

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G507	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 2900 KENTUCKY AVE MADISON, IN 47250		
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W000000	<p>This visit was for the investigation of complaint #IN00134566.</p> <p>Complaint #IN00134566: Unsubstantiated, due to lack of sufficient evidence. Unrelated deficiencies cited.</p> <p>Dates of survey: October 17 and 18, 2013.</p> <p>Facility Number: 001021 Provider Number: 15G507 AIM Number: 100245130</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 10/24/13 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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W000154	<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 for 1 of 2 investigations reviewed (client A), the facility failed to ensure an allegation was thoroughly investigated (all aspects of a behavioral episode were not addressed).</p> <p>Findings include:</p> <p>Review of facility reportable (Bureau of Developmental Disabilities Services/BDDS) incidents and investigations on 10/17/13 at 1:30 PM and on 10/18/13 at 11:00 AM indicated the following:</p> <p>A BDDS report dated 8/10/13 indicated an incident on 8/9/13 at 4:15 PM with client A. The report indicated client A was in his bedroom and was "upset and refusing to take his medications" Client A's behaviors had escalated when he was prompted to take his afternoon medications and he became physically aggressive with house manager/HM #1. Male staff #3 went to client A's bedroom to assist HM #1. The 8/10/13 BDDS report indicated client A "punched both staff in the chest. Staff attempted YSIS, (You're Safe I'm Safe/behavior</p>	W000154	<p>W154: The facility must have evidence that all alleged violations are thoroughly investigated. Corrective Action: (Specific): QA will be in-serviced on the abuse neglect policy and procedure as well as the investigation process to ensure that allegations are thoroughly investigated. How others will be identified: (Systemic) The Program Manager and Human Resources will review investigations to ensure that all allegations have been thoroughly investigated</p> <p>Measures to be put in place: QA will be in-serviced on the abuse neglect policy and procedure as well as the investigation process to ensure that allegations are thoroughly investigated. Monitoring of Corrective Action: Completion date: 11/17/13</p>	11/17/2013	

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	<p>management technique of two person escort) but were unable to because [client A] was kicking, hitting, scratching and flailing. Staff called police for assistance in calming [client A], but another staff yelled that [client A] had stopped breathing. The staff administered one rescue breath and one chest compression and [client A] started breathing on his own. The staff thought he had a seizure. EMS (Emergency Medical Services) transported [client A] to the ER (emergency room of local hospital) for evaluation."</p> <p>The BDDS report indicated at the ER "[client A] stated that a staff had choked him." Review of a facility investigation dated 8/23/13 on 10/17/13 at 1:45 PM indicated the staff in question had been exonerated of any abuse (choking) with client A on 8/9/13.</p> <p>The internal incident report dated 8/9/13 at 4:15 PM by staff #4 (reviewed 10/17/13 2:00 PM) indicated what had transpired that afternoon with client A: "[HM #1] was trying to ask him to take his medication, and he started cursing and another staff [male staff #3] came in to (sic) room see if everything was ok and client turned and punched [staff #3], then turned and punched [HM #1], then [staff #3] tried to place him in YSIS and client was hitting and scratching [staff #3] up.</p>						

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	<p>They fell onto the bed and [staff #3] was lying across [client A's] chest and he kept cursing and telling [staff #3] he was going to kill him, he was kicking and [HM #1] was trying to hold his legs down, the (sic) [staff #4] came in and [HM #1] went to call police in her office, then [staff #3] got up and [staff #4] said he (client A) was blue and administered CPR (Cardio Pulmonary Resuscitation) and then after several attempts shallow breathing (sic) observed but client was still unconscious and it was just like when he has (sic) a seizures. Then EMS arrived and client then became alert. Client was taken to ER."</p> <p>Interview with staff #3 on 10/18/13 at 2:15 PM indicated client A was agitated to the point his behaviors were not redirectable on the afternoon of 8/9/13. YSIS was "impossible" to perform with him in the state he was in and the limited area in client A's bedroom was also a hindrance. Staff #3 stated he held client A by the "shoulders" to prevent harm to the client and spoke to him in a calm reassuring manner to calm him.</p> <p>Review of client A's record on 10/18/13 at 9:30 AM indicated the 10/13 physician's orders/PO which indicated his diagnoses included, but were not limited to, impulse control disorder, personality</p>				

