

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G397	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250
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W 000 Bldg. 00	<p>This visit was for a PCR (Post Certification Revisit) to an annual recertification and state licensure survey and to the investigation of complaints #IN00165097 and #IN00165161 completed on 2/19/15.</p> <p>Complaint #IN00165097: Corrected.</p> <p>Complaint #IN00165161: Corrected.</p> <p>Dates of Survey: 3/26/15 and 3/31/15</p> <p>Facility Number: 000911 Provider Number: 15G397 AIMS Number: 100244420</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/7/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 159	483.430(a)			

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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Bldg. 00	<p>QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2) plus 2 additional clients (#3 and #4), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2, #3 and #4's active treatment programs by failing to ensure there were sufficient direct care staff to implement clients #1, #2, #3 and #4's ISPs (Individual Support Plans)/CHRHPs (Comprehensive High Risk Health Plans), to ensure staff working with clients #1, #2, #3 and #4 were competent in regard to meal preparation and to ensure clients #1, #2, #3 and #4 received a continuous active treatment program</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QIDP failed to integrate, coordinate and monitor clients #1, #2, #3 and #4's active treatment program by failing to ensure there were sufficient direct care staff to implement clients #1 and #2's ISPs/CHRHPs. Please see W186. 2. The QIDP failed to integrate, coordinate and monitor clients #1, #2, #3 	W 159	<p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically,</i></p> <p>The QIDP will assure that the Residential Manager modifies the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning medication administration, morning hygiene and breakfast.</p> <p>The QIDP will assure that all direct support staff are retrained and receive ongoing face to face coaching from supervisors regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to assuring all clients participate in all aspects of meal preparation to the extent of their capabilities, family style dining and other domestic activities.</p>	04/30/2015
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	<p>and #4's active treatment program by failing to ensure staff working with clients #1, #2, #3 and #4 were competent in regard to meal preparation. Please see W189.</p> <p>3. The QIDP failed to integrate, coordinate and monitor clients #1, #2, #3 and #4's active treatment program by failing ensure clients #1, #2, #3 and #4 received a continuous active treatment program. Please see W249.</p> <p>This deficiency was cited on 2/19/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>		<p>PREVENTION:</p> <p>The QIDP will assure that the Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation.</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining and other domestic activities.</p> <p>Members of the Operations Team, comprised of Clinical</p>	

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			<p>Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication</p>	

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			<p>administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities.</p>	

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W 186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (#1</p>	W 186	<p>With regard to the QIDP, administrative support at the home will focus on:</p> <ol style="list-style-type: none"> Assuring that adequate direct support staff are on duty to meet the needs of all clients. Assuring continuous active treatment occurs including but not limited to during meal preparation, family style dining and other domestic activities. <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p>	04/30/2015	

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	<p>and #2) plus 2 additional clients (#3 and #4), the facility failed to provide sufficient direct care staff to implement clients #1, #2, #3 and #4's ISPs (Individual Support Plans)/CHRHPs (Comprehensive High Risk Health Plans).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/26/15 from 6:20 AM through 8:15 AM. At 6:20 AM, staff #1 swept and mopped the dining area floors and hallway area of the group home. Client #1 was seated on a couch located across from the kitchen area of the group home while clients #2, #3 and #4 were in their personal bedrooms. Clients #1, #2, #3 and #4 were not encouraged to assist with cleaning/domestic tasks. At 6:30 AM, staff #1 entered clients #2, #3 and #4's bedrooms to prompt them to wake for the day and prepare for day services. Staff #1 then resumed sweeping the floors before returning to the kitchen area to prepare the morning meal. Staff #1 removed a pan of sausage patties from the oven and then placed a tray of uncooked biscuits in the oven. Client #1 was seated on a couch located across from the kitchen area. Client #1 was not encouraged to participate in the morning meal preparation. At 6:35 AM, client #3</p>		<p><i>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Specifically, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning medication administration, morning hygiene and breakfast.</i></p> <p>PREVENTION:</p> <p>The Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the</p>	

