

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 08/18/2015
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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 0000 Bldg. 00	<p>This visit was for the investigation of complaints #IN00180086 and #IN00179268 which resulted in an Immediate Jeopardy which was not removed prior to exit.</p> <p>Complaint #IN00180086: Substantiated, federal and state deficiencies related to the allegation(s) are cited at: W102, W104, W149, W159, W186, W193, W200 and W9999.</p> <p>Complaint #IN00179268: Substantiated, federal and state deficiencies related to the allegation(s) are cited at: W102, W104, W149, W159, W186, W193, W200 and W9999.</p> <p>Dates of Survey: 8/13/15, 8/14/15, 8/17/15 and 8/18/15.</p> <p>Facility Number: 000911 Provider Number: 15G397 AIMS Number: 100244420</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102	483.410			

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>GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 1 of 3 sampled clients (A). The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's management provided oversight and management of operating the group home due to the group home's history of non-compliance with Conditions of Participation within the past year March 31, 2015 to 8/18/15.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 1 of 3 sampled clients (A).</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility and it's property were maintained in a clean manner and promoted positive relations within the community, to ensure the facility implemented its written policy and procedures to prevent neglect of client A and to report 3 incidents of elopement regarding client A to BDDS</p>	W 0102	<p>CORRECTION: <i>The facility must ensure that specific governing body and management requirements are met.</i></p> <p>Specifically, the governing body has facilitated the following: The Governing Body has directed the facility to modify the staffing matrix to assure that one to one staffing is available for Client A during waking hours and that double staffing is in place on the overnight shift in case to provide one to one observation of Client A if he is awake and out of his bedroom and 15 minute checks when he is asleep. For Client A, all staff have been trained on appropriate implementation of enhanced supervision and behavior supports. An enhanced supervisory and administrative presence in the home has been established to assure proper implementation of the current supports with emphasis on Client A's safety, as described below. For Client A, The QIDP has completed assessments of Client A's Social, functional and behavioral needs and has developed support plans based on the assessments, including but not limited to Client A's Safety. All facility staff been retrained regarding procedures for immediate notification of supervisors and the Operations</p>	09/03/2015
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	<p>(Bureau of Developmental Disabilities Services), to ensure the QIDP (Qualified Intellectual Developmental Disabilities Professional) integrated, coordinated and monitored client A's active treatment program, to ensure sufficient staffing levels in the home to implement client A's BSP (Behavior Support Plan) and ensure his safety, to ensure staff working with client A were competent to manage client A's inappropriate behavior and to ensure client A was assessed for behavioral, functional and social needs prior to admission to the group home.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client A and to report 3 incidents of elopement regarding client A to BDDS (Bureau of Developmental Disabilities Services), to ensure the QIDP (Qualified Intellectual Developmental Disabilities Professional) integrated, coordinated and monitored client A's active treatment program, to ensure sufficient staffing levels in the home to implement client A's BSP (Behavior Support Plan) and ensure his safety, to ensure staff working with client A were competent to manage client A's</p>		<p>Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. All staff responsible for failing to report 3 incidents of Client A's evasion of staff supervision have received written corrective action. Addendum, 9/2/15: Root Cause Analysis of why corrections implemented after the 2/19/15 survey have failed. Supervisory staff reviewing all documentation to ensure reporting of incidents. · This correction failed due to insufficient administrative level follow-up. Team leads conducting daily reviews of progress notes, BSP tracking and staff communication logs to ensure incidents were reported. · This correction failed due to the Governing Body failing to hold the Team Lead accountable and failing to develop a functional monitoring tool. Internal and day services reports sent to the clinical supervisor and program director to ensure reporting to state agencies. · This system did not fail. · The Governing Body has determined that incident reports were not generated to lack of sufficient oversight, which in turn resulted in state agencies not being notified of incidents within required time frames. A tracking spreadsheet for incidents</p>	

