

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G333	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4208 W GARVER ST MUNCIE, IN 47305
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaints #IN00180600 and #IN00179992.</p> <p>Complaint #IN00179992: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Complaint #IN00180600: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149 and W154.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: November 18, 19 and 20, 2015.</p> <p>Facility number: 000851 Provider number: 15G333 AIM number: 100243880</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/30/15.</p>	W 0000		

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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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon observation, interview and record review, the governing body failed to ensure the facility maintained the home in good condition for 4 of 4 sampled clients (clients A, B, C and D), and 4 additional clients (clients E, F, G and H).</p> <p>Findings include:</p> <p>Upon entrance to the group home observation on 11/19/15 from 12:06 PM until 3:10 PM where clients A, B, C, D, E, F, G and H lived, the home had a strong odor. The odor was more concentrated in clients A and F's bedroom.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 11/19/15 at 12:07 PM and indicated she did not smell the odor. She indicated client A was incontinent at night and wore incontinent briefs, but bedding was cleaned as needed. She</p>	W 0104	<p>W104: The governing body must exercise general policy, budget, and operating direction over the facility. The carpeting in the room was cleaned December 8th. The QIDP and Residential Manager will do a weekly environmental check to include whether carpeting needs cleaned. If Carpeting needs cleaned they will call the cleaning company immediately to arrange for the cleaning. Environmental checks will be reviewed monthly by the Program Manager. Persons responsible: QIDP, Program Manager and Residential Manager</p>	12/20/2015

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W 0149 Bldg. 00	<p>indicated the carpets were cleaned once yearly or more often as needed. She indicated she was not sure when the carpets were last cleaned, but would provide documentation as evidence of the last cleaning.</p> <p>The Supported Group Living Manager was interviewed on 11/20/15 at 11:30 AM and indicated there was no evidence of the last carpet cleaning of the group home.</p> <p>9-3-1(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 on record review and interview, the facility failed for 1 of 4 sampled clients (client A), to implement the facility's policies and procedures which prohibited abuse, neglect and exploitation. The facility failed to protect client A from the risk of falls and to provide staff supervision to meet her needs and failed to ensure a thorough investigation was completed for an</p>	W 0149	W149: The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. In order to assure that all investigations are thorough, the Quality Manager and Program Manager will meet weekly to discuss any allegations, review all investigations and ensure that all documentation and follow up has	12/20/2015

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	<p>allegation of neglect.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports from 8/2015 through 11/2015 were reviewed on 11/18/15 at 5:10 PM and indicated the following:</p> <p>A BDDS report dated 8/18/15 indicated client A was left in the van and staff went into the house after returning from the pharmacy. The group home nurse walked client A into the house. A follow up report dated 9/4/15 indicated the allegation was unsubstantiated. Client A had exited the van when the nurse found her and walked her into the house. The report indicated client A's risk plan did not indicate that a staff person needs to assist her out of the van into the home. "All staff will be trained that they are to stay with the van and assure that all consumers exit the van and walk into the home."</p> <p>An investigation into the incident dated 8/18/15-8/20/15 was reviewed on 11/18/15 at 5:30 PM and indicated the following undated interviews:</p> <p>The group home nurse indicated she was driving by the group home and saw the</p>		<p>been completed. Specifically if there appear to be discrepancies between witnesses, the investigator will re-interview witnesses to clear up those discrepancies. Persons responsible: Quality Manager and Program Manager.</p>				

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	<p>van pull into the driveway. As she looked in her rearview mirror she saw the driver get out and client A was still in the van. The nurse turned her car around and went back to the group home and "as she pulled back in and walked up, [client A] was getting out of the van." The group home nurse walked client A into the house, and said she found staff #2 doing "kitchen things." Staff #2 indicated to the group home nurse that she had not walked client A into the house. The group home nurse discussed the need to "make sure [client A] got out of the van safely."</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) indicated "she wouldn't leave her in the van and if she did she would stand on the porch to wait for her. She indicated there was nothing official that stated that staff have to help her out of the van and she has not fallen getting out of the van...."</p> <p>Staff #1 indicated staff #2 had come in the door without client A after returning from the pharmacy and client A came in later with the nurse.</p> <p>Staff #2 indicated she had stood by the van and watched client A get out of the van after they returned from the pharmacy. She indicated the nurse had</p>			

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	<p>come into the house after staff #2 and client A came into the house.</p> <p>"Factual Findings" indicated "There is conflicting information as to whether [client A] was left in the van to get on her own or not. The risk plan does not specifically state that staff are to be with [client A] when exiting/entering the van."</p> <p>The Conclusion indicated "The allegation was not substantiated. [Client A] is capable of getting out of the van herself and has done it previously. In this incident she was in the process of getting out of the van when the nurse arrived and exited without assistance. All staff will be trained that they are to stay with the van and assure that all consumers exit the van and are walked into the home."</p> <p>Client A's record was reviewed on 11/19/15 at 2:22 PM. A Functional Behavior Analysis dated 5/22/15 indicated client A required 24 hour supervision. Identified behaviors included self-injurious behaviors (slap or bite herself or others), dementia symptoms (blank stare, wandering around aimlessly, walk into the street, or being non-compliant), and Verbal Aggression (cursing at other people). A Risk Plan dated 6/1/15 indicated client A had "Increased potential for falls d/t (due to):</p>			