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	<p>entered the kitchen area and was prompted to go to the lower level/basement area of the home for medication administration. Client #1 was seated on the couch while staff #1 checked the biscuits in the oven and finished sweeping the kitchen floor. Clients #1 and #3 were not encouraged to assist with meal preparation or cleaning tasks.</p> <p>At 6:50 AM, staff #1 finished passing clients #3 and #4's medications in the group home's basement and returned to the kitchen and dining room areas where he resumed sweeping the floors and wiping down the counters. Client #1 was seated on the couch located next to the kitchen area and was not encouraged to participate in the morning cleaning or meal preparation or offered an activity. Staff #1 continued meal preparation as he prepared boiled eggs and began putting dishes away from the home's dishwasher. Client #1 sat on the couch next to kitchen and was not encouraged to assist to prepare the boiled eggs or put away dishes. Clients #2, #3 and #4 were located in their personal bedrooms and not encouraged to participate in the morning's meal or domestic chore tasks. At 6:53 AM, staff #1 got a bowl, spoon and milk from a kitchen cabinet and filled the bowl with cereal and milk. Staff</p>		<p>Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks</p>	

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	<p>#1 then took the bowl of cereal to the table and prompted client #1 to come eat his breakfast. Client #1 was not encouraged to get his own bowl, silverware or pour his own cereal. Client #1 sat at the kitchen table eating his cereal while staff #1 returned to clients #2, #3 and #4's bedrooms to prompt them to prepare for day services. At 7:02 AM, staff #1 used a damp rag to wipe down/clean the furniture in the home's living room and washed dishes while client #1 was seated at the dining room table eating cereal.</p> <p>At 7:03 AM, staff #1 prompted client #2 to go downstairs to the basement/medication administration area to receive his morning medications. Staff #1 was in the group home's basement area with client #2 from 7:03 AM through 7:07 AM while client #1 ate cereal at the dining room table unsupervised. At 7:07 AM, staff #2 arrived at the group home. At 7:09 AM, staff #2 exited the group home out the front door while client #1 was eating his cereal at the dining room table while staff #1 and client #2 remained downstairs. At 7:11 AM, staff #2 re-entered the group home and sat down on the couch next to the kitchen area while client #1 was eating at the dining room table unsupervised. At 7:12 AM, staff #1 and</p>		<p>at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring adequate direct support staff are on duty to meet the needs of all clients.</p> <p>The Clinical Supervisor will perform periodic spot checks of attendance records to assure ongoing compliance. Prior to each schedule period, the Operations Team will follow-up verbally and via email to assure that appropriate coverage has been arranged.</p>	

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	<p>client #2 returned upstairs while staff #2 remained seated on the couch. Client #1 continued eating unsupervised while staff #1 resumed cleaning the kitchen area. At 7:15 AM, staff #1 offered client #1 a second portion of cereal and poured his bowl full of cereal. At 7:18 AM, client #2 entered the kitchen area and prepared himself a plate of 2 biscuits and 2 sausage patties. Staff #1 peeled the shell of a hard boiled egg and then placed the egg on client #2's plate. Client #2 was not encouraged to eat from the Living Lite Menu. At 7:24 AM, client #4 entered the kitchen area. Staff #1 prepared a plate of 2 biscuits, 2 sausage patties and a hard boiled egg on client #4's plate. Staff #1 then prepared a plate of 2 biscuits, 2 sausage patties and a hard boiled egg for client #3. At 7:28 AM, clients #1, #3 and #4 were seated at the dining room table eating while staff #1 began washing the pans used for morning meal preparation.</p> <p>Staff #1 was interviewed on 3/26/15 at 6:30 AM. Staff #1 stated, "They tell me that I'm doing too much for the clients. I'm the only staff here until 7:00 AM. I'm doing all the cleaning and getting them up and ready. It's overnights responsibility to do all the cleaning."</p> <p>1. Client #1's record was reviewed on 3/26/15 at 9:33 AM. Client #1's ISP</p>		<p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>dated 9/22/14 indicated, "given skills training, a choice of activities and 1 verbal prompt, [client #1] will participate in the activity of his choice." Client #1's CHRHP regarding potential for choking dated 10/13/14 indicated, "The CHRHP is not a nursing care plan. It is not designed to be carried out by nurses but by all staff who support the person." The 10/13/14 CHRHP for choking indicated, "[Client #1] must have supervision during all food/drink intake including snacks. Encourage [client #1] to eat/drink slowly, [client #1] is to remain sitting upright for at least 30 minutes after eating or drinking, monitor for signs/symptoms of choking during intake (coughing, grabbing of throat)."</p> <p>2. Client #2's record was reviewed on 3/26/15 at 8:30 AM. Client #2's ISP dated 9/20/14 indicated, "Given 3 verbal prompts, [client #2] will prepare a meal during meal time...." Client #2's CHRHP regarding diabetes dated 10/13/14 indicated, "The CHRHP is not a nursing care plan. It is not designed to be carried out by nurses but by all staff who support the person." Client #2's CHRHP regarding diabetes dated 10/13/14 indicated, "Encourage Living Lite menu at all times."</p> <p>3. Client #3's record was reviewed on</p>			