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	<p>inappropriate behavior and to ensure client A was assessed for behavioral, functional and social needs prior to admission to the group home. Please see W104.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 1 of 3 sampled clients (A). Please see W122.</p> <p>This federal tag relates to complaints #IN00180086 and #IN00179268.</p> <p>9-3-1(a)</p>		<p>maintained and distributed daily to supervisors and Operations Team. · The tracking spreadsheet remains in use and is an effective tool for incident management. · The Governing Body has determined that incident reports were not generated to lack of sufficient oversight, which in turn resulted in state agencies not being notified of incidents within required time frames. Residential managers to attend inservices about incident investigations and their responsibilities. · Inservices focused on investigation needs but failed to adequately address identifying incidents which needed to be reported to administrative staff and state agencies. Residential managers were to develop and maintain a staff matrix that assured adequate direct support staff with training, skills, and abilities—such matrix to be reviewed and approved by the clinical supervisor and checked by the Program Manager. · This system failed because the Governing Body did not assure that the QIDP completed adequate assessments prior to admitting a new client to the facility. · Appropriate assessment would have alerted the team to the need for additional staffing at the facility. PREVENTION:The Residential Manager will be expected to observe no less than one morning and two evening</p>		

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			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 implement all training and behavior supports as written. The Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to participate in and monitor active treatment to assure all supports are implemented as written. The Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation. The QIDP has been retrained regarding the need to assure that all relevant assessments are obtained prior to admitting new clients to assure placement is appropriate and to facilitate the development of initial supports. After admission, additional assessment will occur for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will follow up with the QIDP no less twice weekly when clients are being considered for admission to the facility to assure appropriate assessments are obtained as required. Prior to admitting new clients, the Clinical	

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			Supervisor will assist the QIDP with developing appropriate initial supports. Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. The Executive Director or Program Manager will be on site for eight hours daily –observing active treatment and completing documentation reviews, Monday through Friday and complete additional observations at the facility on weekends until the Immediate Jeopardy status is resolved. When the Immediate Jeopardy is removed, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and	

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			<p>Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions and documentation reviews no less than five times weekly for the next 14 days, no less than three times weekly for an additional 30 days and twice weekly for an additional 60 days. The Program Manager will maintain a schedule for administrative monitoring and follow-up as needed. 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. 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, and visit the facility no less than monthly for the next 60 days. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will focus on:</p> <ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff. 2. Assuring adequate staffing is in place to ensure the safety of all clients. 3. Assuring staff implement support plans as written. 4. These administrative documentation reviews will focus 	

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			<p>on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. Additionally, Administrative documentation audits will include review of assessment data for all clients. Addendum, 9/2/15: Preventative measures to be implemented based on Root Cause Analysis of why corrections implemented after the 2/19/15 survey have failed. Supervisory staff reviewing all documentation to ensure reporting of incidents. · Enhanced administrative presence in the home will continue as described above, until such a time as the Governing Body determines that front line supervisors are consistently meeting documentation review expectations and that incidents are reported and investigated as required. · Administrative oversight will focus on coaching and training supervisors toward development of effective auditing skills and a clear understanding of reportable incident criteria. Team leads conducting daily reviews of progress notes, BSP tracking and staff communication logs to ensure incidents were reported. · The facility Team Lead received progressive written corrective action for failing to conduct daily documentation</p>	

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			<p>reviews. · The Governing Body has developed a daily Team Lead checklist to assist with time management and task completion. · The Team Lead checklist will be reviewed daily by the Residential Manager and no less than weekly by the Clinical Supervisor. · Operations Team documentation reviews will occur as described above to assure front line supervisors and direct support staff meet expectations. Internal and day services reports sent to the clinical supervisor and program director to ensure reporting to state agencies. · Incident reports will continue to be sent via electronic fax to the Clinical Supervisors and Program Manager to assure prompt and appropriate follow-up. · The Governing Body has determined that incident reports were not generated to lack of sufficient oversight, which in turn resulted in state agencies not being notified of incidents within required time frames. A tracking spreadsheet for incidents maintained and distributed daily to supervisors and Operations Team. · The tracking spreadsheet will remain in use and as an effective tool for incident management. · The Governing Body will continue with on-sight documentation reviews and supervision to assure incident reports are generated as required. Residential managers to attend</p>	

