

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G317	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/08/2016
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 580 MAIN ST LAWRENCEBURG, IN 47025
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W 0000  Bldg. 00	<p>This visit was for a full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00196140.</p> <p>Complaint #IN00196140: Substantiated. Federal/state deficiencies related to the allegation are cited at W149 and W249.</p> <p>Survey Dates: April 5, 6, 7 and 8, 2016</p> <p>Facility Number: 000835 Provider Number: 15G317 AIM Number: 100243660</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/13/16.</p>	W 0000		
W 0149  Bldg. 00	<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 for 2 of 7 incident/investigative reports reviewed affecting clients D, H and former client C, the facility neglected to implement its policies and procedures to</p>	W 0149	<p><b>W149:</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect</p>	04/22/2016

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>prevent client to client abuse and ensure client C's Behavior Support Plan was implemented as written.</p> <p>Findings include:</p> <p>On 4/5/16 at 11:53 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 3/14/16 at 7:00 AM in the group home van, client C argued with and called client H names. The group home van was at the group home. Client H called client C names. Client H swung her arm in an attempt to hit client C but did not make contact. The staff pulled the van back into the driveway and separated the clients. Client C yelled she was going to call the police. Staff dialed 911. The police came to the group home and spoke with the clients. The police did not file a report and both clients got back onto the van and went to the workshop without incident. The 3/14/16 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "Both ladies have a BSP (behavior support plan) that addresses physical aggression. Staff followed the plan stopping the van and separating the two ladies. The staff separated the two ladies preventing further aggression and avoiding a physical confrontation...." The 3/18/16 Client to Client Aggression</p>		<p>or abuse of the client.</p> <p><b>Corrective Action:</b></p> <ul style="list-style-type: none"> <li>· Client C, Addendum written to add reactive strategies to her BSP. <b>(Attachment A)</b></li> <li>· Staff trained on Client C BSP and Addendum adding reactive strategies. <b>(Attachment B)</b></li> <li>· Staff trained on Chain of Command. <b>(Attachment B)</b></li> <li>· Staff trained on Abuse/Neglect Policy. <b>(Attachment C)</b></li> </ul> <p><b>How we will identify others:</b></p> <ul style="list-style-type: none"> <li>· The QIDP will ensure all behaviors plans are current and staff are trained and follow these plans.</li> </ul> <p><b>Measures to be put in place:</b></p> <ul style="list-style-type: none"> <li>· Staff trained monthly on Abuse Neglect Policy. <b>(Attachment C) (Attachment I)</b></li> </ul>	

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	<p>Investigation indicated, "...Staff (#9) called the police because [client C] was 'screaming' she was calling the police." Client C indicated in the investigation client H made contact with her when client H swung at her. Client H denied making contact with client C. Clients B, F and G indicated in the investigation client H hit client C on the arm.</p> <p>On 3/15/16 at 8:30 PM, client D reported to staff that during the incident in the van on 3/14/16 at 7:00 AM, client C hit her on the right leg causing bruising. Client D indicated she did not report the incident to the staff. Client D indicated after speaking to her mom on the phone, client D's mom told client D to press charges against client C. Client D called 911 and officers responded. The police spoke with clients C and D. Client D indicated she wanted to press charges against client C. Client C was arrested and taken to jail.</p> <p>The 3/17/16 BDDS Incident Follow-Up Report indicated, "[Client C] attended an initial hearing in Superior Court in [name of county] this morning. Preliminary charge is battery with injury. [Client C] was provided a court appointed attorney and she plead not guilty to the charge...."</p> <p>The 3/21/16 Client to Client Aggression</p>		<ul style="list-style-type: none"> <li>· QIDP will ensure Behavior plans are current, are trained and being followed.</li> <li>· The Residential Manager will complete 2 weekly Active treatment observations to ensure that clients are free from abuse and neglect. <b>(Attachment H)</b></li> </ul> <p><b>Monitoring of Corrective Action:</b></p> <ul style="list-style-type: none"> <li>· Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members.</li> </ul> <p><b>Completion Date: 4-22-16</b></p>	

