

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Survey Dates: December 8, 9, 10, 11, 12 and 22, 2014.</p> <p>Facility Number: 000844 Provider Number: 15G326 AIMS Number: 100243650</p> <p>Surveyors: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 2, 2015 by Dotty Walton, QIDP.</p>	W000000		
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#2), the facility failed to ensure the rights of the client by not ensuring a legally sanctioned representative or a health care representative for client #2 when making informed decisions in</p>	W000125	<p>Addendum W125: The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due</p>	01/28/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>regards to the client #2's medical and psychological needs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/8/14 between 3:45 PM and 6 PM and on 12/10/14 between 5:45 AM and 7 AM. Client #2 was a tall elderly gentleman that stood slightly stooped in posture and walked with an unsteady gait. Client #2 was quiet and communicated minimally and was difficult to understand when talking.</p> <p>Client #2's record was reviewed on 12/10/14 at 5 PM.</p> <p>Client #2's record indicated client #2 was elderly at 70 years of age and had diagnoses of, but not limited to, severe mental disabilities, OCD (Obsessive Compulsive Disorder), IED (Intermittent Explosive Disorder), anxiety disorder, hypertension (high blood pressure), severe deformity of both feet with bunions, elevated cholesterol levels, arthritis, IBS (Irritable Bowel Syndrome) with diarrhea, anemia (a below normal volume of red cells in the blood), mycotic (fungal) nails, Tinea Pedis (Athlete's foot), Eczema of the hands, Bradycardia (slow heart rate), Allergic Rhinitis (allergies that affect the respirations),</p>		<p>process.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> The QIDP designee convened client 2's IDT on 12/19/14 to review need for a legal representative and/or health care representative in regards to client #2's abilities to make medical decisions. (Attachment A) The QIDP designee convened client #2's IDT on 12/19/14 to discuss obtaining and ensuring a legally sanctioned representative or health care representative to assist client #2 when making informed decisions in regards to medical and psychological needs. Appointment of Health Care Representative paperwork was sent to client 2's family with appointment of a Health Care Representative obtained on 12/24/14. (Attachment B) <p>How we will identify others:</p> <ul style="list-style-type: none"> QIDP or designee will complete the informed assessment annually reviewing quarterly for needed revisions. QIDP or designee will review with IDT any identified changes to assessed skill set quarterly. <p>Measures to be put in place:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Hemorrhoids, Diverticulitis (bowel problems) and a Hiatal hernia (a condition in which part of the stomach sticks upward into the chest, through an opening in the diaphragm).</p> <p>Client #2's ISP (Individual Support Plan) dated 12/12/13 indicated: __ Client #2 communicated with phrases and simple sentences but when frustrated he had difficulty in expressing his thoughts and required clarifying questions from staff, eye contact and time to process information. __ Client #2 required "24 hour supervision to ensure that basic ADLs (Adult Daily Living Skills) are completed."</p> <p>Client #2's quarterly physician's orders for December 2014 indicated client #2 received: __ Luvox 300 mg (milligrams) daily for IED (Intermittent Explosive Disorder). __ Invega 3 mg daily for IED. __ Ativan 5 mg daily for OCD (Obsessive Compulsive Disorder). __ Cogentin 2 mg daily for EPS (Extrapyramidal Symptoms - A group of side effects associated with antipsychotic medications).</p> <p>Client #2's 12/18/13 revised BSP (Behavior Support Plan) indicated client</p>		<ul style="list-style-type: none"> · Residential Manager will conduct monthly staff meetings for the purpose of reviewing annual assessments to review with QIDP or designee accuracy of assessments. · Residential Manager will conduct monthly staff meetings for the purpose of reviewing quarterly assessments of individuals to discuss with QIDP or designee any changes. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · Residential Manager will conduct monthly staff meetings for the purpose of reviewing annual assessments to review with QIDP or designee accuracy of assessments. · Residential Manager will conduct monthly staff meetings for the purpose of reviewing quarterly assessments of individuals to discuss with QIDP or designee any changes. <p>Completion Date: 1-28-2015</p> <p>W125: The facility must ensure the rights of all clients. Therefore, the facility must</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>#2 had targeted behaviors of physical aggression, verbal aggression and OCD.