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W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility's governing body failed to	W 0104	inservices about incident investigations and their responsibilities. · In addition to focusing on investigation, weekly inservicve training will adequately address identifying incidents which needed to be reported to administrative staff and state agencies. Residential managers were to develop and maintain a staff matrix that assured adequate direct support staff with training, skills, and abilities—such matrix to be reviewed and approved by the clinical supervisor and checked by the Program Manager. · The Governing Body will follow-up with the QIDP when new clients are referred to the facility to assure completion of adequate assessments prior to admitting a new client to the facility. · The Governing body will review assessment data for new admission and approve and facilitate the acquisition of additional staffing at the facility, as needed. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Operations Team CORRECTION: <i>The facility must ensure that specific governing body and management requirements are met.</i>	09/03/2015	

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	<p>exercise general policy and operating direction over the facility to ensure the facility's management provided oversight and management of operating the group home due to the group home's history of non-compliance with Conditions of Participation within the past year March 31, 2015 to 8/18/15.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility and it's property were maintained in a clean manner and promoted positive relations within the community, to ensure the facility implemented its written policy and procedures to prevent neglect of client A and to report 3 incidents of elopement regarding client A to BDDS (Bureau of Developmental Disabilities Services), to ensure the QIDP (Qualified Intellectual Developmental Disabilities Professional) integrated, coordinated and monitored client A's active treatment program, to ensure sufficient staffing levels in the home to implement client A's BSP (Behavior Support Plan) and ensure his safety, to ensure staff working with client A were competent to manage client A's inappropriate behavior and to ensure client A was assessed for behavioral, functional and social needs prior to admission to the group home.</p>		Specifically, the governing body has facilitated the following: The Governing Body has directed the facility to modify the staffing matrix to assure that one to one staffing is available for Client A during waking hours and that double staffing is in place on the overnight shift in case to provide one to one observation of Client A if he is awake and out of his bedroom and 15 minute checks when he is asleep. For Client A, all staff have been trained on appropriate implementation of enhanced supervision and behavior supports. An enhanced supervisory and administrative presence in the home has been established to assure proper implementation of the current supports with emphasis on Client A's safety, as described below. For Client A, The QIDP has completed assessments of Client A's Social, functional and behavioral needs and has developed support plans based on the assessments, including but not limited to Client A's Safety. All facility staff been retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. All staff responsible				

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	<p>Findings include:</p> <p>1. Confidential interview A stated, "The outside of the group home is not being kept up. House looks shabby. They are not keeping it landscaped and have a basketball goal in the street on the cul de sac where the clients congregate. The garbage truck and mail truck have to go around the goal. There is a lot of trash under the goal."</p> <p>Neighbor #1 was interviewed on 8/13/15 at 11:24 AM. Neighbor #1 indicated the group home had trash in the front yard and trash under the basketball goal in the street.</p> <p>Neighbor #2 was interviewed on 8/13/15 at 4:00 PM. Neighbor #2 stated, "They seem to have a lot of trash. I know there are a lot of people living in the home but they only have 2 trash cans. They put the 2 cans out in the street and then have piles of trash on the ground around the cans. There's usually stuff in the yard. It just doesn't look good. We try to keep our neighborhood looking nice." Neighbor #2 stated, "They have meetings or something over there and staff will park in the street and cul de sac. I don't know why the staff don't park in the drive way. They park in the street and block my driveway. The mail carrier and trash truck have to go</p>		<p>for failing to report 3 incidents of Client A's evasion of staff supervision have received written corrective action. Addendum, 9/2/15: Root Cause Analysis of why corrections implemented after the 2/19/15 survey have failed. Supervisory staff reviewing all documentation to ensure reporting of incidents. · This correction failed due to insufficient administrative level follow-up. Team leads conducting daily reviews of progress notes, BSP tracking and staff communication logs to ensure incidents were reported. · This correction failed due to the Governing Body failing to hold the Team Lead accountable and failing to develop a functional monitoring tool. Internal and day services reports sent to the clinical supervisor and program director to ensure reporting to state agencies. · This system did not fail. · The Governing Body has determined that incident reports were not generated to lack of sufficient oversight, which in turn resulted in state agencies not being notified of incidents within required time frames. A tracking spreadsheet for incidents maintained and distributed daily to supervisors and Operations Team. · The tracking spreadsheet remains in use and is an effective tool for incident management. · The Governing Body has determined that incident reports were not</p>		

