP, BSP, Active treatment, and Changing Area Protocol (Attachment C). How we will identify others: Clinical Supervisors will observe Active treatment at New Horizons Workshop to ensure that Active Treatment is being implemented per client plans. Cleaning of changing table will also be observed. Measures to be put in place: Day Training Observation form will be implemented (Attachment D). Monitoring of Corrective Action: Operations Manager, Clinical Supervisors, and New Horizons Management staff will hold monthly meeting to review Day Program observations (Attachment E) Completion Date: 11-8-2013 11-19-2013-Addendum : Weekly Workshop observations will be performed by Clinical Supervisors.</p>	11/08/2013			

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	<p>stimulation, including self injurious behavior. Staff provides sensory stimulating activities on a daily basis. Client #4's BSP of 9/23/13 indicated client #4 had targeted behaviors of SIB (self injurious behaviors) defined as: hitting and/or slapping herself, biting the heel of her hands, and/or banging her elbows/legs on items. The BSP indicated client #4 had non-abusive self-stimulation defined as: sucking her thumb, grinding her teeth, holding her breath, waving her fingers/hands in the air and stomping her feet. The BSP indicated "Through functional assessment, it was determined that the self-abuse, ongoing non-abusive self stimulation, and public masturbation have caused or can cause the most interruption in [client #4's] daily life and are ongoing safety risks. Sensory integration activities will be implemented to assist in lowering the amount of inappropriate sensory stimulation by increasing her ability to process information through her senses." The BSP indicated proactive strategies of, but not limited to: the staff were to engage client #4 in sensory integration activities to increase client #4's appropriate use of her senses and to provide client #4 with a favored sensory stimulation activity like lighted items, things that vibrate and items with various textures to touch. The BSP indicated reactive strategies for non-abusive self-stimulation was to offer client #4 choices of her "favored/appropriate self stimulant activity or training opportunity."</p> <p>During interview with DP staff #1 on 10/10/13 at 9:45 AM, DP staff #1 stated, "It's hard to get her (client #4) to participate in activities when all she wants to do is lay down." DP staff #1 indicated the twin bed in the corner was used as a changing bed for incontinent clients and pointed to other clients in the room in wheelchairs that also used the bed. Staff #1 indicated client #4 likes to lay on the bed and "we try to redirect her before she lays down,</p>			

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	<p>but that's not always easy to do." DP staff #1 indicated the sheets are changed daily.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/13 at 1 PM, the QIDP stated when client #4 was exhibiting SIB, the staff were to follow client #4's BSP and "should have" offered client #4 alternate sensory stimulating objects.</p> <p>Telephone interview with the GHM (Group Home Manager) on 10/18/13 at 4 PM indicated the staff at the DP were to follow client #4's plan of care and were to provide a sanitary environment for all of the clients at all times. The GHM stated the bed at the DP "should be cleaned and the sheets changed" between each client and client #4 "shouldn't be lying on the bed unless she's being changed."</p> <p>9-3-4(a)</p>			

