

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725
---	--

(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 an extended recertification and state licensure survey.</p> <p>Dates of Survey: April 2, 3, 4 and 5, 2012.</p> <p>Facility number: 000737 Provider number: 15G211 AIM number: 100243270</p> <p>Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/17/12 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725			
(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			
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 to implement their neglect policy, for 1 of 1 deceased client (client #6). The facility neglected to ensure client #6's death was thoroughly and timely investigated.</p> <p>Findings include:</p> <p>On 04/02/12 at 1:45 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>03/01/12: A BDDS report submitted 03/01/12 for an incident on 03/01/12 at 1:15 AM indicated the following regarding client #6: "On 3/1/12, at 1:15 am, [client #6] passed away at [hospital]. On 2/29/12, while taking routine vitals, his blood pressure was 78/55 and oxygen saturation was in the 70's. The agency nurse was contacted and instructed staff to call 911. [Client #6] was taken by EMS to [hospital] Emergency Room. Once at the ER, he was given a Dopamine Drip in an attempt to increase his blood pressure. He was admitted for further</p>	W0149	The facility has modified its policy pertaining to the death of an individual. If the death is "expected", the facility will follow DDRS policy number BQIS 460 0530 029 "Mortality Review" and complete an internal review. The provider internal review of death shall, in conjunction with all providers of services to the deceased individual, collect and review documentation of all events, incidents and occurrences in the individuals life for a minimum of the thirty (30) day period immediately before the death of the individual and if applicable, the hospitalization or placement in a hospice setting or nursing facility in which the individual's death occurred. The internal review into the death of an individual shall include identification of the individual involved, the date and time of the death, a statement describing the death including in a time-line format of what happened, where it happened, when it happened and who was involved. It shall also include a narrative summary description of the internal review and how it was executed, identification of all provider staff assigned to work with the individual, identification of all involved provider staff present at	04/27/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725			
(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>observation. His blood pressure continued to drop throughout the morning. [Client #6's] guardian was contacted and requested comfort measures only. All monitors were removed and Dopamine discontinued. [Client #6] passed away at 1:15 am." The undated and unsigned Investigative Case Summary regarding client #6's 03/01/12 incident indicated group home staff were interviewed on 03/16/12.</p> <p>Client #6's records were reviewed on 04/03/12 at 1:00 PM. The Progress Notes dated 02/29/12 indicated, "[Client #6] was awake screaming when staff arrived. Shortly after other staff & I transferred him to his recliner for more comfort. [Client #6] was given 2 (325) mg (milligram) tylenol for pain. At 1A [client #6's] vitals were taken as follows: BP (blood pressure) 84/45 - O2 68 - T (temperature) 96.9 - R (respiration) 18. Nurse was notified. Per nurses instructions to call 911." The progress notes did not document a time.</p> <p>The facility's records were reviewed on 04/02/12 at 2:30 PM. A review of the facility's policy on, "Reporting and Investigating Abuse/ Neglect/Exploitation/Mistreatment," dated 06/2011, indicated, "All allegations or occurrences of</p>		<p>the time of death and signed and dated statements from provider staff assigned and present at the time of death. In the event the death was unexpected, an internal investigation will be completed per guidelines, including; who, what, when, where, how, etc. questions formulated based on the circumstances surrounding the death and pertinent to completion of a thorough investigation. The investigation will include a thorough review of documentation and interviews with pertinent witnesses. The interviews will be completed within five (5) business days. The Licensing & Compliance Coordinator has been retrained on mortality procedure and investigation. The Executive Director, Director of Quality and Director of Supported Group Living will ensure that the mortality review is completed in a timely and thorough manner.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725
---	--

(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>abuse/neglect/exploitation/mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated...One of the investigators will complete a detailed investigative case summary based on witness statements and other evidence collected...All investigations will be completed within 5 business days of the reported incident."</p> <p>On 04/03/12 at 3:00 PM, an interview with the Director of Supported Group Living (DSGL) was conducted. The DSGL indicated the policy was not followed because the Investigative Case Summary was not thorough or timely. She indicated the Confidential Witness Statement Forms which recorded the statements of the staff regarding the incident on 03/01/12 did not detail the events on 02/29/12 related to client #6's death on 03/01/12. She indicated the statements related to questions asked on client #6's health over the past few months, medical appointments, his interactions with peers and communication. She further indicated the statements were not within the 5 business days for the investigation and contained no information related to the events of 02/29/12 and they should have contained that specific information.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725
---	--