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	<p>around their cars. I've had their staff knock over my mailbox with their cars. I need to replace the post and box. I talked to one guy over there about it but they never have made any attempts to say anything about it or offer any reimbursement."</p> <p>Observations were conducted at the group home on 8/13/15 from 1:30 PM to 2:45 PM. At 1:30 PM, upon arriving at the group home, client A was outside the group home walking up the driveway of the house. Client A approached the surveyor, introduced himself and indicated he was having a yard sale. Client A then pointed to a small wooden table on the curb which had a stack of magazines, a shirt, a stuffed animal and two pairs of shoes. The home's entry walkway had overgrown weeds and an area of yellow powdery substance spread on a section of the sidewalk. Staff #1 indicated on 8/13/15 at 2:00 PM client A had dumped a bag of an unknown substance on the sidewalk. Near the front porch area there were pants, shoes and a metal piece of broken bicycle. Client A's bedroom had debris on the floor, walls and stains on his pillows and sheets. The room had a 3 drawer dresser with one drawer missing/broken. The closet had a pile of dirty clothing on the floor with no clean clothing hanging on the rack. Client</p>		<p>generated to lack of sufficient oversight, which in turn resulted in state agencies not being notified of incidents within required time frames. Residential managers to attend inservices about incident investigations and their responsibilities. · Inservices focused on investigation needs but failed to adequately address identifying incidents which needed to be reported to administrative staff and state agencies. Residential managers were to develop and maintain a staff matrix that assured adequate direct support staff with training, skills, and abilities—such matrix to be reviewed and approved by the clinical supervisor and checked by the Program Manager. · This system failed because the Governing Body did not assure that the QIDP completed adequate assessments prior to admitting a new client to the facility. · Appropriate assessment would have alerted the team to the need for additional staffing at the facility. 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 implement all training and behavior supports as written. The Team Lead will be</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 08/18/2015
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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>B's bedroom had a pungent odor.</p> <p>Clinical Supervisor (CS) #1 was interviewed on 8/13/15 at 5:15 PM. CS #1 indicated staff should pick up the trash and articles of clothing from the front yard.</p> <p>RM (Residential Manager) #1 was interviewed on 8/14/15 at 1:15 PM. RM #1 indicated client A had cleaned his room on Tuesday 8/11/15. RM #1 indicated client A had damaged his dresser and should keep his room clean. RM #1 indicated client B had nocturnal enuresis (bed wetting) and had urinated in the corner and closet of the room in the past. RM #1 indicated the facility was working with maintenance to determine if client B's urine had soaked into or was beneath the floor in the room.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client A and to report 3 incidents of elopement regarding client A to BDDS. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP</p>		<p>present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to participate in and monitor active treatment to assure all supports are implemented as written. The Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation. The QIDP has been retrained regarding the need to assure that all relevant assessments are obtained prior to admitting new clients to assure placement is appropriate and to facilitate the development of initial supports. After admission, additional assessment will occur for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will follow up with the QIDP no less twice weekly when clients are being considered for admission to the facility to assure appropriate assessments are obtained as required. Prior to admitting new clients, the Clinical Supervisor will assist the QIDP with developing appropriate initial supports. Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior</p>	