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	<p>disorder, and convulsive disorder. The 10/13 PO indicated he received levetiraceta 1000 mg. (milligrams) twice daily and phenobarbital 64.8 mg three times daily for his seizure disorder.</p> <p>The review of the 8/23/13 investigation did not indicate the Quality Assurance manager had considered the information contained in the incident report made by staff #4 on 8/9/13 at 4:15 PM. There was nothing in the investigation about the factors which may have led to client A's turning "blue" and the need for CPR.</p> <p>Interview with Quality Assurance Manager #1 on 10/18/13 at 11:18 AM indicated the investigation did not contain any recommendations in regards to client A's severe agitation, the failed attempt to implement YSIS and his needing CPR. The investigation focused only on the allegation of choking; not the circumstances of the behavioral episode surrounding the allegation.</p> <p>9-3-2(a)</p>				

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W000214	<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 observation, record review and interview for 1 of 3 sampled clients (client A) the facility failed to ensure the client's behavioral needs were assessed.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 10/18/13 from 9:15 AM until 3:00 PM. During the observations, client A was not attending an outside day program. Client A accompanied staff #4 on a shopping trip after making a grocery list. Client A played video games, watched television and ate lunch. After lunch, client A relaxed in his bedroom and was assisted with showering by staff #3.</p> <p>Review of facility reportable (Bureau of Developmental Disabilities Services/BDDS) incidents and investigations on 10/17/13 at 1:30 PM and on 10/18/13 at 11:00 AM indicated the following:</p> <p>1. A BDDS report dated 8/10/13 indicated an incident on 8/9/13 at 4:15 PM with client A. The report indicated client A</p>	W000214	<p>W214: The comprehensive functional assessment must identify the clients specific developmental and behavioral management needs. Corrective Action: (Specific) Client A's assessments and behavior support plan will be reviewed to determine if any changes need to be made to assist with behavior management and progress toward behavior goals. How others will be identified: (Systemic) The Residential Manager will complete assessments at least annually and more often if needed and develop plans based on the needs of the client to ensure all programming and behavioral needs are covered in plans that are implemented. The Program Manager will review assessments and plans prior to implementation to ensure that all clients programming and behavioral needs are met. Measures to be put in place: Client A's assessments and behavior support plan will be reviewed to determine if any changes need to be made to assist with behavior management and progress toward behavior goals.</p> <p>Monitoring of Corrective Action: The Residential Manager will</p>	11/17/2013			

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	<p>was in his bedroom and was "upset and refusing to take his medications" Client A's behaviors had escalated when he was prompted to take his afternoon medications and he became physically aggressive with house manager/HM #1. Male staff #3 went to client A's bedroom to assist HM #1. The 8/10/13 BDDS report indicated client A "punched both staff in the chest. Staff attempted YSIS, (You're Safe I'm Safe/behavior management technique of two person escort) but were unable to because [client A] was kicking, hitting, scratching and flailing. Staff called police for assistance in calming [client A], but another staff yelled that [client A] had stopped breathing. The staff administered one rescue breath and one chest compression and [client A] started breathing on his own. The staff thought he had a seizure. EMS (Emergency Medical Services) transported [client A] to the ER (emergency room of local hospital) for evaluation."</p> <p>The BDDS report indicated at the ER "[client A] stated that a staff had choked him." Review of a facility investigation dated 8/23/13 on 10/17/13 at 1:45 PM indicated the staff in question had been exonerated of any abuse (choking) with client A on 8/9/13.</p> <p>The internal incident report dated 8/9/13</p>		<p>complete assessments at least annually and more often if needed and develop plans based on the needs of the client to ensure all programming and behavioral needs are covered in plans that are implemented. The Program Manager will review assessments and plans prior to implementation to ensure that all clients programming and behavioral needs are met.</p> <p>Completion date: 11/17/13</p>		

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	<p>at 4:15 PM by staff #4 (reviewed 10/17/13 2:00 PM) indicated what had transpired that afternoon with client A: "[HM #1] was trying to ask him to take his medication, and he started cursing and another staff [male staff #3] came in to (sic) room see if everything was ok and client turned and punched [staff #3], then turned and punched [HM #1], then [staff #3] tried to place him in YSIS and client was hitting and scratching [staff #3] up. They fell onto the bed and [staff #3] was lying across [client A's] chest and he kept cursing and telling [staff #3] he was going to kill him, he was kicking and [HM #1] was trying to hold his legs down, the (sic) [staff #4] came in and [HM #1] went to call police in her office, then [staff #3] got up and [staff #4] said he (client A) was blue and administered CPR (Cardio Pulmonary Resuscitation) and then after several attempts shallow breathing (sic) observed but client was still unconscious and it was just like when he has (sic) a seizures. Then EMS arrived and client then became alert. Client was taken to ER."</p> <p>2. A BDDS report dated 8/29/13 indicated an incident on 8/28/13 at 8:00 PM with client A. The report indicated client A's behaviors had become unmanageable so he was transported to the local hospital on 8/28/13 and was subsequently admitted to</p>						