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	<p>Investigation indicated in client G's interview, "Where was staff when [client C] hitting (sic) [client D]? The staff was out on the porch smoking waiting on the police. Police got there and they didn't do nothing (sic)...." The investigation indicated, in part, "Were any behavior strategies not followed? If so what behavior strategies were not followed? Police were called which is not in the BSP. Staff called because [client C] stated she was going to call." Client H's interview in the investigation indicated at the time client C hit client D on the leg, the staff was on the porch smoking. Client C had 3 bruises on her left leg measuring 1/4 inch round bruise above her left knee, 1/4 inch round bruise on her left thigh and 2 3/4 inch below her left knee. The investigation indicated client C admitted to hitting client D on the leg with her fist. The investigation indicated client C returned to the group home with one on one staffing on 3/17/16. Client C was moved to a supported living home on 3/18/16.</p> <p>On 4/7/16 at 10:45 AM, a review of client H's record was conducted. Client H's 10/7/15 Behavior Support Plan (BSP) did not include a reactive strategy to call the police for physical aggression.</p> <p>On 4/5/16 at 11:53 AM, a focused review</p>			

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	<p>of client C's BSP was conducted (the BSP was included in the investigative packet). There was no documentation in client C's BSP indicating the police was to be contacted for verbal or physical aggression. The Reactive Strategies section for verbal aggression (defined as yelling, cursing or threatening others) indicated, in part, "When [client C] becomes verbally aggressive, staff will immediately go to one on one staffing with [client C]." Staff will clear the area of other clients, calmly ask [client C] to calm down and ask what is bothering her...."</p> <p>On 4/5/16 at 12:39 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse of the clients. The QIDP indicated client H was taken inside the group home and another staff was on the porch calling the police. The QIDP indicated neither staff observed client C hit client D. Client D reported the incident the following evening after speaking to her mom. The QIDP indicated client D had bruising on her leg. The QIDP indicated client C admitted to hitting client D twice on the leg. The QIDP indicated client C took</p>			

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	<p>client D's purse (in order to move it off her lap) and hit client D on the leg. The QIDP indicated client H denied hitting client C however client C indicated client H hit her. On 4/8/16 at 12:08 PM, the QIDP indicated the staff should have implemented client C's plan as written. The QIDP indicated the staff attempted to get client C off the van but she refused to leave the van. The QIDP indicated client C should have been one on one as soon as she was verbally aggressive. The QIDP indicated calling the police was not part of client C or any other clients' plans. The QIDP indicated the staff could have asked the other clients to exit the van. The QIDP indicated if the staff initiated client C's one on one, staff may have observed client C hit client D. The QIDP indicated if the staff asked everyone else to exit the van, the client to client aggression may have been avoided.</p> <p>On 4/7/16 at 11:20 AM, the QIDP-D (Qualified Intellectual Disabilities Professional - Designee) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP-D indicated the facility had a policy and procedure prohibiting abuse of the clients. The QIDP-D indicated the staff did not follow the clients' plans. The QIDP-D indicated the staff should not have called the</p>			

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	<p>police. The QIDP-D indicated calling the police was not in any of the clients' plans. On 4/8/16 at 12:19 PM, the QIDP-D indicated the staff should have implemented client C's plan as written. The QIDP-D indicated the police should not have been contacted. The QIDP-D indicated client C should have been one on one as indicated in her plan. The QIDP-D indicated since client C refused to leave the van, the other clients could have been removed from the area. The QIDP-D indicated if the staff implemented the plan as written, the client to client aggression may have been avoided.</p> <p>On 4/6/16 at 10:09 AM, client D indicated client C took her purse off her lap and hit her on the leg. Client D indicated client H slapped client C prior to the incident between her and client C. Client D indicated her leg was bruised due to the incident. Client D indicated she called the police the next day after speaking with her mom. Client D indicated client C was arrested.</p> <p>On 4/5/16 at 11:13 AM, an interview with the Executive Director (ED) was conducted. The ED indicated client C was arrested for hitting client D on the leg. The ED indicated client D did not immediately report the incident. Client D</p>			

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W 0249  Bldg. 00	<p>reported the incident to her mom who advised client D to call the police to press charges. The ED indicated client C was moved out of the group home.</p> <p>On 4/5/16 at 11:14 AM, the Assistant Executive Director (AED) indicated client C was moved to a supported living site the day after she was released from jail. The AED indicated the day client C was released from jail she returned to the group home with one on one staffing for one night.</p> <p>On 4/5/16 at 12:23 PM, a review was conducted of the facility's Abuse, Neglect, Exploitation Operation Standard, dated 7/18/11. The policy indicated, "CASC (Community Alternatives South Central) staff actively advocate for the rights and safety of all individuals... ResCare strictly prohibits abuse/neglect/exploitation/mistreatment..."</p> <p>This federal tag relates to complaint #IN00196140.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>				