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 08/18/2015
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>integrated, coordinated and monitored client A's active treatment program. Please see W159.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient staffing levels in the home to implement client A's BSP and assure his safety. Please see W186.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure staff working with client A were competent to manage client A's inappropriate behavior. Please see W193.</p> <p>6. The governing body failed to exercise general policy and operating direction over the facility to ensure client A was assessed for behavioral, functional and social needs prior to admission to the group home. Please see W200.</p> <p>This federal tag relates to complaints #IN00180086 and #IN00179268.</p> <p>9-3-1(a)</p>		<p>support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. The Executive Director or Program Manager will be on site for eight hours daily –observing active treatment and completing documentation reviews, Monday through Friday and complete additional observations at the facility on weekends until the Immediate Jeopardy status is resolved. When the Immediate Jeopardy is removed, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions and documentation reviews no less than five times weekly for the next 14 days, no less than three times weekly for an additional 30 days</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 08/18/2015
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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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			and twice weekly for an additional 60 days. The Program Manager will maintain a schedule for administrative monitoring and follow-up as needed. 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. 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, and visit the facility no less than monthly for the next 60 days. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i> . Administrative support at the home will focus on: 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff. 2. Assuring adequate staffing is in place to ensure the safety of all clients. 3. Assuring staff implement support plans as written. 4. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. Additionally, Administrative documentation audits will include	

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 08/18/2015
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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>review of assessment data for all clients. Addendum, 9/2/15: Preventative measures to be implemented based on Root Cause Analysis of why corrections implemented after the 2/19/15 survey have failed.</p> <p>Supervisory staff reviewing all documentation to ensure reporting of incidents. · Enhanced administrative presence in the home will continue as described above, until such a time as the Governing Body determines that front line supervisors are consistently meeting documentation review expectations and that incidents are reported and investigated as required. · Administrative oversight will focus on coaching and training supervisors toward development of effective auditing skills and a clear understanding of reportable incident criteria. Team leads conducting daily reviews of progress notes, BSP tracking and staff communication logs to ensure incidents were reported. · The facility Team Lead received progressive written corrective action for failing to conduct daily documentation reviews. · The Governing Body has developed a daily Team Lead checklist to assist with time management and task completion. · The Team Lead checklist will be reviewed daily by the Residential Manager and no less than weekly by the Clinical Supervisor. · Operations Team</p>	

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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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			documentation reviews will occur as described above to assure front line supervisors and direct support staff meet expectations. Internal and day services reports sent to the clinical supervisor and program director to ensure reporting to state agencies. · Incident reports will continue to be sent via electronic fax to the Clinical Supervisors and Program Manager to assure prompt and appropriate follow-up. · The Governing Body has determined that incident reports were not generated to lack of sufficient oversight, which in turn resulted in state agencies not being notified of incidents within required time frames. A tracking spreadsheet for incidents maintained and distributed daily to supervisors and Operations Team. · The tracking spreadsheet will remain in use and as an effective tool for incident management. · The Governing Body will continue with on-sight documentation reviews and supervison to assure incident reports are generated as required. Residential managers to attend inservices about incident investigations and their responsibilities. · In addition to focusing on investigation, weekly inservice training will adequately address identifying incidents which needed to be reported to administrative staff and state agencies. Residential managers were to develop and maintain a	