</p> <p>Client #2's Informed Consent Assessment dated 12/9/14 indicated client #2 was self responsible and capable of making medical decisions on his own and did not require a representative.</p> <p>The QIDPD (Qualified Intellectual Disabilities Professional Designee) was interviewed on 12/12/14 at 11:30 AM. The QIDPD: ___ Indicated client #2 required assistance with making medical decisions ___ Indicated client #2's informed consent assessment was not correct and should be corrected. ___ Indicated client #2 did not have a legal representative and/or a health care representative to make medical decisions for him. ___ Indicated the IDT (Interdisciplinary Team) advocated for client #2 in regard to health care needs. ___ Indicated client #2 had a nephew that visited occasionally and stated, "I can see if he would be willing to serve as his (client #2's) representative." 9-3-2(a)</p>		<p>allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Corrective action: · The QIDP designee will convene client 2's IDT to review and revise client #2's informed consent assessment in regards to client #2's needs for a legal representative and/or health care representative in regards to client #2's abilities to make medical decisions. (Attachment A) · The QIDP designee will convene client #2's IDT to discuss obtaining and ensuring a legally sanctioned representative or health care representative to assist client #2 when making informed decisions in regards to medical and psychological needs. (Attachment B) How we will identify others: · QIDP or designee will complete the informed assessment annually reviewing quarterly for needed revisions. · QIDP or designee will review with IDT any identified changes to assessed skill set quarterly. Measures to be put in place: · Residential Manager will conduct monthly staff meetings for the purpose of reviewing annual assessments to review with QIDP or designee accuracy of assessments. · Residential Manager will conduct monthly staff meetings for the purpose of reviewing quarterly</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000140	<p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 4 sampled clients (#4), the facility failed to provide a full and complete accounting of client #4's personal finances.</p> <p>Findings include:</p> <p>Client #4's financial records from 2013/2014 were reviewed on 12/10/14 at 2 PM with the QIDPD (Qualified Intellectual Disabilities Professional Designee) and the RM (Residential Manager).</p>	W000140	<p>assessments of individuals to discuss with QIDP or designee any changes. Monitoring of Corrective Action: · Residential Manager will conduct monthly staff meetings for the purpose of reviewing annual assessments to review with QIDP or designee accuracy of assessments. · Residential Manager will conduct monthly staff meetings for the purpose of reviewing quarterly assessments of individuals to discuss with QIDP or designee any changes. Completion Date: 1-21-2015</p> <p><u>W140 Client Finances: The facility must establish and maintain a system that assures a full and complete accounting of clients personal funds entrusted to the facility on behalf of clients. Corrective action:</u> · The Clinical Supervisor will provide re-training to the Residential Manager on the agency's financial policies and procedures including training of documentation of resource ledger, documentation of purchases made as related to ensuring receipts are obtained, secured and properly maintained, and procedure for any lost receipts to ensure accurate</p>	01/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Client #4's RLS (Resource Ledger Sheet) for client #4's checking account for August 2014 indicated:</p> <p>__ On 8/19/14 a purchase made at a local department store in the amount of \$86.02 with check #504.</p> <p>__ The \$86.02 was deducted from client #4's checking account leaving client #4 with a balance of \$222.05.</p> <p>__ No receipt for the purchase made on 8/19/14 for \$86.02.</p> <p>The QIDPD and the RM were interviewed on 12/12/14 at 12:30 PM.</p> <p>__ The QIDPD indicated she was not able to locate a receipt and/or a copy of the check for client #4 for the purchase made on 8/19/14.</p> <p>__ The QIDPD indicated the RM was responsible for maintaining the clients' finances and financial records.</p> <p>__ The RM indicated she had called the main office to see if they could find the original and/or a copy of the receipt for the purchase made on 12/12/14.</p> <p>__ The RM indicated the main office staff were unable to locate a receipt for a purchase made on 8/19/14.</p> <p>__ The RM stated, "I have no idea what happened or where the receipt is at."</p> <p>__ The QIDPD and the RM indicated they were unable to explain where the receipt was at and/or what the money was spent on in regard to client #4's RLS.