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	<p>3/26/15 at 9:16 AM. Client #3's ISP dated 9/9/14 indicated, "Given skills training and 2 verbal prompts, [client #3] will prepare a meal independently...."</p> <p>4. Client #4's record was reviewed on 3/26/15 at 9:58 AM. Client #4's ISP dated 4/16/14 indicated, "The team feels that [client #4] still continues to rely on others in order to perform a task. The team feels this goal should be continued...." Client #4's ISP dated 4/16/14 indicated, "Given skills training and 3 verbal prompts, [client #4] will state the steps required to complete an activity...."</p> <p>CS (Clinical Supervisor) #1 was interviewed on 3/26/15 at 9:02 AM. CS #1 indicated the group home's current staffing was one overnight staff from 12:00 AM through 8:00 AM and one additional staff was scheduled to come in at 7:00 AM. CS #1 indicated client #1 should be supervised during meals. CS #1 indicated the facility should have enough staff to implement active treatment and care plans. CS #1 indicated staff #1 could not monitor client #1 or implement active treatment with clients in the upstairs portion of the home while he was in the downstairs/basement portion of the home administering medications.</p>			

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W 189 Bldg. 00	<p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation and interview for 2 of 2 sampled clients (#1 and #2) plus 2 additional clients (#3 and #4), the facility failed to ensure staff working with clients #1, #2, #3 and #4 were competent in regard to meal preparation.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/26/15 from 6:20 AM through 8:15 AM. At 7:51 AM, client #3 was seated at the dining room table eating his breakfast. Client #3 stated to staff #1, "Did you see what she put in our lunches for today?" Staff #1 replied, "Yes." Staff #1 indicated staff #3 had prepared/packed lunches for clients #1, #2, #3 and #4. Staff #1 indicated staff #3 had prepared sandwiches consisting of peanut butter, jelly, ham and cheese all on the same sandwich.</p>	W 189	<p>CORRECTION:</p> <p><i>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Specifically, all current facility staff will receive additional and ongoing training to assure competency with regard to providing active treatment during meal preparation.</i></p> <p>PERVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited</p>	04/30/2015

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	<p>Client #3 was interviewed on 3/26/15 at 7:51 AM. Client #3 stated, "Yeah, it's peanut butter and jelly with ham and cheese. [Staff #3's] done it before. It happens sometimes."</p> <p>Staff #1 was interviewed on 3/26/15 at 7:52 AM. Staff #1 stated, "[Staff #3] is from [country]. She may not really know how or what to make."</p> <p>Home Manager (HM) #1 was interviewed on 3/26/15 at 9:43 AM. HM #1 stated, "[Client #3] told me this morning about the peanut butter, jelly, ham and cheese sandwiches. That's what I'm doing now. Making sandwiches to take to the day program for lunch."</p> <p>This deficiency was cited on 2/19/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>		<p>assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining and other domestic activities. The Team Lead will provide hands-on coaching and training as needed.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days, providing guidance and coaching to direct support staff. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p>		

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			<p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p>	

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W 249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION 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		<p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring staff demonstrate competencies with regard to the provision of active treatment in both formal and informal opportunities.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