(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
	9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725			
(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
W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to assure a thorough and reproducible investigation for 1 of 1 allegation of neglect regarding 1 of 1 deceased client (client #6) emergency medical treatment on 02/29/12.</p> <p>Findings include:</p> <p>On 04/02/12 at 1:45 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>03/01/12: A BDDS report submitted 03/01/12 for an incident on 03/01/12 at 1:15 AM indicated the following regarding client #6: "On 3/1/12, at 1:15 am, [client #6] passed away at [hospital]. On 2/29/12, while taking routine vitals, his blood pressure was 78/55 and oxygen saturation was in the 70's. The agency nurse was contacted and instructed staff to call 911. [Client #6] was taken by EMS to [hospital] Emergency Room. Once at the ER, he was given a Dopamine Drip in an attempt to increase his blood pressure. He was admitted for further</p>			W0154	<p>The facility has modified its policy pertaining to the death of an individual. If the death is "expected", the facility will follow DDRS policy number BQIS 460 0530 029 "Mortality Review" and complete an internal review. The provider internal review of death shall, in conjunction with all providers of services to the deceased individual, collect and review documentation of all events, incidents and occurrences in the individuals life for a minimum of the thirty (30) day period immediately before the death of the individual and if applicable, the hospitalization or placement in a hospice setting or nursing facility in which the individual's death occurred. The internal review into the death of an individual shall include identification of the individual involved, the date and time of the death, a statement describing the death including in a time-line format of what happened, where it happened, when it happened and who was involved. It shall also include a narrative summary description of the internal review and how it was executed, identification of all provider staff assigned to work with the individual, identification of all involved provider staff present at the time of death and signed and</p>		04/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725			
(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>observation. His blood pressure continued to drop throughout the morning. [Client #6's] guardian was contacted and requested comfort measures only. All monitors were removed and Dopamine discontinued. [Client #6] passed away at 1:15 am." The undated and unsigned Investigative Case Summary regarding client #6's 03/01/12 incident indicated group home staff were interviewed on 03/16/12.</p> <p>03/16/12: Confidential Witness Statement Form on staff #1 indicated she was asked the following questions related to client #6:</p> <ol style="list-style-type: none"> 1. "How would [client #6's] interaction (sic)?" 2. "Did he meet all appts (appointments) that were scheduled?" 3. "Did he go out into the community?" 4. "General care?" 5. "Other staff?" 6. "Received adequate nursing care?" <p>The witness was not asked any questions related to the 02/29/12 incident of low blood pressure and oxygen levels which precipitated his need to go to the hospital and his death on 03/01/12.</p> <p>03/16/12: Confidential Witness Statement Form on staff #2 indicated she was asked the following questions related to client #6:</p>		<p>dated statements from provider staff assigned and present at the time of death. In the event the death was unexpected, an internal investigation will be completed per guidelines, including; who, what, when, where, how, etc. questions formulated based on the circumstances surrounding the death and pertinent to completion of a thorough investigation. The investigation will include a thorough review of documentation and interviews with pertinent witnesses. The interviews will be completed within five (5) business days. The Licensing & Compliance Coordinator has been retrained on mortality procedure and investigation. The Executive Director, Director of Quality and Director of Supported Group Living will ensure that the mortality review is completed in a timely and thorough manner.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725
---	--