</p>		<p>accounting of client finances. (Attachment C) · All staff to receive re-training of financial policy and procedures to include responsibility of staff to secure receipts, properly document all transactions and lost receipt procedure. (Attachment D) How we will identify others: · Direct care staff will be responsible to secure and document all receipts on ledgers as transactions occur. · Residential Manager will complete monthly audit sheet of all finances. · Residential Manager will submit monthly finances with audit sheet to financial department. Measures to be put in place: · Clinical Supervisor to provide re-training to Residential Manager on the agencies financial policies and procedures. · All staff to receive re-training of financial policy and procedures. Monitoring of Corrective Action: · Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure financial policy and procedure are being completed accurately. Completion Date: 1-21-2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000249	<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, 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 observation, interview and record review for 1 of 4 sample clients (#2), the facility failed to ensure the staff implemented client #2's ISP (Individual Support Plan) and dining plan.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/8/14 between 3:45 PM and 6 PM and on 12/10/14 between 5:45 AM and 7 AM.</p> <p>__ During the PM observation period client #2 consumed chicken cut into small pieces, mixed vegetables, a pasta mix, bread and a fruit.</p> <p>__ During the AM observation period client #2 consumed cereal with milk and toast.</p> <p>__ During both meals, client #2 took large bites of food, ate at a fast pace and did not place his spoon down between bites.</p>	W000249	<p>Addendum</p> <p>W 249: 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 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> Direct care staff received re-training, on 1/8/15, of client #2's mealtime needs as it relates to client #2's dining plan goal. (Attachment C) Direct care staff specifically receive training to ensure client #2 is prompted to eat slowly, take small bites and lay his utensil down after 	01/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>__ During both meals, the staff did not prompt client #2 to lay his eating utensils down between bites of food, prompt client #2 to take smaller bites and/or prompt client #2 to slow his pace of consumption when eating too fast.</p> <p>Client #2's record was reviewed on 12/10/14 at 5 PM.</p> <p>__ Client #2's 2/6/14 ISP indicated a formal objective for client #2 to lay down his eating utensil between bites with 1 verbal prompt from the staff.</p> <p>__ Client #2's 12/13/13 dining plan indicated the staff were to prompt client #2 to lay down his eating utensils between bites of food to ensure safe consumption of food. The plan indicated the staff were to prompt client #2 to slow his pace of eating and drinking.</p> <p>The QIDPD (Qualified Intellectual Disabilities Professional Designee) was interviewed on 12/12/14 at 11:30 AM. The QIDPD: __ Indicated client #2 would take large bites and eat at a fast pace if not prompted by the staff to slow down and/or to take smaller bites. __ Indicated the staff were to follow client D's ISP and dining plan with every meal. __ Indicated the staff were to prompt client #2 to lay down his eating utensils after each bite of food consumed and</p>		<p>each bite.</p> <p>)</p> <p>How we will identify others:</p> <ul style="list-style-type: none"> Four Activity Treatment Observations will be performed weekly in home to ensure that Client # 2's mealtime goal is completed accurately. Observations will be completed by the Residential Manager, QIDP or designee, and Clinical Supervisor for 1 month at which time observations will be reviewed for staff competence and need to continue. (Attachment D) Residential Manager, QIDP or designee and Clinical Supervisor will offer immediate correction, training and feedback to all staff during observations. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> Four Activity Treatment Observations will be performed weekly in home to ensure that Client # 2's mealtime goal is completed accurately. Observations will be completed by the Residential Manager, QIDP or designee, and Clinical Supervisor for 1 month at which time observations will be reviewed for staff competence and 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	were to ask him to slow down when eating too fast. 9-3-4(a)		<p>need to continue.</p> <ul style="list-style-type: none"> Residential Manager, QIDP or designee and Clinical Supervisor will offer immediate correction, training and feedback to all staff during observations. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> Four Activity Treatment Observations will be performed weekly in home to ensure that Client # 2's mealtime goal is completed accurately. Observations will be completed by the Residential Manager, QIDP or designee, and Clinical Supervisor for 1 month at which time observations will be reviewed for staff competence and need to continue. Residential Manager, QIDP or designee and Clinical Supervisor will offer immediate correction, training and feedback to all staff during observations. <p>Completion Date: 1-28-2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>W 249: 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 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Corrective action:</p> <ul style="list-style-type: none"> · Direct care staff to receive re-training of client #2's mealtime needs as it relates to client #2's dining plan goal. (Attachment E) · Direct care staff will specifically receive training to ensure client #2 is prompted to eat slowly, take small bites and lay his utensil down after each bite.) <p>How we will identify others:</p> <ul style="list-style-type: none"> · Two Activity Treatment Observations will be performed weekly in home to ensure that Client # 2's mealtime goal is completed accurately. Observations will be completed by the Residential Manager, QIDP or designee, and Clinical Supervisor for 1 month at which time observations will be reviewed for staff competence and need to continue. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>(Attachment F) · Residential Manager, QIDP or designee and Clinical Supervisor will offer immediate correction, training and feedback to all staff during observations. Measures to be put in place: · Two Activity Treatment Observations will be performed weekly in home to ensure that Client # 2's mealtime goal is completed accurately. Observations will be completed by the Residential Manager, QIDP or designee, and Clinical Supervisor for 1 month at which time observations will be reviewed for staff competence and need to continue. · Residential Manager, QIDP or designee and Clinical Supervisor will offer immediate correction, training and feedback to all staff during observations.</p> <p>Monitoring of Corrective Action: · Two Activity Treatment Observations will be performed weekly in home to ensure that Client # 2's mealtime goal is completed accurately. Observations will be completed by the Residential Manager, QIDP or designee, and Clinical Supervisor for 1 month at which time observations will be reviewed for staff competence and need to continue. · Residential Manager, QIDP or designee and Clinical Supervisor will offer immediate correction, training and feedback to all staff during observations.</p> <p>Completion Date: 1-21-2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure the staff documented a descriptive note in regard to client #2's verbal and physical aggression.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 12/10/14 at 5 PM.</p> <p>Client #2's 12/18/13 BSP (Behavior Support Plan) indicated: __ Targeted behaviors of verbal and physical aggression. __ Physical aggression was "hitting others, throwing items, breaking items, slamming doors." __ Verbal aggression was "Yelling at/cursing others, calling people names, threatening others. May make statements blaming others after an act of physical or verbal aggression."</p> <p>Client #2's July through December 2014 BDRs (Behavior Data Records) indicated client #2 had 8 incidents of physical aggression and 34 incidents of verbal aggression.</p>	W000252	<p>W 252: Program Documentation: Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> · Direct care staff will receive training to ensure a descriptive note is documented on the back of the BDR's for any verbal or physical aggression. (Attachment G) · QIDP or designee will monitor monthly to ensure any verbal or physical aggression has a descriptive note on the back of the BDR to correspond with each documented verbal or physical aggression. <p>How we will identify others:</p> <ul style="list-style-type: none"> · Direct care staff will document any occurrence of verbal or physical aggression providing a descriptive note on the back of each BDR. · QIDP or designee will monitor 	01/21/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Client #2's record indicated no descriptive documentation from the staff to indicate the severity of the behaviors displayed and/or if client #2 was aggressive with staff and/or other clients.</p> <p>The QIDPD (Qualified Intellectual Disabilities Professional Designee) was interviewed on 12/12/14 at 11:30 AM. The QIDPD indicated the clients with verbal and physical aggression required more than a slash mark on the front of their BDRs. The QIDPD indicated the staff had been trained to document a descriptive note on the back of each of the clients' BDRs in regard to all incidents of aggression.