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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the clients' rights in regard to restricting the clients from access to the sharps.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 8/16/13 at 2 PM. The facility records indicated no incidents and/or attempts of improper use of sharps for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Observations were conducted at the group home on 10/9/13 between 5 PM and 6 PM and on 10/10/13 between 5:45 AM and 7 AM. During both observations the sharp knives and scissors were stored in a lidded plastic box on top of the refrigerator.</p> <p>Client #1's record was reviewed on 10/10/13 at 2 PM. Client 1's record indicated no need to restrict client #1 from sharp objects.</p> <p>Client #2's record was reviewed on 10/10/13 at 1 PM. Client 2's record indicated no need to restrict client #2 from sharp objects.</p> <p>Client #3's record was reviewed on 10/10/13 at 11 AM. Client 3's record indicated no need to restrict client #3 from sharp objects.</p>	W000125	<p>W125: The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Corrective action: Staff have been inserviced on ensuring that all sharps are available to clients unless a rights restriction has been implemented (Attachment F). Sharps have been placed in cutlery drawer. How we will identify others: Clinical Supervisors will ensure that all sharps are available in home unless a rights restriction is in place. Measures to be put in place: Clinical Supervisors will perform weekly active treatment observations (Attachment G) to ensure that sharps are available. Monitoring of Corrective Action: Periodic Service reviews, including BIC, will be performed periodically by Quality Assurance, Operations Manager, and Program Manager to ensure that rights restrictions are being implemented</p>	11/08/2013
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	<p>Client #4's record was reviewed on 10/10/13 at 12 PM. Client 4's record indicated no need to restrict client #4 from sharp objects.</p> <p>Interview with staff #1 on 10/9/13 at 6 PM indicated the sharp knives and scissors were stored in a lidded box on top of the refrigerator and whenever clients #1, #2, #3, #4, #5, #6, #7 and #8 wanted something from the box, the clients would have to ask the staff. Staff #1 indicated the sharps were put in the box because client #2 liked to cut straws and craft items and she might cut herself if client #2 was to use the items without assistance. When asked if clients #1, #2, #3, #4, #5, #6, #7 and #8 could reach the box on the refrigerator, staff #1 stated clients #3 and #6 "maybe could, but they ask when they want to use it."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/13 at 1 PM, the QIDP stated, "To my knowledge" there was no reason to restrict clients #1, #2, #3, #4, #5, #6, #7 and #8 from free access to the sharps."</p> <p>9-3-2(a)</p>		appropriately. Completion Date: 11-8-2013		

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W000130	<p><b>483.420(a)(7)</b> <b>PROTECTION OF CLIENTS RIGHTS</b> The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #3), the facility failed to provide client #3 personal privacy while showering/bathing.</p> <p>Findings include:</p> <p>Interview with staff #1 on 10/10/13 at 6 AM indicated the staff stand in the bathroom while client #3 showered and/or bathed to ensure the client used adequate soap/shampoo and bathed adequately. Staff #1 indicated client #3 was higher functioning than the other clients in the group home.</p> <p>During interview with client #3 on 10/10/13 at 8:45 AM while at the workshop, client #3 was asked if she had any concerns or issues she wanted to discuss and client #3 stated, "Yes, I don't understand why the staff have to stand in the bathroom the whole time while I'm taking a shower. It makes me feel uncomfortable and I don't like it." Client #3 stated, "I am higher functioning than the others and I don't think they (the staff) should have to be in the bathroom the whole time with me like they do the others." Client #3 indicated the staff were present when she undressed, stepped into the shower, showered and got out of the shower to dry off.</p> <p>Client #3's record was reviewed on 10/10/13 at 11 AM. Client #3's 6/4/13 ISP (Individual Support Plan) indicated client #3 was a young woman, previously married for 13 years, had 2 children and was currently divorced. The ISP indicated</p>	W000130	<p>W130: The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Corrective action: Client #3's hygiene goal has been revised (Attachment H). Staff have been inserviced on revision (Attachment F). How we will identify others: Clinical Supervisors will review personal hygiene goals to ensure that clients are afforded privacy and safety per policy. Measures to be put in place: Comprehensive Functional Assessments will be reviewed periodically to ensure that goals are written specific to client abilities and safety requirements. Monitoring of Corrective Action: Operations Manager will periodically perform chart reviews to ensure that goals are written to provide privacy and supervision per policy. Completion Date: 11-8-2013-11-19-2013-Addendum : Operations Manager will review Client Goals quarterly (Attachment #1). Clinical Supervisors will perform weekly Active Treatment observations, including personal hygiene, to ensure client privacy (Attachment #2).</p>	11/08/2013			

