

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2014
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: July 22, 23, 24, 25 and 28, 2014.</p> <p>Facility Number: 001079 Provider Number: 15G565 AIM Number: 100245500</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/4/14 by Ruth Shackelford, QIDP.</p>	W000000		
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>	W000125	CORRECTION:	08/27/2014

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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	<p>Based upon observation, record review and interview for 1 of 4 sampled clients (client #2), the facility failed to assess client #2's ability to consent to medical procedures and a behavior management program which included medications to control behavior.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 7/24/14 at 11:20 AM. A Lifestyle Plan dated 7/29/13 indicated client #2's mother was her guardian until the death of client #2's mother (date not specified). The record indicated client #2's brother was her health care representative. Client #2's record indicated she was being treated for a bone spur causing pain and inflammation. A Behavior Support Plan (BSP) dated 7/29/13 indicated target behaviors of verbal aggression, physical aggression and non-compliance. The plan included the use of Buspar 15 mg (milligrams) for symptoms of bi-polar, Risperdal 4 mg, (psychosis), Ativan 0.5 mg (anxiety), Depakote 1,000 mg (bi-polar), Ability 10 mg for agitation. There was no evidence in the record of consent by client #2's health care representative for her plan, Client #2's record did not include an assessment of her ability to provide consent to medical procedures or for the plan which included</p>		<p><i>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. Specifically, the facility will update Client #2's Informed Consent Assessment including assessment of Client #2's ability to consent to medical procedures and behavior support programs. The team will assure that informed consent has been obtained from Client #2's healthcare representative for all restrictive programs. A review of facility support documents indicated this deficient practice did not affect any other clients.</i></p> <p>PERVENTION: The QIDP has been retrained regarding the need to assess all clients' ability to give informed consent and to obtain appropriate representation for clients as indicated through the assessment process. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing client's ability to give informed consent. Members of the Operations Team will review facility support documents no less than monthly to assure that accurate informed</p>	

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W000148	<p>the use of behavior management medication.</p> <p>The Clinical Supervisor #2 and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 7/24/14 at 12:00 PM and indicated client #2's health care representative was not involved in her life and it was difficult to obtain signatures from him. When asked if client #2 had been assessed for her ability to give consent, the QIDP indicated client #2 had not been assessed for her ability to give informed consent to medical procedures or medications to control behavior.</p> <p>9-3-2(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & 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. Based upon observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #4) to ensure her health care representative was notified of</p>	W000148	<p>consent assessments are in place and that prior written informed consent is obtained for all restrictive programs.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Operations Team</p> <p>CORRECTION: <i>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition</i></p>	08/27/2014			

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	<p>significant events.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/22/14 at 11:15 AM and indicated the following reports:</p> <p>A BDDS report dated 6/23/14 indicated client #4's wheelchair tipped in the van while in transit to day services, causing damage to her eyeglasses. Client #4 had a 30 second seizure immediately after the incident. The report was marked N/A (not applicable) in the section to indicate guardian notification of the incident, and there was no indication in the report of notification of a guardian or health care representative of the incident.</p> <p>Client #4's record was reviewed on 7/23/14 at 1:50 PM and indicated client #4 had relatives as emergency contacts and listed as health care representatives.</p> <p>The Clinical Supervisor #1 was interviewed on 7/23/14 at 11:10 AM and indicated the BDDS reports marked N/A for guardian notification did not have guardians unless the reports were marked in error.</p>		<p><i>including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</i></p> <p>Specifically facility Professional staff have been retrained regarding the need to communicate about significant events to clients' parents, guardians and healthcare representatives.</p> <p>PERVENTION: The residential Manager will be the single point of accountability for communicating with family, guardians and healthcare representatives regarding significant events. Documentation of this communication will be maintained in each client's record and will be noted in required reports to state agencies. The Clinical Supervisor will monitor incident documentation and follow-up with the Residential Manager as needed to assure communication has occurred.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Operations Team</p>		

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W000149	<p>The QIDP and Clinical Supervisor #2 were interviewed on 7/24/14 at 11:45 AM and indicated documentation of guardian/healthcare representative notification should be on the report either on the front page of the report or in the narrative details of the report. They indicated they would look for documentation of client #4's health care representative notification of the incident involving client #4. No documentation was provided.</p> <p>9-3-2(a)</p> <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 upon observation, record review and interview for 1 of 4 sampled clients (client #4), the facility neglected to implement policy and procedures to protect her from harm resulting from her wheelchair being improperly restrained during transportation by facility staff.</p>	W000149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, Administrative staff have retrained all facility employees on safe loading and unloading techniques including but not limited to safe boarding</i></p>	08/27/2014