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	<p>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 on record review and interview for 1 of 3 non-sampled clients (client C), the facility failed to ensure staff implemented her Behavior Support Plan as written.</p> <p>Findings include:</p> <p>On 4/5/16 at 11:53 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 3/14/16 at 7:00 AM in the group home van, client C argued with and called client H names. The group home van was at the group home. Client H called client C names. Client H swung her arm in an attempt to hit client C but did not make contact. The staff pulled the van back into the driveway and separated the clients. Client C yelled she was going to call the police. Staff dialed 911. The police came to the group home and spoke with the clients. The police did not file a report and both clients got back onto the van and went to the workshop without incident. The 3/14/16 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "Both ladies have a BSP (behavior support plan) that addresses</p>	W 0249	<p><b>W249:</b> The facility failed to ensure staff implemented the Behavior Support Plan as written.</p> <p><b>Corrective action:</b></p> <ul style="list-style-type: none"> <li>Staff trained on Client C Behavior Support Plan. <b>(Attachment B)</b></li> <li>Behavior Support Plans are reviewed quarterly and Annually by the Interdisciplinary Team.</li> </ul> <p><b>How we will identify others:</b></p> <ul style="list-style-type: none"> <li>The QIDP will ensure all Behavior Support Plans are trained and implemented as written.</li> </ul> <p><b>Measures to be put in place:</b></p> <ul style="list-style-type: none"> <li>The QIDP will review Behavior Support Plans quarterly and Annually with the Interdisciplinary Team.</li> </ul>	04/22/2016

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	<p>physical aggression. Staff followed the plan stopping the van and separating the two ladies. The staff separated the two ladies preventing further aggression and avoiding a physical confrontation...."</p> <p>The 3/18/16 Client to Client Aggression Investigation indicated, "...Staff (#9) called the police because [client C] was 'screaming' she was calling the police." Client C indicated in the investigation client H made contact with her when client H swung at her. Client H denied making contact with client C. Clients B, F and G indicated in the investigation client H hit client C on the arm.</p> <p>On 3/15/16 at 8:30 PM, client D reported to staff that during the incident in the van on 3/14/16 at 7:00 AM, client C hit her on the right leg causing bruising. Client D indicated she did not report the incident to the staff. Client D indicated after speaking to her mom on the phone, client D's mom told client D to press charges against client C. Client D called 911 and officers responded. The police spoke with clients C and D. Client D indicated she wanted to press charges against client C. Client C was arrested and taken to jail.</p> <p>The 3/21/16 Client to Client Aggression Investigation indicated in client G's interview, "Where was staff when [client</p>		<p><b>Monitoring of Corrective Action:</b></p> <ul style="list-style-type: none"> <li>· The QIDP will ensure all Behavior Support Plans are current and staff are trained.</li> <li>· Behavior Support Plans are reviewed all monthly house meetings. (<b>Attachment I</b>)</li> <li>· The Residential Manager will complete 2 Active Treatment Observations weekly to ensure Behavior Support Plans are being implemented.</li> </ul> <p><b>Completion Date: 4-22-16</b></p>	

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	<p>C] hitting (sic) [client D]? The staff was out on the porch smoking waiting on the police. Police got there and they didn't do nothing (sic)...." The investigation indicated, in part, "Were any behavior strategies not followed? If so what behavior strategies were not followed? Police were called which is not in the BSP. Staff called because [client C] stated she was going to call."</p> <p>On 4/7/16 at 10:45 AM, a review of client H's record was conducted. Client H's 10/7/15 Behavior Support Plan (BSP) did not include a reactive strategy to call the police for physical aggression.</p> <p>On 4/5/16 at 11:53 AM, a focused review of client C's BSP was conducted (the BSP was included in the investigative packet). There was no documentation in client C's BSP indicating the police was to be contacted for verbal or physical aggression. The Reactive Strategies section for verbal aggression (defined as yelling, cursing or threatening others) indicated, in part, "When [client C] becomes verbally aggressive, staff will immediately go to one on one staffing with [client C]." Staff will clear the area of other clients, calmly ask [client C] to calm down and ask what is bothering her...."</p>			