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	<p>client #3 "...needs to be monitored while bathing and completing oral and personal hygiene." Client #3's ISP personal hygiene objective indicated the staff will monitor client #3 while showering/bathing and prompt her at each opportunity to add the appropriate amount of shampoo or soap to the appropriate places on her body. The ISP did not indicate how the staff were to provide client #3 personal privacy while bathing while monitoring client #3 as she showered/bathed.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/13 at 1 PM, the QIDP stated, "I think she wanted us to stay in there with her when she first came here, but I'm not sure." The QIDP indicated client #3 was admitted in June of 2010. The QIDP indicated whenever a client had a hygiene and/or bathing objective or had a diagnosis of seizure disorders, the staff were to stay in the bathroom with the client while showering and bathing to ensure the objective was met and/or for the client's safety. The QIDP indicated all clients were to be prompted and assisted with their personal privacy.</p> <p>9-3-2(a)</p>			

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W000148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp;</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8, the facility neglected to notify the clients' families and legally appointed representatives of 2 infestations of bed bugs in the group home.</p> <p>Findings include:</p> <p>The facility's reportable records were reviewed on 10/9/13 at 2 PM. The facility records indicated no reports of bed bug infestation in February and May of 2013 and no notification to the families and/or legal representatives of all the clients in the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8) of a bed bug infestation.</p> <p>Review of the facility receipts from professional exterminators on 10/10/13 at 1 PM indicated bedbugs were found in the group home on 2/12/13 and again on 5/17/13.</p> <p>Review of the 5/30/13 facility "Bed Bug Protocol" on 10/10/13 at 1 PM indicated guardians, HCRs (Health Care Representatives) and families were to be notified of a bed bug infestation.</p> <p>Telephone interview with client #4's legally sanctioned representative on 10/18/13 at 1 PM indicated she was not informed of the bed bug infestation in February. Client #4's representative indicated she found out about the infestation when</p>	W000148	<p>W148: The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Corrective action: Bed Bug Protocol has been implemented, including notification of families, guardians (Attachment I) and staff have been inserviced (Attachment F). Staff will continue to receive monthly and Annual training on client Behavior Support Plans, Abuse and Neglect (Attachment B). How we will identify others: Clinical Supervisors will be trained in Bed Bug Protocol to ensure that Guardians, families are notified. Measures to be put in place: Bed Bug Protocol (Attachment I) has been implemented. Monitoring of Corrective Action: Operations Manager and Quality Assurance Manager will review Incident report to ensure that guardians and families have been notified per protocol. Completion Date: 11-8-201311-19-2013-Addendum : Operations Manager, Quality</p>	11/08/2013			

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	<p>she went to visit client #4 at the group home and found client #4's personal items outside on the back patio of the home. Client #4's representative stated, "It just made me sick. They should have called me to let me know. I should not have had to walk into that."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/13 at 2 PM stated, "I'm new to the group home, so I don't know if the families were notified or not."</p> <p>9-3-2(a)</p>		Assurance Manager will ensure that Bed Bug Protocol, including notification of guardians, families, is implemented for every infestation.	