</p> <p>9-3-4(a)</p>		<p>documentation monthly and at each quarterly review to ensure proper documentation is completed on the back of each BDR for both verbal and physical aggression.</p> <ul style="list-style-type: none"> · Clinical Supervisor will monitor quarterly reviews to ensure proper documentation. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · Direct care staff will document any occurrence of verbal or physical aggression, providing a descriptive note on the back of each BDR. · QIDP or designee will monitor documentation monthly and at each quarterly review to ensure proper documentation is completed on the back of each BDR for both verbal and physical aggression. · Clinical Supervisor will monitor quarterly reviews to ensure proper documentation. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · Direct care staff will document any occurrence of verbal 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for	W000312	or physical aggression, providing a descriptive note on the back of each BDR. · QIDP or designee will monitor documentation monthly and at each quarterly review to ensure proper documentation is completed on the back of each BDR for both verbal and physical aggression. · Clinical Supervisor will monitor quarterly reviews to ensure proper documentation. Completion Date: 1-21--2015	01/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1 of 3 sampled clients receiving medications to control behaviors (#2), the facility failed to ensure the use of all behavior modification medications were included in client #2's plan of care.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 12/10/14 at 5 PM. Client #2's quarterly physician's orders for December 2014 indicated client #2 received:</p> <p>__ Luvox 300 mg (milligrams) daily for IED (Intermittent Explosive Disorder).</p> <p>__ Invega 3 mg daily for IED.</p> <p>__ Ativan 5 mg daily for OCD (Obsessive Compulsive Disorder).</p> <p>__ Cogentin 2 mg daily for EPS (Extrapyramidal Symptoms - A group of side effects associated with antipsychotic medications).</p> <p>Client #2's 12/18/13 revised BSP (Behavior Support Plan) indicated client #2 had targeted behaviors of physical aggression, verbal aggression and OCD. Client #2's BSP did not include the use of Cogentin in client #2's program plan.</p> <p>Interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 12/12/14 at 11:30 AM indicated client #2's BSP/program plans did not include the use of Cogentin.</p>		<p>W312: Drug Usage: Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors to which the drugs are employed.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> · The Clinical Supervisor will provide training to the QIDP in regards to the use of behavior modification medications to ensure all behavior modification medications are included in the individual BSP. (Attachment H) · The QIDP or designee will revise client #2's BSP to include the use of Cogentin in client #2's plan of care.(Attachment I) · The QIDP or designee will in-service direct care staff of the revision to include Cogentin in client #2's BSP. (Attachment J) <p>How we will identify others:</p> <ul style="list-style-type: none"> · QIDP or designee will monitor behavior modification programs monthly to ensure all behavior modification medications are included in BSP. · Clinical Supervisor will review plans quarterly to ensure behavior 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	9-3-5(a)		<p>modification medications are included in each BSP.</p> <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · QIDP or designee will monitor behavior modification programs monthly to ensure all behavior modification medications are included in BSP. · Clinical Supervisor will review plans quarterly to ensure behavior modification medications are included in each BSP. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · QIDP or designee will monitor behavior modification programs monthly to ensure all behavior modification medications are included in BSP. · Clinical Supervisor will review plans quarterly to ensure behavior modification medications are included in each BSP. <p>Completion Date: 1-21--2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000316	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. Based on record review and interview for 1 of 3 sample clients receiving medications to control maladaptive behaviors (#4), the facility failed to provide evidence an annual medication reduction had been attempted or specific contraindications as to why an attempt was not made.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 12/10/14 at 4 PM.