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	<p>Findings include:</p> <p>The facility's internal incident reports, reports to the Bureau of Developmental Disabilities Services (BDDS) from 12/13 to 7/22/14 and investigations of allegations of abuse/neglect/exploitation from 7/22/13 were reviewed on 7/22/14 at 11:10 AM and indicated the following:</p> <p>A BDDS report dated 6/23/14 indicated client #4 was riding to day service when staff made a right turn. Client #4's lap belt "came undone causing her wheelchair to tilt to the right and her eyeglasses to come off causing some damage. Staff immediately pulled over to assist [client #4] into a secure upright position when [client #4]...appeared to be having a 30 second seizure...." Client #4 was checked for bruises and none were noted and she was assessed as "okay" and taken to day services. Corrective action indicated "An injury flow chart was initiated and team will investigate."</p> <p>An investigation conducted 6/23/14-6/30/14 indicated on 6/23/14 client #4's wheelchair tipped in the van while traveling to day services. The investigation indicated client #4 had broken her glasses during the incident and had a seizure immediately after the incident. The investigation indicated staff</p>		<p>procedures, appropriate use of wheelchair tie downs, securing with lap and shoulder harnesses and use of wheelchair seatbelts.</p> <p>PREVENTION: Supervisory staff will be expected to observe loading and unloading of the facility van no less than twice weekly, at the facility and day service providers, providing hands on training and coaching as needed. Members of the Operations Team will monitor documentation to assure front line supervision occurs as directed. Additionally members of the Operations Team will observe facility staff preparing for transport and unloading the facility van no less than weekly for 60 days and as needed but no less than monthly thereafter. Formal classroom-style and competency-based transport training will occur as needed but no less than annually.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>#9 had not implemented training he received to secure clients' wheelchairs securely before transporting individuals.</p> <p>The Clinical Supervisor was interviewed on 7/23/14 at 11:20 AM. He indicated a peer review had been completed regarding the incident and a new restraint system to secure wheelchairs had been purchased for the van used by the group home and all staff working in the group home had been trained to competency using the new system. He indicated staff #9 had been trained before the incident to ensure all clients were secured properly before transporting clients. He indicated it was uncertain if the incident had caused client #4 to have a seizure, but stated, "It was traumatic" to client #4.</p> <p>The facility's Abuse, Neglect, Exploitation Operating Standard revised 9/14/07 was reviewed on 7/25/14 at 1:32 PM and indicated "ResCare staff actively advocate for the rights and safety of all individuals...All staff will be trained on the detection, reporting and prevention of abuse, neglect and exploitation at time of hire and at least monthly thereafter...Definitions: Medical Neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide necessary medical attention, proper</p>			

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W000192	<p>nutritional support or administering medications as prescribed...."</p> <p>9-3-2(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based upon observation, record review and interview for 1 of 4 sampled clients (client #4), the facility failed to ensure facility staff implemented training to client #4's safety by properly restraining her wheelchair while being transported.</p> <p>Findings include:</p> <p>The facility's internal incident reports, reports to the Bureau of Developmental Disabilities Services (BDDS) from 12/13 to 7/22/14 and investigations of allegations of abuse/neglect/exploitation from 7/22/13 were reviewed on 7/22/14</p>	W000192	<p>CORRECTION: <i>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</i> Specifically, Administrative staff have retrained all facility employees on safe loading and unloading techniques including but not limited to safe boarding procedures, appropriate use of wheelchair tie downs, securing with lap and shoulder harnesses and use of wheelchair seatbelts.</p> <p>PREVENTION: Supervisory staff will be expected to observe loading and unloading of the facility van no less than twice weekly, at the facility and</p>	08/27/2014