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	<p>interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2) plus 2 additional clients (#3 and #4), the facility failed to ensure clients #1, #2, #3 and #4 received a continuous active treatment program.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/26/15 from 6:20 AM through 8:15 AM. At 6:20 AM, staff #1 swept and mopped the dining area floors and hallway area of the group home. Client #1 was seated on a couch located across from the kitchen area of the group home while clients #2, #3 and #4 were in their personal bedrooms. Clients #1, #2, #3 and #4 were not encouraged to assist with cleaning/domestic tasks. At 6:30 AM, staff #1 entered clients #2, #3 and #4's bedrooms to prompt them to wake for the day and prepare for day services. Staff #1 then resumed sweeping the floors before returning to the kitchen area to prepare the morning meal. Staff #1 removed a pan of sausage patties from the oven and then placed a tray of uncooked biscuits in the oven. Client #1 was seated on a couch located across from the kitchen area. Client #1 was not</p>	W 249	<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> Specifically, all direct support staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to meal preparation, family style dining and other domestic activities.</p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited</p>	04/30/2015

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	<p>encouraged to participate in the morning meal preparation. At 6:35 AM, client #3 entered the kitchen area and was prompted to go to the lower level/basement area of the home for medication administration. Client #1 was seated on the couch while staff #1 checked the biscuits in the oven and finished sweeping the kitchen floor. Clients #1 and #3 were not encouraged to assist with meal preparation or cleaning tasks.</p> <p>At 6:50 AM, staff #1 finished passing clients #3 and #4's medications in the group home's basement and returned to the kitchen and dining room areas where he resumed sweeping the floors and wiping down the counters. Client #1 was seated on the couch located next to the kitchen area and was not encouraged to participate in the morning cleaning or meal preparation or offered an activity. Staff #1 continued meal preparation as he prepared boiled eggs and began putting dishes away from the home's dishwasher. Client #1 sat on the couch next to kitchen and was not encouraged to assist to prepare the boiled eggs or put away dishes. Clients #2, #3 and #4 were located in their personal bedrooms and not encouraged to participate in the morning's meal or domestic chore tasks. At 6:53 AM, staff #1 got a bowl, spoon</p>		<p>assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining and other domestic activities.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM</p>	

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	<p>and milk from a kitchen cabinet and filled the bowl with cereal and milk. Staff #1 then took the bowl of cereal to the table and prompted client #1 to come eat his breakfast. Client #1 was not encouraged to get his own bowl, silverware or pour his own cereal. Client #1 sat at the kitchen table eating his cereal while staff #1 returned to clients #2, #3 and #4's bedrooms to prompt them to prepare for day services. At 7:02 AM, staff #1 used a damp rag to wipe down/clean the furniture in the home's living room and washed dishes while client #1 was seated at the dining room table eating cereal.</p> <p>At 7:03 AM, staff #1 prompted client #2 to go downstairs to the basement/medication administration area to receive his morning medications. Staff #1 was in the group home's basement area with client #2 from 7:03 AM through 7:07 AM while client #1 ate cereal at the dining room table unsupervised. At 7:07 AM, staff #2 arrived at the group home. At 7:09 AM, staff #2 exited the group home out the front door while client #1 was eating his cereal at the dining room table while staff #1 and client #2 remained downstairs. At 7:11 AM, staff #2 re-entered the group home and sat down on the couch next to the kitchen area while client #1 was</p>		<p>and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and</p>		