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	<p>gait abnormality, drug induced parkinsonism. Sensory impairment: vision/cataracts." The risk plan indicated client A wore a helmet as needed when out of bed to prevent injury d/t frequent falls, if gait is unsteady...." A health care plan dated 8/1/15 indicated client A was a fall risk-potential for injury due to "occasional unsteady gait and history of falling upon rising, rapid gait...." The plan indicated client A was to wear a helmet while out of bed and staff were to monitor ambulation, encourage to slow down and assist as needed.</p> <p>During observation at the group home on 11/19/15 from 12:06 PM until 3:10 PM, client A wore a helmet as she walked around the group home after returning from an outing. Staff #1 stood in front of client A as she got in and out of the van during the observation.</p> <p>Staff #1 was interviewed on 11/19/15 at 1:35 PM and indicated client A required assistance to get in and out of the van.</p> <p>The QIDP was interviewed on 11/19/15 at 3:46 PM and indicated staff #2 should not have left client A alone in the van to come in the home by herself.</p> <p>The Supported Group Living Manager was interviewed on 11/20/15 at 11:30</p>				

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	<p>AM and indicated the conflicting information was not resolved and additional information or interviews had not been obtained to clarify/resolve the information.</p> <p>The facility's Policy/Procedure for Reporting and Investigating Abuse, Neglect, Exploitation, and Mistreatment of clients dated 6/2011 was reviewed on 11/18/15 at 5:45 PM and indicated "All allegations or occurrences of abuse/neglect/exploitation/mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare Northern Region Indiana, local, state and federal guidelines...Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse/neglect/exploitation should immediately notify the Director of Supported Group Living (group homes), then complete an Incident Report. The Director of Supported Group Living/Supported Living will then notify the Executive Director. This step should be done within 24 hours. The Director of the program (SGL or SL) or designee will report the suspected abuse, neglect or exploitation within 24 hours of the initial report to the appropriate contacts, which may include:...Bureau of Developmental</p>			

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	<p>Disabilities Service Coordinator...The Director of the Program (SGL or SL) will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures or investigations...One of the investigators will complete a detailed investigative case summary based on witness statements and other evidence collected...An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Director of Supported Living or SGL, and a Human Resources representative."</p> <p>This federal tag relates to complaint #IN00180600.</p> <p>9-3-2(a)</p>			

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W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client A), to ensure a thorough investigation was completed for an allegation of neglect.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports from 8/2015 through 11/2015 were reviewed on 11/18/15 at 5:10 PM and indicated the following:</p> <p>A BDDS report dated 8/18/15 indicated client A was left in the van and staff went into the house after returning from the pharmacy. The group home nurse walked client A into the house. A follow up report dated 9/4/15 indicated the allegation was unsubstantiated. Client A had exited the van when the nurse found her and walked her into the house. The report indicated client A's risk plan did not indicate that a staff person needs to</p>	W 0154	W154: The facility must have evidence that all alleged violations are thoroughly investigated. In order to assure that all investigations are thorough, the Quality Manager and Program Manager will meet weekly to discuss any allegations, review all investigations and ensure that all documentation and follow up has been completed. Specifically if there appear to be discrepancies between witnesses, the investigator will re-interview witnesses to clear up those discrepancies. Persons responsible: Quality Manager and Program Manager.	12/20/2015

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	<p>assist her out of the van into the home. "All staff will be trained that they are to stay with the van and assure that all consumers exit the van and walk into the home."</p> <p>An investigation into the incident dated 8/18/15-8/20/15 was reviewed on 11/18/15 at 5:30 PM and indicated the following undated interviews:</p> <p>The group home nurse indicated she was driving by the group home and saw the van pull into the driveway. As she looked in her rearview mirror she saw the driver get out and client A was still in the van. The nurse turned her car around and went back to the group home and "as she pulled back in and walked up, [client A] was getting out of the van." The group home nurse walked client A into the house, and said she found staff #2 doing "kitchen things." Staff #2 indicated to the group home nurse that she had not walked client A into the house. The group home nurse discussed the need to "make sure [client A] got out of the van safely."</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) indicated "she wouldn't leave her in the van and if she did she would stand on the porch to wait for her. She indicated there was nothing</p>			

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	<p>official that stated that staff have to help her out of the van and she has not fallen getting out of the van...."</p> <p>Staff #1 indicated staff #2 had come in the door without client A after returning from the pharmacy and client A came in later with the nurse.</p> <p>Staff #2 indicated she had stood by the van and watched client A get out of the van after they returned from the pharmacy. She indicated the nurse had come into the house after staff #2 and client A came into the house.</p> <p>"Factual Findings" indicated "There is conflicting information as to whether [client A] was left in the van to get on her own or not. The risk plan does not specifically state that staff are to be with [client A] when exiting/entering the van."</p> <p>The Conclusion indicated "The allegation was not substantiated. [Client A] is capable of getting out of the van herself and has done it previously. In this incident she was in the process of getting out of the van when the nurse arrived and exited without assistance. All staff will be trained that they are to stay with the van and assure that all consumers exit the van and are walked into the home."</p>			

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	<p>The QIDP was interviewed on 11/19/15 at 3:46 PM and indicated staff #2 should not have left client A alone in the van to come in the home by herself.</p> <p>The Supported Group Living Manager was interviewed on 11/20/15 at 11:30 AM and indicated the conflicting information was not resolved and additional information or interviews had not been obtained to clarify/resolve the information.</p> <p>This federal tag relates to complaint #IN00180600.</p> <p>9-3-2(a)</p>			