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	<p>at 11:10 AM and indicated the following:</p> <p>A BDDS report dated 6/23/14 indicated client #4 was riding to day service when staff made a right turn. Client #4's lap belt "came undone causing her wheelchair to tilt to the right and her eyeglasses to come off causing some damage. Staff immediately pulled over to assist [client #4] into a secure upright position when [client #4]...appeared to be having a 30 second seizure...." Client #4 was checked for bruises and none were noted and she was assessed as "okay" and taken to day services. Corrective action indicated "An injury flow chart was initiated and team will investigate."</p> <p>An investigation conducted 6/23/14-6/30/14 indicated on 6/23/14 client #4's wheelchair tipped in the van while traveling to day services. The investigation indicated client #4 had broken her glasses during the incident and had a seizure immediately after the incident. The investigation indicated staff #9 had not implemented training he received to secure clients' wheelchairs securely before transporting individuals.</p> <p>The Clinical Supervisor was interviewed on 7/23/14 at 11:20 AM. He indicated a peer review had been completed regarding the incident and a new restraint</p>		<p>day service providers, providing hands on training and coaching as needed. Members of the Operations Team will monitor documentation to assure front line supervision occurs as directed. Additionally members of the Operations Team will observe facility staff preparing for transport and unloading the facility van no less than weekly for 60 days and as needed but no less than monthly thereafter. Formal classroom-style and competency-based transport training will occur as needed but no less than annually.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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W000214	<p>system to secure wheelchairs had been purchased for the van used by the group home and all staff working in the group home had been trained to competency using the new system. He indicated staff #9 had been trained before the incident to ensure all clients were secured properly before transporting clients, but had not implemented the training he received. He stated, "[staff #9] was trained to ensure clients are secure before transporting."</p> <p>A Corrective Action Form dated 7/8/14 was reviewed on 7/25/14 at 2:37 PM indicated staff #9 failed to secure client #4's wheelchair properly and staff #9 would adhere to the facility procedures to ensure wheelchairs are properly secured.</p> <p>9-3-3(a)</p> <p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on interview and clinical record review for 1 of 4 sampled clients (client #3), the facility failed to assess her slapping behavior.</p>	W000214	<p>CORRECTION: <i>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. Specifically for Client #3, the Interdisciplinary Team will</i></p>	08/27/2014	

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	<p>Findings include:</p> <p>During observations at the group home on 7/22/14 from 3:55 PM until 5:40 PM client #3 slapped her head with an open hand 15 times without redirection from staff.</p> <p>Observations were completed at the group home on 7/23/14 from 6:38 AM until 8:15 AM. During medication administration at 7:10 AM, client #3 slapped her head with an open hand 23 times causing a slapping sound and slapped her chest 8 times without redirection from staff. Client #3 had a bald spot near where she slapped her head.</p> <p>Client #3's record was reviewed on 7/23/14 at 12:30 PM. Her comprehensive assessments dated 3/28/14 did not include an assessment of her slapping behavior. A Behavior Support Plan dated 3/28/14 did not address slapping behavior.</p> <p>The Clinical Director (CD) #1, CD #2 and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 7/23/14 at 3:10 PM. The QIDP and CD #2 indicated client #3 had historically slapped herself without injury, and indicated the slapping</p>		<p>assess and develop programs to address Client #3's slapping behavior</p> <p>PERVENTION: The QIDP has been retrained regarding the need to identify and address specific developmental and behavioral needs through ongoing assessment. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing developmental and behavioral needs. Additionally, members of the Operations Team and/or the QIDP will conduct active treatment observations on no less than a bi-weekly basis, comparing observed behaviors and needs with current assessment data and making recommendations for revisions as appropriate.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>		

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W000240	<p>behavior may be self stimulatory in nature. They indicated client #3's slapping behavior had not been assessed. CD #2 indicated client #3's bald spot was most likely caused by her rubbing her head. CD #1 indicated client #3's slapping behavior should be assessed.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based upon observation, record review and interview, the facility failed for 2 of 4 sampled clients (clients #3 and #4), to ensure their plans included the use of a clothing protector for client #3, and the use of a movement monitor/alert for client #4.</p> <p>Findings include:</p> <p>During observations at the group home on 7/23/14 from 6:38 AM until 8:15 AM, client #4 had a box with wires attached to the back of her wheelchair and the wires came down the back of</p>	W000240	<p>CORRECTION: <i>The individual program plan must describe relevant interventions to support the individual toward independence. Specifically, Client #3 and Client #4 will be reassessed to determine of a meal time clothing protector is indicated. If the Interdisciplinary Team determines that clothing protectors are necessary, their use will be incorporated into the client(s) support plans in such a manner as to protect personal dignity to the maximum extent possible.</i></p> <p>PERVENTION:</p>	08/27/2014