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	<p>eating at the dining room table unsupervised. At 7:12 AM, staff #1 and client #2 returned upstairs while staff #2 remained seated on the couch. Client #1 continued eating unsupervised while staff #1 resumed cleaning the kitchen area. At 7:15 AM, staff #1 offered client #1 a second portion of cereal and poured his bowl full of cereal. At 7:18 AM, client #2 entered the kitchen area and prepared himself a plate of 2 biscuits and 2 sausage patties. Staff #1 peeled the shell of a hard boiled egg and then placed the egg on client #2's plate. Client #2 was not encouraged to eat from the Living Lite Menu. At 7:24 AM, client #4 entered the kitchen area. Staff #1 prepared a plate of 2 biscuits, 2 sausage patties and a hard boiled egg on client #4's plate. Staff #1 then prepared a plate of 2 biscuits, 2 sausage patties and a hard boiled egg for client #3. At 7:28 AM, clients #1, #3 and #4 were seated at the dining room table eating while staff #1 began washing the pans used for morning meal preparation.</p> <p>The group home's Week 6 Living Lite Menu dated 11/18/12 was reviewed on 3/31/15 at 11:45 AM. The review indicated, "Thursday, Breakfast: Apple juice 4 fluid ounces, hot cereal 1/2 cup or cold cereal 3/4 cup, bagel 1 each, skim milk 8 fluid ounces, coffee 8 fluid ounces and low fat cream cheese 1 tablespoon."</p>		<p>Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>1. Client #1's record was reviewed on 3/26/15 at 9:33 AM. Client #1's ISP dated 9/22/14 indicated, "given skills training, a choice of activities and 1 verbal prompt, [client #1] will participate in the activity of his choice." Client #1's CHRHP regarding potential for choking dated 10/13/14 indicated, "The CHRHP is not a nursing care plan. It is not designed to be carried out by nurses but by all staff who support the person." The 10/13/14 CHRHP for choking indicated, "[Client #1] must have supervision during all food/drink intake including snacks. Encourage [client #1] to eat/drink slowly, [client #1] is to remain sitting upright for at least 30 minutes after eating or drinking, monitor for signs/symptoms of choking during intake (coughing, grabbing of throat)."</p> <p>2. Client #2's record was reviewed on 3/26/15 at 8:30 AM. Client #2's ISP dated 9/20/14 indicated, "Given 3 verbal prompts, [client #2] will prepare a meal during meal time...." Client #2's CHRHP regarding diabetes dated 10/13/14 indicated, "The CHRHP is not a nursing care plan. It is not designed to be carried out by nurses but by all staff who support the person." Client #2's CHRHP regarding diabetes dated 10/13/14 indicated, Encourage Living Lite menu at</p>			

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	<p>all times."</p> <p>3. Client #3's record was reviewed on 3/26/15 at 9:16 AM. Client #3's ISP dated 9/9/14 indicated, "Given skills training and 2 verbal prompts, [client #3] will prepare a meal independently...."</p> <p>4. Client #4's record was reviewed on 3/26/15 at 9:58 AM. Client #4's ISP dated 4/16/14 indicated, "The team feels that [client #4] still continues to rely on others in order to perform a task. The team feels this goal should be continued...." Client #4's ISP dated 4/16/14 indicated, "Given skills training and 3 verbal prompts, [client #4] will state the steps required to complete an activity...."</p> <p>QIDPD (Qualified Intellectual Disabilities Professional Designee) was interviewed on 3/26/15 at 9:09 AM. QIDPD indicated active treatment should occur at each available opportunity.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 3/26/15 at 9:02 AM. CS #1 indicated clients #1, #2, #3 and #4 should be encouraged to participate in the morning meal preparation and household cleaning activities to the extent they are capable.</p>			

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W 488 Bldg. 00	<p>This deficiency was cited on 2/19/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2) plus 2 additional clients (#3 and #4), the facility failed to ensure clients #1, #2, #3 and #4 participated in all aspects of meal preparation to the extent of their capabilities.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/26/15 from 6:20 AM through 8:15 AM. At 6:30 AM, staff #1 entered clients #2, #3 and #4's bedrooms to prompt them to wake for the day and prepare for day services. Staff #1 then resumed sweeping the floors before returning to the kitchen area to prepare the morning meal. Staff #1 removed a pan of sausage patties from the oven and then placed a tray of uncooked biscuits in</p>	W 488	<p>CORRECTION: <i>The facility must assure that each client eats in a manner consistent with his or her developmental level.</i></p> <p>Specifically, staff will be retrained regarding the need to assure all clients participate in all aspects of meal preparation to the extent of their capabilities. Additionally, the facility will modify the staffing matrix to assure that there are no less than two staff on duty at meal times. PREVENTION: The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt Residential</p>	04/30/2015