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 08/18/2015
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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 0122 Bldg. 00	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients (A). The facility failed to implement its policy and procedures to prevent neglect of client A and to report 3 incidents of elopement regarding client A to the BDDS (Bureau of Developmental Disabilities Services).</p> <p>This non-compliance resulted in an</p>	W 0122	<p>staff matrix that assured adequate direct support staff with training, skills, and abilities—such matrix to be reviewed and approved by the clinical supervisor and checked by the Program Manager. · The Governing Body will follow-up with the QIDP when new clients are referred to the facility to assure completion of adequate assessments prior to admitting a new client to the facility. · The Governing body will review assessment data for new admission and approve and facilitate the acquisition of additional staffing at the facility, as needed. RESPONSIBLE PARTIES:QIDP, Residential Manager, Team Leader, Operations Team</p> <p>CORRECTION: <i>The facility must ensure that specific client protections requirements are met. Specifically, the governing body has facilitated the following:</i> The Governing Body has directed the facility to modify the staffing matrix to assure that one to one staffing is available for Client A during waking hours and that double staffing is in place on the overnight shift in case to provide one to one observation of Client A if he is awake and out of his bedroom and 15 minute checks</p>	09/03/2015

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 08/18/2015	
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>Immediate Jeopardy. The Immediate Jeopardy was identified on 8/13/15 at 5:22 PM. The Immediate Jeopardy began on 7/18/15 when the facility failed to assess, develop and implement a plan of supervision to ensure client A's safety regarding elopement and client A's making of weapons. Clinical Supervisor #1 was notified of the immediate jeopardy on 8/13/15 at 5:22 PM. The facility neglected to provide supervision of client A while in the community and failed to ensure client A did not bring weapons or items that could be re-purposed as weapons into the group home.</p> <p>On 8/14/15 at 3:21 PM the facility submitted an Allegation for Removal of Immediate Jeopardy document which outlined the facility's plan of correction. The 8/14/15 Allegation of Removal of Immediate Jeopardy indicated, "(1.) The IDT (Interdisciplinary Team) has developed and implemented a BSP (Behavior Support Plan) for [client A] that addresses all of his assessed targeted behaviors including but not limited to elopement/evasion of staff supervision. (2.) The IDT has incorporated enhanced supervision into [client A's] plan defined as line of sight observation by facility staff at home, at work and in the community. (3.) All staff currently</p>		<p>when he is asleep. For Client A, all staff have been trained on appropriate implementation of enhanced supervision and behavior supports. An enhanced supervisory and administrative presence in the home has been established to assure proper implementation of the current supports with emphasis on Client A's safety, as described below. For Client A, The QIDP has completed assessments of Client A's Social, functional and behavioral needs and has developed support plans based on the assessments, including but not limited to Client A's Safety. All facility staff been retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. All staff responsible for failing to report 3 incidents of Client A's evasion of staff supervision have received written corrective action.</p> <p>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</p>				

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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>assigned to the facility have been trained on [client A's] behavior supports and enhanced supervision protocols. Additional, staff brought in to assist the facility will be trained on the procedures prior to being permitted to work. (4.) Daily administrative level oversight by members of the Operations Team, comprised of Clinical Supervisors, the Executive Director, Program Manager and Nurse Manager will occur at the facility until the governing body had determined that the safety protocols are effective and implemented properly. Additionally, salaried supervisors will maintain a presence on every shift, providing ongoing training and coaching, during the period of intensive oversight and assessment."</p> <p>Observations were conducted at the home on 8/18/15 at 2:20 PM through 2:45 PM. Upon arriving at the group home, client A was in the front yard of the home. Client A was dressed in a black long sleeve shirt, black jeans and a black face mask. Client A had a 4 foot fiber-glass boundary marker pole which he was throwing like a spear in the front yard. Client A used the fiberglass pole as a spear and twirled the pole around and over his head simulating fighting. No staff were present outside the home with client A.</p>		<p>but not limited assuring staff implement all training and behavior supports as written. The Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to participate in and monitor active treatment to assure all supports are implemented as written. The Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation. The QIDP has been retrained regarding the need to assure that all relevant assessments are obtained prior to admitting new clients to assure placement is appropriate and to facilitate the development of initial supports. After admission, additional assessment will occur for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will follow up with the QIDP no less twice weekly when clients are being considered for admission to the facility to assure appropriate assessments are obtained as required. Prior to admitting new clients, the Clinical Supervisor will assist the QIDP with developing appropriate initial supports. Supervisory staff will review all facility documentation</p>				