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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 1 of 4 sampled clients (#4), the facility failed to implement its policy and procedures to ensure all injuries of unknown origin were investigated.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 10/9/13 at 2 PM. The facility records indicated no investigations in regard to injuries of unknown origin for client #4.</p> <p>Client #4's record was reviewed on 10/10/13 at 12 PM and on 10/18/13 at 4 PM. Client #4's Behavior Data Records (BDRs) indicated SIB (Self Injurious Behavior) was defined as client #4 hitting/slapping herself, biting the heel of her hands and/or banging her elbows/legs on items. The BDRs indicated each time client #4 exhibited SIB the staff were to place a hash mark on client #4's BDRs and then the hash marks were tallied each day. The BDRs did not distinguish what behavior the client was exhibiting with each hash mark and/or any injury (scratches and/or bruises) received due to SIB.</p> <p>Client #4's daily progress notes of 10/9/13 indicated "bruise on right lower leg in front (lower calf) looks consistent with her taking her other foot with the heel and hitting it against her leg. Measure at 1 x 1.5 inches." The note indicated the staff notified the nurse and the QIDP (Qualified Intellectual Disabilities Professional).</p> <p>Client #4's Daily Skin Assessments (DSAs) indicated:</p>	W000149	<p>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Corrective action: Client #4's SIB definitions have been revised to define her SIB behaviors (Attachment J). Staff have been inserviced on correct documentation of the behavior data record and the daily skin assessment form (Attachment F). How we will identify others: Clinical Supervisors will review Behavior Data Records to ensure correct documentation is being done, including description of any apparent injury.. Measures to be put in place: Reviewing client incidents at monthly staff meetings to ensure that all documentation is correct and timely.. Monitoring of Corrective Action: Operations Manager and Quality Assurance will be notified per policy of any unknown injury and investigation, if indicated, will be done. Completion Date: 11-8-2013 Measures to be put in place: Reviewing client incidents at monthly staff meetings to ensure that all documentation is correct and timely. 11-19-2013-Addendum: Incident Reporting Process has been implemented, including the</p>	11/08/2013			

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	<p>7/13/13 "Light small bruise" (location not indicated).</p> <p>7/14/13 "Light small bruise" (location not indicated).</p> <p>7/15/13 "Fading bruise, almost gone."</p> <p>7/16/13 "Fading bruise, almost gone."</p> <p>8/15/13 "Scratch on her chest."</p> <p>8/16/13 "Scratch on her chest."</p> <p>8/17/13 "Scratch on her chest."</p> <p>8/18/13 "Scratch fading, spot on back of left leg."</p> <p>8/20/13 "Scratch on chest going away spot on back of left leg gone."</p> <p>10/9/13 "Lower right leg in front, round 1 x 1.5 inch bruise outer is dark, lighter in color in the middle."</p> <p>10/10/13 "Lower right leg in front round 1 x 1/5 inch bruise little lighter."</p> <p>10/11/13 "Left leg lower shin 1 x 3 inch round dark bruise in color."</p> <p>10/12/13 "Left leg lower shin 1 x 3/4 inch round bruise getting some lighter in color. Left lower right leg in front bruise 1 x 1.5 inch is fading."</p> <p>10/15/13 "Left leg lower shin from incident on 10/11/13 still shows bruising 1 x 3/4 inch due to SIB. Assessed by [names of staff]."</p> <p>10/16/13 Left leg left lower shin from incident on 10/11/13 shows bruising, starting to get lighter in color."</p> <p>During telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) and the GHM (Group Home Manager) on 10/18/13 at 4 PM, the QIDP stated, "Most of [client #4's] injuries are from her SIB." The GHM stated the staff were to document and describe each SIB on the back of client #4's BDRs which "should" explain the bruises and scratches documented on the DSAs. The QIDP indicated the staff did not document a description of client #4's SIB on the back of the BDRs. The QIDP could not explain the injuries noted on the DSAs. The GHM</p>		<p>assignment of investigations to Investigator as deemed appropriate (Attachment #3). Monitoring of Corrective Action: Operations Manager and Quality Assurance will be notified per policy of any unknown injury and investigation, if indicated, will be done. 11-19-2013-Addendum: Executive Director, Investigation Committee will review all investigations to ensure that they are completed per policy and procedure.</p>				

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	indicated all injuries of unknown origin were to be investigated.  9-3-2(a)				