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	<p>client #4's seat back. Client #3 ate her breakfast with a towel draped around her neck, frayed on one edge.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 7/23/14 at 7:35 AM and indicated there were no other clothing protectors available in the home at this time, but other options for clothing protectors were available.</p> <p>During observations at day service on 7/23/14 from 10:15 until 10:35 AM, client #4's wheelchair back had a box with wires attached to client #4's clothing at her shoulders.</p> <p>The day services coordinator was interviewed on 7/24/14 at 10:20 AM and stated the box on the back of client #4's wheelchair was to alert staff if client #4 had a "drop seizure."</p> <p>Client #3's records were reviewed on 7/23/14 at 12:30 PM. Her plan did not include the use of a clothing protector.</p> <p>Client #4's records were reviewed on 7/23/14 at 1:50 PM. Her plan did not include the use of a monitor to alert staff of her seizures.</p> <p>The QIDP was interviewed on 7/24/14 at 10:30 AM. She indicated the box with wires on client #4's wheelchair was to alert staff to seizures, but was not in her plan and indicated client #3's clothing protector was not listed in her plan.</p> <p>9-3-4(a)</p>		<p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment and interdisciplinary input. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing developmental and behavioral needs. Additionally, members of the Operations Team and/or the QIDP will conduct active treatment observations on no less than a bi-weekly basis, comparing observed behaviors and needs with current support documents and making recommendations for revisions as appropriate.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</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 upon observation, record review and interview for 1 of 4 sampled clients (client #3), the facility failed to implement her Individual Support Plan (ISP) objectives.</p> <p>Findings include:</p> <p>During observations at the group home on 7/22/14 from 3:55 PM until 5:40 PM, client #3 sat in her wheelchair without activity until dinner when she was prompted to use her utensils to eat, and to drink prune juice during medication administration.</p> <p>During observations at the group home on 7/23/14 from 6:38 AM until 8:15 AM, client #3 sat without activity until dinner when she was prompted to use her utensils to eat and to drink prune juice during medication administration.</p> <p>Client #3's record was reviewed on 7/23/14 at 12:30 PM. Client #3's ISP dated 3/28/14 indicated objectives to engage in activity of choice, use a noise maker to notify staff she needs to use the</p>	W000249	<p>CORRECTION:</p> <p><i>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.</i></p> <p>Specifically for Client #3, staff have been retrained on current learning objectives and their implementation schedules.</p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct</p>	08/27/2014

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W000252	<p>restroom, hold a quarter in her hand and to wash lower body.</p> <p>The Clinical Supervisor #1 was interviewed on 7/23/14 at 3:06 PM and stated objectives should be implemented at all "reasonable opportunities."</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based upon record review and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2 and #3) to ensure their behavior program data was documented.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 7/24/14 at 10:55 AM. A Behavior Support Plan (BSP) dated 6/2/14 indicated target behaviors of verbal</p>	W000252	<p>support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff train toward learning objectives per the implementation schedule and provide choices of activities in which to participate at frequent intervals. Additionally, members of the Operations Team and/or the QIDP will conduct active treatment observations on a bi-weekly basis, providing hands-on coaching and training as needed.</p> <p>RESPONSIBLE PARTIES: Residential Manager, Team Leader, direct support staff, QIDP, Operations Team</p> <p>CORRECTION: <i>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</i> Specifically facility direct support staff will be retrained regarding the need to document program data as directed. An audit of facility documentation indicated that this deficient practice also affected Client #4 and Client #6. Staff will also be retrained toward proper data collection for these clients as well.</p>	08/27/2014