</p> <p>Client #4's 2014 physician's orders indicated client #4 took Risperdal 1 milligram a day for IED (Intermittent</p>	W000316	<p>W316: Drug Usage: Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> · The Clinical Supervisor will provide training to the QIDP in regards to specific contraindications for annual medication reductions in the event that the BSP medication reduction criteria are not met. (Attachment K) · The QIDP will ensure quarterly reviews are completed for client #4 specifically gathering and reviewing and monitoring behavioral 	01/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Explosive Disorder).</p> <p>Client #4's 11/6/14 BSP (Behavior Support Plan) indicated: __ Client #4 had targeted behaviors of verbal and physical aggression. __ A plan of reduction for the Risperdal: "When [client #4] has achieved overall objective of 5 physical/verbal aggression incidents per month, Risperdal may be considered for a reduction up to 10/5 per psychiatric recommendation and IDT (Interdisciplinary Team) consensus." Client #4's behavior medication reviews by client #4's physician indicated: __ 10/21/14 - no changes __ 6/24/14 - no changes __ 3/18/14 - no changes __ 12/5/13 - no changes</p> <p>Client #4's BDRs (Behavior Data Records) from December 2013 through December 2014 indicated no incidents of verbal and/or physical aggression.</p> <p>Client #4's record indicated no evidence an annual medication reduction had been attempted and/or specific contraindications as to why an attempt was not made.</p> <p>The QIDPD (Qualified Intellectual Disabilities Professional Designee) was</p>		<p>data to determine if medication reduction criteria are met.</p> <p>How we will identify others:</p> <ul style="list-style-type: none"> · QIDP or designee will monitor behavior modification programs monthly to ensure all behavior modification medications are included in BSP. · QIDP or designee will monitor the BSP monthly specifically gathering, reviewing and monitoring behavioral data to determine if medication reduction criteria are met. · Clinical Supervisor will review plans quarterly to ensure medication reductions are occurring if criteria's are met. · <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · QIDP or designee will monitor behavior modification programs monthly to ensure all behavior modification medications are included in BSP. · QIDP or designee will monitor the BSP monthly specifically gathering, reviewing and monitoring 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>interviewed on 12/12/14 at 11:30 AM. The QIDPD: ___ Indicated client #4 had not had a decrease in his behavior modification medications in the previous 12 months. ___ Indicated client #4 saw his physician quarterly to review his progress, behaviors and medication needs. ___ Indicated no changes in client #4's behavior medications by client #4's physician in the past year.</p> <p>9-3-5(a)</p>		<p>behavioral data to determine if medication reduction criteria are met.</p> <ul style="list-style-type: none"> · Clinical Supervisor will review plans quarterly to ensure medication reductions are occurring if criteria are met. · Monitoring of Corrective Action: · QIDP or designee will monitor behavior modification programs monthly to ensure all behavior modification medications are included in BSP. · QIDP or designee will monitor the BSP monthly specifically gathering, reviewing and monitoring behavioral data to determine if medication reduction criteria are met. · Clinical Supervisor will review plans quarterly to ensure medication reductions are occurring if criteria's are met. <p>Completion Date: 1-21--2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 34 doses of medications administered, the facility failed to ensure client #3's medications were administered as ordered by the physician.</p> <p>Findings include:</p> <p>Observations of the morning medication pass were conducted at the facility on 12/10/14 between 5:45 AM and 6:30 AM. Between 5:50 AM and 6 AM staff #4 gave client #3 his AM medications. Client #3 did not receive a nasal spray during this observation period.</p> <p>On 12/10/14 at 6:40 AM after the completion of the medication pass for all of the clients in the home, client #3's Medication Administration Record (MAR) for December 2014 was reviewed. Client #3's MAR indicated client #3 was to receive Nasonex two</p>	W000369	<p>Addendum W369: Drug Administration: The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> The Clinical Supervisor will provide staff #4 with re-training of proper administration of medication including proper documentation and the 6 rights of medication administration. (Attachment E) <p>How we will identify others:</p> <ul style="list-style-type: none"> Two Med Pass Observations will be performed weekly in home to ensure that clients including client # 3's medications are administered correctly without error. Med Pass observation to include staff # 4. Med pass observations will be completed by the Residential Manager, QIDP or designee, and Clinical Supervisor for 1 month at 	01/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>sprays into each nostril every morning at 6 AM for seasonal allergies. Client #3's MAR indicated staff #4 had initialed client #3's MAR indicating staff #4 had given client #3 his nasal spray 12/10/14 at 6 AM.