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W000154	<p><b>483.420(d)(3)</b> <b>STAFF TREATMENT OF CLIENTS</b> The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 5 of 6 injuries of unknown source reviewed, the facility failed to conduct an investigation in regard to client #4's injuries of unknown origin.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 10/9/13 at 2 PM. The facility records indicated no reports and/or investigations in regard to injuries of unknown origin for client #4.</p> <p>Client #4's record was reviewed on 10/10/13 at 12 PM and on 10/18/13 at 4 PM. Client #4's daily progress notes of 10/9/13 indicated "bruise on right lower leg in front (lower calf) looks consistent with her taking her other foot with the heel and hitting it against her leg. Measure at 1 x 1.5 inches." The note indicated the staff notified the nurse and the QIDP (Qualified Intellectual Disabilities Professional).</p> <p>Client #4's Daily Skin Assessments (DSAs) indicated: 7/13/13 "Light small bruise" (location not indicated). 8/15/13 "Scratch on her chest." 8/18/13 "Spot on back of left leg." 10/9/13 "Lower right leg in front, round 1 x 1.5 inch bruise outer is dark, lighter in color in the middle." 10/11/13 "Left leg lower shin 1 x 3 inch round dark bruise in color."</p> <p>During telephone interview with the QIDP</p>	W000154	<p>W154: The facility must have evidence that all alleged violations are thoroughly investigated. Corrective action: Client #4's SIB definitions have been revised to define her SIB behaviors (Attachment J). Staff have been inserviced on correct documentation of the behavior data record and the daily skin assessment form (Attachment F). How we will identify others: Clinical Supervisors will review Behavior Data Records to ensure correct documentation is being done, including description of any apparent injury. Measures to be put in place: Review client incidents at monthly staff meetings to ensure that all documentation is correct and timely Attachment K). Monitoring of Corrective Action: Operations Manager and Quality Assurance will be notified per policy of any unknown injury and investigation, if indicated, will be done. Completion Date: 11-8-2013 Measures to be put in place: Review client incidents at monthly staff meetings to ensure that all documentation is correct and timely Attachment K). 11-19-2013-Addendum: Incident Reporting Process has been implemented, including the</p>	11/08/2013			

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	(Qualified Intellectual Disabilities Professional) and the GHM (Group Home Manager) on 10/18/13 at 4 PM, the QIDP stated, "Most of [client #4's] injuries are from her SIB." The GHM stated the staff were to document and describe each SIB on the back of client #4's BDRs which "should" explain the bruises and scratches documented on the DSAs. The QIDP indicated the staff did not document a description of client #4's SIB on the back of the BDRs. The QIDP could not explain each injury noted on the DSAs. The GHM indicated all injuries of unknown source were to be investigated.  9-3-2(a)		assignment of investigations to Investigator as deemed appropriate (Attachment #3). Monitoring of Corrective Action: Operations Manager and Quality Assurance will be notified per policy of any unknown injury and investigation, if indicated, will be done. 11-19-2013-Addendum: Executive Director, Investigation Committee will review all investigations to ensure that they are completed per policy and procedure and within 5 days.				

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W000227	<p><b>483.440(c)(4)</b> <b>INDIVIDUAL PROGRAM PLAN</b> The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the clients' Individual Support Plans (ISPs) failed to address the clients' identified training needs in regard to meal preparation and client #3's identified educational needs in regard to smoking cigarettes and safe sex.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/10/13 between 4 PM and 6 PM. Sloppy Joe sandwiches, tater tots and green beans were prepared for the evening meal. Staff #3 placed the tater tots on a baking pan and put them in the oven and browned the hamburger for the sandwiches. When the tater tots were done, staff #3 removed them from the oven. Client #3 assisted to brown the hamburger and to prepare the green beans.</p> <p>Client #1's record was reviewed on 10/10/13 at 2 PM. Client #1's CFA (Comprehensive Functional Assessment) of 9/27/13 indicated client #1 could not prepare a meal independently and required staff assistance. Client #1's ISP of 9/27/13 indicated no objectives to assist client #1 with meal preparation.</p> <p>Client #2's record was reviewed on 10/10/13 at 1 PM. Client #2's CFA of 12/13/12 indicated client #2 could not prepare a meal independently and required staff assistance. Client #2's ISP of 12/13/12 indicated no objectives to assist client #2 with meal preparation.</p>	W000227	<p>W227: The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Corrective Action: IDT's have been held for Client #1, #2, #3, and #4, with new goals being implemented to address identified needs (Attachment L, H, J). Staff have been inserviced on new goals (Attachment F). How we will identify others: Clinical Supervisors will review client goals and Comprehensive Functional Assessments to ensure that necessary goals are being implemented.. Measures to be put in place: Operations Manager and Clinical Supervisor will review Comprehensive Functional Assessments periodically to ensure that needed goals are implemented. Monitoring of Corrective Action: Operations Manager, Quality Assurance will perform periodic service reviews, including goal review, to ensure that client needs are being met. Completion Date: 11-8-2013</p>	11/08/2013	