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	<p>aggression, property destruction, physical aggression and self injurious behavior. The plan included the use of Clozapine 100 mg (milligrams) to address verbal aggression and Haloperidol 100 mg to address self injurious behavior. The Human Rights Committee (HRC) approval form dated 5/28/14 was blank in the area of target behavior monthly average and a section "What has been done to alter the behavior other than medication?"</p> <p>Client #2's record was reviewed on 7/24/14 at 11:20 AM. A BSP dated 7/29/13 indicated target behaviors of verbal aggression, physical aggression and non-compliance. The plan indicated behavior was to be collected but was blank of data collected. The plan included the use of Risperdal 4 mg twice daily to address verbal aggression and physical aggression, Ativan .05 mg to address verbal and physical aggression, Depakote 1000 mg to address verbal and physical aggression, Buspar 15 mg three times daily and Abilify 15 mg daily to address agitation. A medication reduction plan indicated when client #2 experienced a 20% decrease in targeted behaviors, a reduction would be considered in Buspar. A HRC approval form for the plan dated 7/9/13 was blank in the area of target behavior monthly</p>		<p>PREVENTION: The QIDP will be retrained regarding the need to track and monitor progress on all client learning objectives. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring. Along with the QIDP, members of the Operations Team will conduct active treatment observations and reviews of support documents, to assure data is collected as required at the facility on a bi-weekly basis. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>average and a section "What has been done to alter the behavior other than medication?" A psychiatrist visit form dated 6/3/14 did not show evidence of a review of behavioral data for client #3.</p> <p>Client #3's record was reviewed on 7/23/14 at 12:30 PM. A BSP dated 3/28/14 indicated target behaviors of physical aggression, non-compliance and pica (eating inedibles). The plan included the use of Luvox 50 mg to address physical aggression and Risperdal 0.25 mg to address physical aggression. The plan indicated data was to be collected for client #3's behaviors on all shifts. A HRC approval form for the plan dated 7/9/13 was blank in the area of target behavior monthly average and a section "What has been done to alter the behavior other than medication?" A psychiatrist visit form dated 3/4/14 did not show evidence of a review of behavioral data for client #3.</p> <p>The Clinical Supervisor #2 and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 7/24/14 at 12:15 PM. The QIDP indicated there was no behavior data for client #3, and she would attempt to locate behavior data for clients #1 and #2. The Clinical Supervisor #2 indicated behavior data should be collected to determine</p>			

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W000312	<p>effectiveness of medications. No behavior data was provided.</p> <p>The Clinical Supervisor #1 was interviewed on 7/28/14 at 12:40 PM and indicated there was no documentation of behavior data available for clients #1, #2 and #3.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based upon record review and interview for 3 of 4 sampled clients (clients #1, #2 and #3), the facility failed to implement a plan of reduction to reduce behavior for which the clients received psychoactive medications.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 7/24/14 at 10:55 AM. A Behavior Support Plan (BSP) dated 6/2/14 indicated target behaviors of verbal aggression, property destruction, physical aggression and self injurious behavior. The plan</p>	W000312	<p>CORRECTION: <i>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Specifically for Clients #1 - #3 medication reduction goals will be included in their behavior support plans. A review of facility BSPs indicated this deficient practice also affected to additional clients #6 and #7. Medication reduction plans will be added to their BSPs as well.</i></p>	08/27/2014			

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	<p>included the use of Clozapine 100 mg (milligrams) to address verbal aggression and Haloperidol 100 mg to address self injurious behavior. There was no evidence of a plan of reduction for the use of her medication. There was no evidence of behavior tracking data in the record.</p> <p>Client #2's record was reviewed on 7/24/14 at 11:20 AM. A BSP dated 7/29/13 indicated target behaviors of verbal aggression, physical aggression and non-compliance. The plan indicated behavior was to be collected but was blank of any data collected. The plan included the use of Risperdal 4 mg twice daily to address verbal aggression and physical aggression, Ativan .05 mg to address verbal and physical aggression, Depakote 1000 mg to address verbal and physical aggression, Buspar 15 mg three times daily and Abilify 15 mg daily to address agitation. A medication reduction plan indicated when client #2 experienced a 20% decrease in targeted behaviors, a reduction would be considered in Buspar. A psychiatrist visit form dated 6/3/14 did not show evidence of a review of behavioral data for client #2. There was no evidence of behavior tracking data in the record.</p> <p>Client #3's record was reviewed on 7/23/14 at 12:30 PM. A BSP dated 3/28/14 indicated target behaviors of physical aggression, non-compliance and pica (eating inedible's). The plan included the use of Luvox 50 mg to address physical aggression and Risperdal 0.25 mg to address physical aggression. The plan did not indicate specific criteria to be met to be considered for a reduction in medication. A psychiatrist visit form dated 3/4/14 did not show evidence of a review of behavioral data for client #3. There was no evidence of behavior tracking data in the record.</p>		<p>PERVENTION: The QIDP has been retrained regarding the need to incorporate goals to reduce and eventually eliminate the use of behavior controlling medications into support plans whenever such medications are prescribed. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing developmental and behavioral needs. Additionally, members of the Operations Team will review facility Behavior Support Plans no less than monthly and to assure plans for the reduction and eventual elimination of behavior controlling medications are included.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>				