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	<p>On 4/7/16 at 11:20 AM, the Qualified Intellectual Disabilities Professional -Designee (QIDP-D) indicated the staff did not implement the clients' behavior plans as written. The QIDP-D indicated the police should not have been called. On 4/8/16 at 12:19 PM, the QIDP-D indicated the staff should have implemented client C's plan as written. The QIDP-D indicated the police should not have been contacted. The QIDP-D indicated client C should have been one on one as indicated in her plan. The QIDP-D indicated since client C refused to leave the van, the other clients could have been removed from the area. The QIDP-D indicated if the staff implemented the plan as written, the client to client aggression may have been avoided.</p> <p>On 4/8/16 at 12:08 PM, the QIDP indicated the staff should have implemented client C's plan as written. The QIDP indicated the staff attempted to get client C off the van but she refused to leave the van. The QIDP indicated client C should have been one on one as soon as she was verbally aggressive. The QIDP indicated calling the police was not part of client C or any other clients' plans. The QIDP indicated the staff could have asked the other clients to exit the van. The QIDP indicated if the staff initiated</p>			

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W 0381 Bldg. 00	<p>client C's one on one, staff may have observed client C hit client D. The QIDP indicated if the staff asked everyone else to exit the van, the client to client aggression may have been avoided.</p> <p>This federal tag relates to complaint #IN00196140.</p> <p>9-3-4(a)</p> <p>483.460(l)(1) <b>DRUG STORAGE AND RECORDKEEPING</b> The facility must store drugs under proper conditions of security.</p> <p>Based on observation and interview for 7 of 7 clients living in the group home (A, B, D, E, F, G and H), the facility failed to ensure the clients' medications were secured during the evening observation.</p> <p>Findings include:</p> <p>On 4/5/16 from 3:30 PM to 5:46 PM, an observation was conducted at the group home. At 3:42 PM, one of the medication cabinets was unlocked. There was no staff in the medication area. Clients G and H were in the kitchen area adjacent to the medication area making their lunches. On 4/5/16 at 3:43 PM, staff #2 indicated the medication cabinet should be locked unless medications</p>	W 0381	<p><b>W381:</b> The facility must store drugs under proper conditions of security.</p> <p><b>Corrective action:</b></p> <ul style="list-style-type: none"> <li>· Medication Administration Policy will address that once medication administration has started that the medication storage cabinet will not be left unattended. <b>(Attachment D)</b></li> <li>· Staff will be trained on Medication Administration Policy. <b>(Attachment B)</b></li> </ul>	04/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G317	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/08/2016
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 580 MAIN ST LAWRENCEBURG, IN 47025		
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	<p>were being administered. Staff #2 indicated medications were being administered however none of the clients received medications during the observation until 4:07 PM. The medication cabinet was unlocked and unsecured from 3:42 PM to 4:07 PM. This affected clients A, B, D, E, F, G and H.</p> <p>On 4/7/16 at 11:14 AM, the Qualified Intellectual Disabilities Professional - Designee indicated the medication cabinet should be locked at all times unless medications were being administered or the staff was checking the medications.</p> <p>9-3-6(a)</p>		<p><b>How we will identify others:</b></p> <ul style="list-style-type: none"> <li>· The Residential Manager will review Medication Administration Policy at monthly house meetings. <b>(Attachment D) (Attachment I)</b></li> <li>· Annual Medication Administration training is completed by the nurses. <b>(Attachment E)</b></li> </ul> <p><b>Measures to be put in place:</b></p> <ul style="list-style-type: none"> <li>· A site review will be completed at the home monthly by Management Personnel to ensure medications are locked and controlled medications are double locked. <b>(Attachment F)</b></li> <li>· The Nurse assigned to the home will perform a weekly med observation. <b>(Attachment G)</b></li> </ul> <p><b>Monitoring of Corrective Action</b></p>		

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			<ul style="list-style-type: none"> <li>The Program Manager will ensure monthly the identified measures are carried out by reviewing the site review notes, active treatment observations, all trainings/in-services that are completed, and ensure all staff receive annual medication administration training.</li> <li>The Nurse Manager will ensure the assigned nurses are completing their weekly medication observations. The weekly observation is sent to the Nurse Manager upon completion for review.</li> </ul> <p><b>Completion Date: 4-22-16</b></p>	