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	<p>Client #3's record was reviewed on 10/10/13 at 11 AM. Client #3's ISP of 6/4/13 indicated client #3 could cook and prepare simple meals with assistance from staff. Client #3's ISP indicated no objectives to assist client #3 with meal preparation.</p> <p>Client #4's record was reviewed on 10/10/13 at 12 PM. Client #4's CFA of 9/23/12 indicated client #4 could not prepare a meal independently and required staff assistance. Client #4's ISP of 9/23/12 indicated no objectives to assist client #4 with meal preparation.</p> <p>Interview with staff #3 on 10/10/13 at 5 PM indicated clients #1, #2, #3 and #4 were not independent with meal preparation and required staff assistance.</p> <p>Telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/18/13 at 3 PM indicated clients #1, #2, #3 and #4 did not have training objectives in place to assist them with meal preparation. The QIDP indicated meal preparation training was provided informally.</p> <p>2. Observations were conducted at the group home on 10/10/13 between 4 PM and 6 PM. Upon arriving home from the work shop at 4 PM, client #3 went outside the group home and smoked a cigarette.</p> <p>Client #3's record was reviewed on 10/10/13 at 11 AM. Client #3's ISP of 6/4/13 indicated client #3 bought and smoked her own cigarettes. Client #3's CFA of 6/4/13 indicated client #3 was involved with a male, did not have an understanding of sexually transmitted diseases and was at high risk for sexual exploitation. Client #3's ISP of 6/4/13 indicated no objectives to assist client #3 in</p>						

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	<p>understanding the health risks of smoking cigarettes, to assist client #3 to quit smoking, to educate and assist client #3 in safe sex and sexually transmitted diseases.</p> <p>During interview with client #3 at the workshop on 10/10/13 at 8:45 AM indicated client #3 smoked cigarettes. Client #3 indicated she had tried to quit smoking in the past but was unsuccessful. Client #3 indicated she had been married in the past and had 2 children. Client #3 indicated she had a boyfriend that worked at the day program and pointed across the room to a young man.</p> <p>Interview with staff #1 on 10/10/13 at 5 PM indicated client #3 smoked cigarettes. When asked if client #3 had any training objectives in place to teach her the health risks of smoking and/or to stop smoking, staff #1 stated, "Oh, we are always telling her those are bad for her."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/13 at 1 PM indicated client #3 did not have any formal training objectives to assist client #3 the cessation of smoking cigarettes and/or to learn the health risks involved with smoking cigarettes. The QIDP indicated client #3 did not have any formal training objectives to assist client #3 with understanding safe sex and/or sexually transmitted diseases.</p> <p>9-3-4(a)</p>						