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	<p>a stress center/behavioral unit on 8/29/13. "[Client A] was becoming increasingly verbally and physically aggressive. 911 was called and [client A] was taken to ER for evaluation. At the ER, [client A] progressively got worse. He refused a Zyprexa (antipsychotic medication) shot, meds, vitals, labs and urinated on the hospital floor. The physicians decided that it would be beneficial to [client A's] health and safety if he were admitted to [name of stress center/behavioral unit] and he was transported to there via ambulance. When he is discharged, the Residential Manager will meet with the [agency] team to determine if any programming or BSP (Behavior Support Plan) changes need to be made."</p> <p>Review of client A's record on 10/18/13 at 9:30 AM indicated an IDT (Interdisciplinary Team) meeting dated 9/6/13. The IDT indicated client A was released back to the facility on 9/6/13 after a nine day stay in the behavior unit and "only minor medication adjustments (behavior medications) were made." The record review indicated a CFA/Comprehensive Functional Assessment dated 4/19/13 by staff #6. Staff #6 was not a professional staff/QIDP (Qualified Intellectual Disabilities Professional). There was no behavioral management assessment</p>			

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	<p>component with the CFA.</p> <p>Interview with staff #3 on 10/18/13 at 1:30 PM indicated client A was agitated to the point his behaviors were not redirectable on the afternoon of 8/9/13. YSIS was "impossible" to perform with him in the state he was in and the limited area in client A's bedroom was also a hindrance. Staff #3 stated he held client A by the "shoulders" to prevent harm to the client and spoke to him in a calm reassuring manner to calm him.</p> <p>Interview with HM #1 on 10/18/13 at 9:45 AM indicated his most recent BSP/Behavior Support Plan was dated 4/26/13. The CFA dated 4/19/13 had no behavioral component which assessed his behavior management needs.</p> <p>The interview indicated client A did not attend an outside day program or the local workshop because of his behaviors (non-compliance, verbal and physical aggression).</p> <p>9-3-4(a)</p>						

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W000215	<p>483.440(c)(3)(iv) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's needs for services without regard to the actual availability of the services needed.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client A) the client's individual needs for professional support services had not been identified (in the area behavioral management).</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 10/18/13 from 9:15 AM until 3:00 PM. During the observations, client A was not attending an outside day program. Client A accompanied staff #4 on a shopping trip after making a grocery list. Client A played video games, watched television and ate lunch. After lunch, client A relaxed in his bedroom and was assisted with showering by staff #3.</p> <p>Review of facility reportable (Bureau of Developmental Disabilities Services/BDDS) incidents and investigations on 10/17/13 at 1:30 PM and on on 10/18/13 at 11:00 AM indicated the following:</p> <p>1. A BDDS report dated 8/10/13 indicated</p>	W000215	<p>services without regard to the actual availability of the services needed. Corrective Action: (Specific) Client A's assessments and behavior support plan will be reviewed to determine if any changes need to be made to assist with behavior management and progress toward behavior goals. The residential manager will contact day service providers to facilitate client A's attendance at an outside day service. How others will be identified: (Systemic) The Residential Manager will complete assessments at least annually and more often if needed and develop plans based on the needs of the client to ensure all programming and behavioral needs are covered in plans that are implemented. The Program Manager will review assessments and plans prior to implementation to ensure that all clients programming and behavioral needs are met. Measures to be put in place: Client A's assessments and behavior support plan will be reviewed to determine if any changes need to be made to assist with behavior management and progress toward behavior goals. The residential manager will contact</p>	11/17/2013	