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	<p>the oven. Client #1 was seated on a couch located across from the kitchen area. Client #1 was not encouraged to participate in the morning meal preparation. At 6:35 AM, client #3 entered the kitchen area and was prompted to go to the lower level/basement area of the home for medication administration. Client #1 was seated on the couch while staff #1 checked the biscuits in the oven and finished sweeping the kitchen floor. Clients #1 and #3 were not encouraged to assist with meal preparation or cleaning tasks.</p> <p>At 6:50 AM, staff #1 finished passing clients #3 and 4's medications in the group home's basement and returned to the kitchen and dining room areas where he resumed sweeping the floors and wiping down the counters. Client #1 was seated on the couch located next to the kitchen area and was not encouraged to participate in meal preparation. Staff #1 continued meal preparation as he prepared boiled eggs and began putting dishes away from the home's dishwasher. Client #1 sat on the couch next to kitchen and was not encouraged to assist prepare the boiled eggs or put away dishes. Clients #2, #3 and #4 were located in their personal bedrooms and not encouraged to participate in the mornings</p>		<p>Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation and other domestic activities. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure</p>	

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	<p>meal. At 6:53 AM, staff #1 got a bowl, spoon and milk from a kitchen cabinet and filled the bowl with cereal and milk. Staff #1 then took the bowl of cereal to the table and prompted client #1 to come eat his breakfast. Client #1 was not encouraged to get his own bowl, silverware or pour his own cereal. Client #1 sat at the kitchen table eating his cereal while staff #1 returned to clients #2, #3 and #4's bedrooms to prompt them to prepare for day services.</p> <p>At 7:15 AM, staff #1 offered client #1 a second portion of cereal and poured his bowl full of cereal. At 7:18 AM, client #2 entered the kitchen area and prepared himself a plate of 2 biscuits and 2 sausage patties. Staff #1 peeled the shell of a hard boiled egg and then placed the egg on client #2's plate. At 7:24 AM, client #4 entered the kitchen area. Staff #1 prepared a plate of 2 biscuits, 2 sausage patties and a hard boiled egg on client #4's plate. Staff #1 then prepared a plate of 2 biscuits, 2 sausage patties and a hard boiled egg for client #3. At 7:28 AM, clients #1, #3 and #4 were seated at the dining room table eating while staff #1 began washing the pans used for morning meal preparation.</p> <p>1. Client #1's record was reviewed on 3/26/15 at 9:33 AM. Client #1's ISP</p>		<p>skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to meal preparation and family style dining. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G397	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250
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	<p>(Individual Support Plan) dated 9/22/14 indicated, "Given skills training, a choice of activities and 1 verbal prompt, [client #1] will participate in the activity of his choice." Client #1's ISP dated 9/22/14 indicated client #1 could participate in meal preparation tasks with staff's coaching.</p> <p>2. Client #2's record was reviewed on 3/26/15 at 8:30 AM. Client #2's ISP dated 9/20/14 indicated, "Given 3 verbal prompts, [client #2] will prepare a meal during meal time...."</p> <p>3. Client #3's record was reviewed on 3/26/15 at 9:16 AM. Client #3's ISP dated 9/9/14 indicated, "Given skills training and 2 verbal prompts, [client #3] will prepare a meal independently...."</p> <p>4. Client #4's record was reviewed on 3/26/15 at 9:58 AM. Client #4's ISP dated 4/16/14 indicated, "The team feels that [client #4] still continues to rely on others in order to perform a task. The team feels this goal should be continued...." Client #4's ISP dated 4/16/14 indicated, "Given skills training and 3 verbal prompts, [client #4] will state the steps required to complete an activity...."</p> <p>CS (Clinical Supervisor) #1 was</p>			

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	interviewed on 3/26/15 at 9:02 AM. CS #1 indicated clients #1, #2, #3 and #4 should be encouraged to participate in the morning meal preparation to the extent they are capable. CS #1 indicated clients #1, #2, #3 and #4 were capable of assisting staff prepare the morning meal with coaching. 9-3-8(a)				