(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>1. "How would you describe [client #6's] health, happiness & interaction?"</p> <p>2. "Did he meet all appointments?"</p> <p>3. "Nursing care?"</p> <p>4. "He go out into community often?"</p> <p>5. "How did he interact with his house mates?"</p> <p>6. "Was he happy?"</p> <p>The witness was not asked any questions related to the 02/29/12 incident of low blood pressure and oxygen levels which precipitated his need to go to the hospital and his death on 03/01/12.</p> <p>03/16/12: Confidential Witness Statement Form on staff #3 indicated she was asked the following questions related to client #6:</p> <p>1. "How would you describe [client #6's] health over the past few months?"</p> <p>2. "Did he meet all medical appointments?"</p> <p>3. "How did (sic) interact with housemates?"</p> <p>4. "How did he get along with his staff?"</p> <p>5. "Was he able to go into community much?"</p> <p>6. "Nursing needs met?"</p> <p>7. "Anything you would like to add or tell me about [client #6] and his health and well being?"</p> <p>The witness was not asked any questions related to the 02/29/12 incident of low blood pressure and oxygen levels which</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725			
(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>precipitated his need to go to the hospital and his death on 03/01/12.</p> <p>03/16/12: Confidential Witness Statement Form on staff #4 indicated she was asked the following questions related to client #6:</p> <ol style="list-style-type: none"> 1. "Describe [client #6's] health, happiness, well being and how he interacted with peers, housemates and in his community, was he happy?" 2. "Did he meet all appointments?" 3. "How did he interact with housemates?" 4. "Nursing care good?" 5. "Would you like to tell me anything else about [client #6]?" <p>The witness was not asked any questions related to the 02/29/12 incident of low blood pressure and oxygen levels which precipitated his need to go to the hospital and his death on 03/01/12.</p> <p>03/16/12: Confidential Witness Statement Form on staff #5 indicated she was asked the following questions related to client #6:</p> <ol style="list-style-type: none"> 1. "How would you describe [client #6's] health over the past few months?" 2. "Did he meet medical appts?" 3. "How did he interact?" 4. "How did he interact with peers?" 5. "Did he go into community much?" 6. "Anything note worthy to add?" 						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725			
(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>7. "Is there anything you would like to add or tell me about [client #6] (that I should know)?"</p> <p>The witness was not asked any questions related to the 02/29/12 incident of low blood pressure and oxygen levels which precipitated his need to go to the hospital and his death on 03/01/12.</p> <p>On 04/03/12 at 3:00 PM, an interview with the Director of Supported Group Living (DSGL) was conducted. The DSGL indicated the Investigative Case Summary was not thorough. She indicated the Confidential Witness Statement Forms which recorded the statements of the staff regarding the incident on 03/01/12 did not detail the events on 02/29/12 related to client #6's death on 03/01/12. She indicated the statements related to questions asked on client #6's health over the past few months, medical appointments, his interactions with peers and communication. She further indicated the statements were not within the 5 business days for the investigation and contained no information related to the events of 02/29/12 and they should have contained that specific information.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725
---	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725			
(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			
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 to assure the investigation for 1 of 1 allegation of neglect regarding 1 of 1 deceased client (client #6) emergency medical treatment on 02/29/12 and death on 03/01/12, was completed within 5 working days.</p> <p>Findings include:</p> <p>On 04/02/12 at 1:45 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>03/01/12: A BDDS report submitted 03/01/12 for an incident on 03/01/12 at 1:15 AM indicated the following regarding client #6: "On 3/1/12, at 1:15 am, [client #6] passed away at [hospital]. On 2/29/12, while taking routine vitals, his blood pressure was 78/55 and oxygen saturation was in the 70's. The agency nurse was contacted and instructed staff to call 911. [Client #6] was taken by EMS to [hospital] Emergency Room.</p>	W0156	The facility has modified its policy pertaining to the death of an individual. If the death is "expected", the facility will follow DDRS policy number BQIS 460 0530 029 "Mortality Review" and complete an internal review. The provider internal review of death shall, in conjunction with all providers of services to the deceased individual, collect and review documentation of all events, incidents and occurrences in the individuals life for a minimum of the thirty (30) day period immediately before the death of the individual and if applicable, the hospitalization or placement in a hospice setting or nursing facility in which the individual's death occurred. The internal review into the death of an individual shall include identification of the individual involved, the date and time of the death, a statement describing the death including in a time-line format of what happened, where it happened, when it happened and who was involved. It shall also include a narrative summary description of the internal review and how it was executed, identification of all provider staff assigned to work with the	04/27/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725		
(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>Once at the ER, he was given a Dopamine Drip in an attempt to increase his blood pressure. He was admitted for further observation. His blood pressure continued to drop throughout the morning. [Client #6's] guardian was contacted and requested comfort measures only. All monitors were removed and Dopamine discontinued. [Client #6] passed away at 1:15 am." The undated and unsigned Investigative Case Summary regarding client #6's 03/01/12 incident indicated group home staff were interviewed on 03/16/12.</p> <p>On 04/03/12 at 3:00 PM, an interview with the Director of Supported Group Living (DSGL) was conducted. She indicated the Confidential Witness Statement Forms which recorded the statements of the staff regarding the incident on 03/01/12 did not detail the events on 02/29/12 related to client #6's death on 03/01/12. She further indicated the statements were not within the 5 business days for the investigation.</p> <p>9-3-2(a)</p>		<p>individual, identification of all involved provider staff present at the time of death and signed and dated statements from provider staff assigned and present at the time of death. In the event the death was unexpected, an internal investigation will be completed per guidelines, including; who, what, when, where, how, etc. questions formulated based on the circumstances surrounding the death and pertinent to completion of a thorough investigation. The investigation will include a thorough review of documentation and interviews with pertinent witnesses. The interviews will be completed within five (5) business days. The Licensing & Compliance Coordinator has been retrained on mortality procedure and investigation. The Executive Director, Director of Quality and Director of Supported Group Living will ensure that the mortality review is completed in a timely and thorough manner.</p>		