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observations, record review and interview for 3 of 4 sampled clients (#1, #2 and #4), the facility failed to ensure the staff followed client #4's ISP/BSP (Individual Support Plan/Behavior Support Plan) and to follow client #1's and #2's dining plans.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/10/13 between 5:45 AM and 7 AM and on 10/10/13 between 4 PM and 6 PM. During both observations, client #4 walked around the group home, lay on a bean bag on the floor and/or lay on the picnic table outside. During all observations client #4 was observed chewing/mouthing on the palms of her hands, sucking on her thumb, waving her hands and arms in the air and dropping down to the floor onto a bean bag. During each observation the staff did not offer client #4 a choice of alternate sensory items and/or activities when displaying SIB (self injurious behaviors).</p> <p>Client #4's record was reviewed on 10/10/13 at 12 PM. Client #4's ISP dated 9/23/13 indicated client #4 had diagnoses of, but not limited to, Autism, Severe MR (Mental Retardation) and hearing impaired. The ISP indicated client #4 "requires a consistent routine to maximize her potential. She enjoys her vibrating toys, recliner, sitting outside in the sun, and engages in various forms of self</p>	W000249	<p>W249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Corrective action: Staff have been inserviced on Client #4's BSP (Attachment F). Staff have been inserviced on correct implementation of Client #1, #2's mealtime safety goals (Attachment F). How we will identify others: Clinical Supervisors Managers will perform Active Treatment observations (Attachment G) to ensure that active treatment is being provided and goals are implemented as written. Measures to be put in place: Active Treatment observations (Attachment G) will be conducted, at minimum weekly, by Clinical Supervisor to ensure that active treatment is</p>	11/08/2013			

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	<p>stimulation, including self injurious behavior. Staff provides sensory stimulating activities on a daily basis. Client #4's BSP of 9/23/13 indicated client #4 had targeted behaviors of SIB defined as: hitting and/or slapping herself, biting the heel of her hands, and/or banging her elbows/legs on items. The BSP indicated client #4 had non-abusive self-stimulation defined as: sucking her thumb, grinding her teeth, holding her breath, waving her fingers/hands in the air and stomping her feet. The BSP indicated "Through functional assessment, it was determined that the self-abuse, ongoing non-abusive self stimulation, and public masturbation have caused or can cause the most interruption in [client #4's] daily life and are ongoing safety risks. Sensory integration activities will be implemented to assist in lowering the amount of inappropriate sensory stimulation by increasing her ability to process information through her senses." The BSP indicated proactive strategies of, but not limited to: the staff were to engage client #4 in sensory integration activities to increase client #4's appropriate use of her senses and to provide client #4 with a favored sensory stimulation activity like lighted items, things that vibrate and items with various textures to touch. The BSP indicated reactive strategies for non-abusive self-stimulation was to offer client #4 choices of her "favored/appropriate self stimulant activity or training opportunity."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/13 at 1 PM, the QIDP stated when client #4 was exhibiting SIB, the staff were to follow client #4's BSP and "should have" offered client #4 alternate sensory stimulating objects.</p> <p>2. Observations were conducted at the group home on 10/10/13 between 4 PM and 6 PM. Clients #1 and #2 ate Sloppy Joe sandwiches, tater tots and</p>		<p>being provided and mealtime safety goals are implemented. Monitoring of Corrective Action: . Operations Manager, Quality Assurance Director/Coordinators will perform periodic service reviews, including Best in Class, to ensure that Active Treatment is present and mealtime safety goals are implemented as written.</p> <p>Completion Date: 11-8-2013 11-19-2013-Addendum: Clinical Supervisors will perform Weekly Active Treatment observations (Attachment #2) to ensure Active Treatment is implemented as written.</p> <p>Operations Manager will perform bi-monthly EDOM checklist, including observation of Active Treatment.</p>				

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	<p>green beans for their evening meal. Clients #1 and #2 were observed to take large bites and eat at a fast pace. Clients #1 and #2 did not set their utensils down between bites and/or take a drink between bites. The staff did not prompt clients #1 and #2 to put their eating utensils down between bites and/or to take a drink after each bite.</p> <p>Client #1's record was reviewed on 10/10/13 at 2 PM. Client #1's ISP dated 9/27/13 indicated client #1 "tends to eat too fast and not swallow before taking another bite. All her meals need to be supervised. [Client #1] needs prompts to take small bites, eat slowly, chew food and swallow before taking another bite." Client #1's ISP indicated client #1 was at risk of choking and had a dining goal to set her utensil down between bites of food.</p> <p>Client #2's record was reviewed on 10/10/13 at 1 PM. Client #2's ISP dated 12/13/12 indicated client #2 was at risk of choking and the staff were to prompt client #2 to set her spoon down and take a drink in between bites.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/13 at 1 PM indicated the staff were to follow the clients' dining plans and ISPs and provide the clients training as indicated in their ISPs.</p> <p>9-3-4(a)</p>			