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	<p>an incident on 8/9/13 at 4:15 PM with client A. The report indicated client A was in his bedroom and was "upset and refusing to take his medications" Client A's behaviors had escalated when he was prompted to take his afternoon medications and he became physically aggressive with house manager/HM #1. Male staff #3 went to client A's bedroom to assist HM #1. The 8/10/13 BDDS report indicated client A "punched both staff in the chest. Staff attempted YSIS, (You're Safe I'm Safe/behavior management technique of two person escort) but were unable to because [client A] was kicking, hitting, scratching and flailing. Staff called police for assistance in calming [client A], but another staff yelled that [client A] had stopped breathing. The staff administered one rescue breath and one chest compression and [client A] started breathing on his own. The staff thought he had a seizure. EMS (Emergency Medical Services) transported [client A] to the ER (emergency room of local hospital) for evaluation."</p> <p>The BDDS report indicated at the ER "[client A] stated that a staff had choked him." Review of a facility investigation dated 8/23/13 on 10/17/13 at 1:45 PM indicated the staff in question had been exonerated of any abuse (choking) with client A on 8/9/13.</p>		<p>day service providers to facilitate client A's attendance at an outside day service. Monitoring of Corrective Action: The Residential Manager will complete assessments at least annually and more often if needed and develop plans based on the needs of the client to ensure all programming and behavioral needs are covered in plans that are implemented. The Program Manager will review assessments and plans prior to implementation to ensure that all clients programming and behavioral needs are met.</p> <p>Completion date: 11/17/13</p>				

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	<p>The internal incident report dated 8/9/13 at 4:15 PM by staff #4 (reviewed 10/17/13 2:00 PM) indicated what had transpired that afternoon with client A: "[HM #1] was trying to ask him to take his medication, and he started cursing and another staff [male staff #3] came in to (sic) room see if everything was ok and client turned and punched [staff #3], then turned and punched [HM #1], then [staff #3] tried to place him in YSIS and client was hitting and scratching [staff #3] up. They fell onto the bed and [staff #3] was lying across [client A's] chest and he kept cursing and telling [staff #3] he was going to kill him, he was kicking and [HM #1] was trying to hold his legs down, the (sic) [staff #4] came in and [HM #1] went to call police in her office, then [staff #3] got up and [staff #4] said he (client A) was blue and administered CPR (Cardio Pulmonary Resuscitation) and then after several attempts shallow breathing (sic) observed but client was still unconscious and it was just like when he has (sic) a seizures. Then EMS arrived and client then became alert. Client was taken to ER."</p> <p>2. A BDDS report dated 8/29/13 indicated an incident on 8/28/13 at 8:00 PM with client A. The report indicated client A's behaviors had become unmanageable so</p>			

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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250
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	<p>he was transported to the local hospital on 8/28/13 and was subsequently admitted to a stress center/behavioral unit on 8/29/13. "[Client A] was becoming increasingly verbally and physically aggressive. 911 was called and [client A] was taken to ER for evaluation. At the ER, [client A] progressively got worse. He refused a Zyprexa (antipsychotic medication) shot, meds, vitals, labs and urinated on the hospital floor. The physicians decided that it would be beneficial to [client A's] health and safety if he were admitted to [name of stress center/behavioral unit] and he was transported to there via ambulance. When he is discharged, the Residential Manager will meet with the [agency] team to determine if any programming or BSP (Behavior Support Plan) changes need to be made."</p> <p>Review of client A's record on 10/18/13 at 9:30 AM indicated an IDT (Interdisciplinary Team) meeting dated 9/6/13. The IDT indicated client A was released back to the facility on 9/6/13 after a nine day stay in the behavior unit and "only minor medication adjustments (behavior medications) were made." Client A was also treated with an antibiotic for a urinary tract infection. The IDT had a component called "Plan of Action Taken: Continue with suggested med (medication) changes and</p>			

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	<p>environmental changes and proactive strategies to assure an appropriate amount of sleep." These changes were suggested by client A's guardian and included client A following a healthier diet (eating menued foods rather than cereal for the evening meal) and relinquishing the controller to his video games at 8:30 PM so he would not be tempted to play games instead of going to sleep. The IDT form was signed by LPN #1, HM #1, client A and client A's guardian was listed as participating via phone. No QIDP (Qualified Intellectual Disabilities Professional) or Behavioral Management Professional had participated.</p> <p>Interview with staff #3 on 10/18/13 at 1:30 PM indicated client A was agitated to the point his behaviors were not redirectable on the afternoon of 8/9/13. YSIS was "impossible" to perform with him in the state he was in and the limited area in client A's bedroom was also a hindrance. Staff #3 stated he held client A by the "shoulders" to prevent harm to the client and spoke to him in a calm reassuring manner to calm him.</p> <p>Interview with HM #1 on 10/18/13 at 9:45 AM indicated his most recent BSP/Behavior Support Plan was dated 4/26/13 and had been written by HM #1. Interview with HM#1 indicated she was</p>			

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	<p>not a QIDP and the BSP had not been written in consultation with a Behavioral Management Professional. The interview indicated client A did not attend outside day programming due to his behavior management needs.</p> <p>9-3-4(a)</p>			