</p> <p>During interview with staff #4 on 12/10/14 at 6:40 AM, staff #4 was asked if client #3 was given his nasal spray. Staff #4 stated, "I forgot to give it to him. I'll call him back in here right now and give it to him." Staff #4 indicated she should have given client #3 his nasal spray at the time he received his other AM medications. Staff #4 indicated the MAR was to be initialed after the medication was given to the clients.</p> <p>Interview with the facility's RN on 12/12/14 at 11:30 AM indicated all medications were to be given as the physician had prescribed and without error. The RN indicated the staff were not to initial the MAR prior to giving the medication to the client.</p> <p>9-3-6(a)</p>		<p>which time observations will be reviewed for staff competence and need to continue.(Attachment M)</p> <ul style="list-style-type: none"> Residential Manager, QIDP or designee and Clinical Supervisor will offer immediate correction, training and feedback to all staff during observations. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> Two Med Pass Observations will be performed weekly in home to ensure that clients including client # 3's medications are administered correctly without error. Med Pass observation to include staff # 4. Med pass observations will be completed by the Residential Manager, QIDP or designee, and Clinical Supervisor for 1 month at which time observations will be reviewed for staff competence and need to continue. Residential Manager, QIDP or designee and Clinical Supervisor will offer immediate correction, training and feedback to all staff during observations. Monitoring of Corrective Action: Two Med Pass Observations will be performed weekly in home to ensure that clients including client # 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>3's medications are administered correctly without error. Med Pass observation to include staff # 4. Med pass observations will be completed by the Residential Manager, QIDP or designee, and Clinical Supervisor for 1 month at which time observations will be reviewed for staff competence and need to continue.</p> <p>Residential Manager, QIDP or designee and Clinical Supervisor will offer immediate correction, training and feedback to all staff during observations.</p> <p>Completion Date: 1-21--2015</p> <p>W316: Drug Usage: Drugs used</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Corrective Action: · The Clinical Supervisor will provide training to the QIDP in regards to specific contraindications for annual medication reductions in the event that the BSP medication reduction criteria are not met. (Attachment K) · The QIDP will ensure quarterly reviews are completed for client #4 specifically gathering and reviewing and monitoring behavioral data to determine if medication reduction criteria are met. How we will identify others: · QIDP or designee will monitor behavior modification programs monthly to ensure all behavior modification medications are included in BSP. · QIDP or designee will monitor the BSP monthly specifically gathering, reviewing and monitoring behavioral data to determine if medication reduction criteria are met. · Clinical Supervisor will review plans quarterly to ensure medication reductions are occurring if criteria's are met. ·</p> <p>Measures to be put in place: · QIDP or designee will monitor behavior modification programs monthly to ensure all behavior modification medications are included in BSP. · QIDP or designee will monitor the BSP monthly specifically gathering, reviewing and monitoring</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G326	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 9 SUMMIT DR AURORA, IN 47001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			behavioral data to determine if medication reduction criteria are met. · Clinical Supervisor will review plans quarterly to ensure medication reductions are occurring if criteria are met. · Monitoring of Corrective Action: · QIDP or designee will monitor behavior modification programs monthly to ensure all behavior modification medications are included in BSP. · QIDP or designee will monitor the BSP monthly specifically gathering, reviewing and monitoring behavioral data to determine if medication reduction criteria are met. · Clinical Supervisor will review plans quarterly to ensure medication reductions are occurring if criteria's are met. Completion Date: 1-21--2015		