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W000322	<p>The Clinical Supervisor #2 and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 7/24/14 at 12:15 PM. The QIDP indicated there was no behavior data for client #3, and she would attempt to locate behavior data for clients #1 and #2. The Clinical Supervisor #2 indicated behavior data should be collected to determine effectiveness of medications and to determine when a reduction of medication was indicated. No behavior tracking data was provided or evidence of a plan to reduce the use of medication to address behavior for clients #1 and #3.</p> <p>9-3-5(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based upon record review and interview, the facility failed for 3 of 4 sampled clients (clients #2, #3 and #4) to ensure an annual physical examination was completed.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 7/24/14 at 11:20 AM. Client #2's most recent physical examination was dated</p>	W000322	<p>CORRECTION: <i>The facility must provide or obtain preventive and general medical care. Specifically, the facility has scheduled and will obtain physical examinations for Clients #2, #3 and #4. An audit of facility medical charts indicated this deficient practice also affected Clients #5 - #8 and the facility will assure completion of physical examinations for these clients as well.</i></p>	08/27/2014			

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W000323	<p>4/29/13. There was no evidence of a more recent evaluation in the record.</p> <p>Client #3's record was reviewed on 7/23/14 at 12:30 PM. Client #3's most recent physical examination was dated 4/25/13. There was no evidence of a more recent evaluation in the record.</p> <p>Client #4's record was reviewed on 7/23/14 at 1:50 PM. Client #4's most recent physical examination was dated 4/29/13. There was no evidence of a more recent evaluation in the record.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 7/24/14 at 12:00 PM and indicated the physical examinations had been scheduled, but not yet completed. The QIDP indicated there were no more recent physical examinations for clients #2, #3 and #4.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision</p>		<p>PERVENTION: The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations, occur within required time frames. Supervisory staff will review medical charts on an ongoing basis but no less than monthly to assure medical follow-along occurs as required. Members of the Operations Team and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that examinations including but not limited to physical evaluations take place as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p>		

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	<p>and hearing. Based upon record review and interview, the facility failed to ensure annual screenings of vision and hearing were completed for 2 of 4 sampled clients (clients #2 and #3).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 7/24/14 at 11:20 AM. Client #2's more recent evaluation of hearing was dated 5/16/13 and her most recent evaluation of vision was dated 9/12/12. There was no evidence of more recent screening of client #2's vision and hearing.</p> <p>Client #3's record was reviewed on 7/23/14 at 12:30 PM. Client #3's most recent hearing evaluation was on 6/11/09. Her most recent vision examination was dated 9/6/12. There was no evidence of a more recent screening of client #3's vision and hearing.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 7/24/14 at 12:00 PM and indicated the hearing and vision examinations had been scheduled, but not yet completed. The QIDP indicated there were no more recent vision and hearing screenings for clients #2 and #3.</p>	W000323	<p>CORRECTION: <i>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Specifically, the facility has scheduled and will obtain visual and hearing screenings for Client #2 and Client #3. Additionally, the facility has scheduled and will obtain visual and audiological screening for Clients #5, #7 and #8 as an audit determined that this deficient practice affected Clients #5, #7 and #8 as well.</i></p> <p>PREVENTION: The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to visual and Audiological screening, occur within required time frames. Supervisory staff will review medical charts on an ongoing basis but no less than monthly to assure medical follow-along occurs as required. Members of the Operations Team and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that examinations including but not limited to visual and hearing evaluations take place as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager,</p>	08/27/2014	

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W000352	<p>9-3-6(a)</p> <p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based upon record review and interview for 1 of 4 sampled clients (client #3), the facility failed to ensure she had an annual dental examination.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 7/23/14 at 12:30 PM. Client #3's most dental examination was dated 5/22/13. There was no evidence of a more recent dental examination for client #3.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 7/24/14 at 12:00 PM and indicated client #3's dental examination had been scheduled, but not yet completed. The QIDP indicated there was not a more recent dental examination for client #3.</p> <p>9-3-6(a)</p>	W000352	<p>Team Leader, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION: <i>Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Specifically, the facility has scheduled and will obtain a dental examination for Client #3. An audit of facility medical charts indicated this deficient practice also affected Client #5 and a dental examination has been scheduled for Client #5 as well.</i></p> <p>PERVENTION: The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to dental examinations, occur within required time frames. Supervisory staff will review medical charts on an ongoing basis but no less than monthly to assure medical follow-along occurs as required. Members of the Operations Team and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that</p>	08/27/2014			