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure the client's hearing was evaluated annually.</p> <p>Findings Include:</p> <p>Client #4's record was reviewed on 10/10/13 at 12 PM. Client #4's ISP of 9/23/13 indicated a diagnosis of, but not limited to, Hearing Impairment. Client #4's most recent hearing evaluation is dated 3/1/12. Client #4's annual physical by the physician on 10/29/12 did not address client #4's hearing.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/13 at 1 PM indicated client #4 was hearing impaired. The QIDP indicated client #4's hearing evaluation of 3/1/12 was the most current hearing evaluation for client #4.</p> <p>9-3-6(a)</p>	W000323	<p>W323: The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Corrective action: Hearing exam has been scheduled for Client #4, 11-18-13, soonest available. How we will identify others: Nursing Coordinators will review client charts to ensure that hearing exams are performed annually. Measures to be put in place: Nursing Coordinators will review Annual Physicals to ensure that hearing exam has been preformed.. Monitoring of Corrective Action: Nursing Manager, Quality Assurance, will perform periodic reviews, including Best in Class, to ensure that client medical needs are being met per policy. Completion Date: 11-8-2013</p>	11/08/2013			

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division (6. A service delivery site with a structural or environmental problem that jeopardizes or compromises the health or welfare of an individual.).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, record review and interview for 4 of 4 sample clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to notify the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law of an infestation of bed bugs within the group home.</p> <p>Findings include:</p> <p>During observations at the group home on 10/9/13 between 5 PM and 6 PM client #1's, #2's, #3's, #4's, #5's, #6's, #7's and #8's mattresses and box springs were enclosed in plastic covers.</p> <p>Interview with staff #1 on 10/9/13 at 5:30 PM indicated all of the clients' mattresses and box springs were enclosed in plastic covers due to a previous problem with bed bugs. Staff #1 indicated the group home had 2 episodes of bed</p>	W009999	W999: 460 IAC 9-3-1 Governing Body(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division (6. A service delivery site with a structural or environmental problem that jeopardizes or compromises the health or welfare of an individual.). Corrective action: Quality Assurance Manager has been inserviced on reporting procedures for infestations (Attachment M). How we will identify others: Quality Assurance Manager will review all incidents to ensure that infestations have been reported. Measures to be put in place: Bed Bug Protocol has been implemented (Attachment I). Monitoring of Corrective Action: Safety Committee will review infestations to ensure that reporting procedures have been completed. Completion Date: 11-8-2013	11/08/2013			

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	<p>bug infestation within the past 9 months. Staff #1 indicated after the second incident of bed bugs, the company that conducted the extermination instructed the group home staff to place every clients' mattress and box spring into an enclosed plastic cover and not to remove the plastic cover for 18 months. Staff #1 indicated after several inspections made by the exterminators, the group home did not have bed bugs at the present time.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/13 at 2 PM indicated professional exterminators had been to the home due to bed bugs and provided receipts for review. The QIDP indicated she was informed by the GHOM (Group Home Operation Manager/Administrator) infestation of bed bugs was not a reportable incident and had not been reported to BDDS.</p> <p>Review of the facility receipts from the professional exterminators indicated bedbugs were found in the group home on 2/12/13. After extermination, the group home was found to be free of bedbugs on 2/28/13. On 5/6/13 bed bugs were again discovered in the group home. After extermination, the group home was found to be free of bed bugs on 5/17/13.</p> <p>The facility's reportable records were reviewed on 10/9/13 at 2 PM. The facility records indicated no reports of bed bug infestation and/or the need for exterminators.</p> <p>9-3-1(b)</p>						