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W000389	<p>483.460(m)(1)(ii) DRUG LABELING Labeling for drugs and biologicals must include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.</p> <p>Based upon observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #3) to ensure her medication was labeled with appropriate precautions for administration.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 7/23/14 from 6:38 AM until 8:15 AM. At 7:10 AM client #3 was given 3 capsules of Phenytoin Ex (extended release) 100 mg (milligrams) for seizures. The capsules had been twisted open and the medication poured into in applesauce by staff #10. The capsules' casings were intact in the applesauce. The label on the medication did not indicate the capsules should be taken intact.</p> <p>Client #3's 7/14 MAR (medication administration record) was reviewed on 7/23/14 at 7:28 AM. The MAR did not include the Phenytoin capsules should be taken intact.</p> <p>Client #3's records were reviewed on 7/23/14 at</p>	W000389	<p>medical follow-along including but not limited to dental examinations take place as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION: <i>Labeling for drugs and biologicals must include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable. Specifically the attending neurologist has changed Client #3's anticonvulsant medications to a combination of liquid and chewable tablets to conform to Client #3's modified texture swallowing needs. Staff have been trained on proper administration techniques.</i></p> <p>PERVENTION: The facility nurse will review medication labels and the Medication Administration Record (MAR) each month prior to implementation to assure that labeling includes the appropriate accessory and cautionary instructions. Facility Supervisor staff will cross review medications and the MAR prior to</p>	08/27/2014

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
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W000436	<p>12:30 PM. Physician's orders dated 6/18/14 did not include Phenytoin Ex 100 mg capsules were to be taken intact.</p> <p>Staff #10 was interviewed on 7/23/14 at 7:20 AM. She indicated client #3 was to receive her medications crushed. She indicated she was not able to crush client #3's Phenytoin capsules as they were time released, but indicated she opened the capsules and poured the medication into the applesauce.</p> <p>The website nim.nih.gov titled MedlinePlus was reviewed on 7/23/14 at 8:30 AM. The site indicated for Phenytoin "Swallow the extended-release capsules whole; do not split, chew, or crush them."</p> <p>The group home nurse was interviewed on 7/24/14 at 10:40 AM and stated the extended release Phenytoin capsules "shouldn't be pulled apart." She indicated she had contacted the pharmacy to ensure the instructions for Phenytoin would indicate the capsules should not be altered. She indicated client #3's physician was contacted to notify him client #3's medication had been altered.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other</p>		<p>implementation each month to provide a check and balance to assure that labeling includes the appropriate accessory and cautionary instructions. Additionally, the QIDP and members of the Operations Team and nursing staff will incorporate review of medication labeling into an audit process that occurs no less than monthly.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p>	

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	<p>devices identified by the interdisciplinary team as needed by the client.</p> <p>Based upon observation, record review and interview, the facility failed to ensure recommended adaptive equipment was available or in good repair for 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>Observations were completed at the group home on 7/22/14 from 3:55 PM until 5:40 PM and on 7/23/14 from 6:38 AM until 8:15 AM. Client #3's sat in her wheelchair throughout the observation. Client #3's wheelchair did not have arm rests or foot rests.</p> <p>Client #3's record was reviewed on 7/23/14 at 12:30 PM. A physician order dated 6/18/14 indicated "wheelchair use if needed...use leg rests on wheelchair for longer distances..." A physical therapy evaluation dated 4/9/14 indicated "new wheelchair is recommended." A Comprehensive High Risk Health Plan dated 5/19/14 for edema indicated "Encourage [client #3] to elevate feet (prop up) when sitting...Use leg rests on w/c (wheelchair) when w/c used for extended periods."</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 7/24/14 at 12:28 PM and indicated client #3's new wheelchair was in process, but had not yet been purchased.</p> <p>9-3-7(a)</p>	W000436	<p>CORRECTION: <i>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Specifically, Client #3 has been fitted for a new wheelchair which has been ordered and will be purchased by the facility. A review of current adaptive equipment needs demonstrated that this deficient practice did not affect any additional clients.</i></p> <p>PERVENTION: Facility Professional staff have been retrained regarding the need to furnish all necessary adaptive equipment to all clients. Members of the Operations Team will review assessment data and compare it to adaptive equipment available at the facility, making recommendations and expediting the acquisition of new and additional adaptive equipment as appropriate.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	08/27/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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