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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>Staff #2 was interviewed on 8/18/15 at 2:40 PM. Staff #2 indicated staff should be outside supervising client A when he outside.</p> <p>AS (Administrative Staff) #1 was interviewed on 8/18/15 at 3:45 PM. AS #1 indicated staff should maintain line of sight supervision of client A. AS #1 stated, "They should be within 10 feet of him at all times."</p> <p>The facility did not implement client A's one on one staffing protocol on 8/18/15 during observations in the home. The Immediate Jeopardy was not removed.</p> <p>Findings include:</p> <p>The facility failed to prevent neglect of client A and failed to report 3 incidents of elopement regarding client A to BDDS. Please see W149.</p> <p>This federal tag relates to complaints #IN00180086 and #IN00179268.</p> <p>9-3-2(a)</p>		<p>to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. The Executive Director or Program Manager will be on site for eight hours daily –observing active treatment and completing documentation reviews, Monday through Friday and complete additional observations at the facility on weekends until the Immediate Jeopardy status is resolved. When the Immediate Jeopardy is removed, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions and</p>		

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			documentation reviews no less than five times weekly for the next 14 days, no less than three times weekly for an additional 30 days and twice weekly for an additional 60 days. The Program Manager will maintain a schedule for administrative monitoring and follow-up as needed. 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. 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, and visit the facility no less than monthly for the next 60 days. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i> . Administrative support at the home will focus on: 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff. 2. Assuring adequate staffing is in place to ensure the safety of all clients. 3. Assuring staff implement support plans as written. 4. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support	

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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 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 observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to prevent neglect of client A and failed to report 3 incidents of elopement regarding client A to BDDS (Bureau of Developmental Disabilities Services).</p> <p>Findings include:</p> <p>Confidential interview A stated, "There is a new resident who looks to be about 12 years old called, [client A], who is not supervised and trespasses on neighbors' properties. [Client A] is home all day and walks all the way down the street and to a horse barn by himself, trespassing properties along the way." Confidential interview A stated, "On August 11, 2015, [client A] was not supervised and had a trimmer or weed whacker with a gas engine and trimmed another neighbor's</p>	W 0149	<p>staff to assure all incidents are reported in a timely manner. Additionally, Administrative documentation audits will include review of assessment data for all clients. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the governing body has facilitated the following: The Governing Body has directed the facility to modify the staffing matrix to assure that one to one staffing is available for Client A during waking hours and that double staffing is in place on the overnight shift in case to provide one to one observation of Client A if he is awake and out of his bedroom and 15 minute checks when he is asleep. For Client A, all staff have been trained on appropriate implementation of enhanced supervision and behavior supports. An enhanced supervisory and administrative presence in the home has been established to assure proper implementation of the current supports with emphasis on Client</i></p>	09/03/2015	

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 08/18/2015
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	<p>grass down to the dirt. The neighbor is trying to sell her house and was upset that he did this." Confidential interview A stated, "... [client A] to ask him if he has supervision. [Client A] said yes, but there was no one around." Confidential interview A stated, "On August 9, 2015 two young boys showed up at the group home and were talking to [client A] through a window on the side of the house. [Client A] came out and was talking with them and then took off on his bike."</p> <p>Confidential interview A stated, "In the last 2 to 2 and 1/2 weeks, [client A] has been out on the street in the cul de sac entire days. In temperatures of humid, upper 80's, four inches of rain for four hours or more until dark. [Client A] in and out of front yard in all events, no one ever came after [client A] even in prolonged stays and inclement weather."</p> <p>Observations were conducted at the group home on 8/13/15 from 1:30 PM to 2:45 PM. At 1:30 PM, upon arriving at the group home, client A was outside the group home walking up the driveway of the house. There were no staff present and the front door of the house was shut. Client A approached the surveyor, introduced himself and indicated he was having a yard sale. Client A then pointed</p>		<p>A's safety, as described below. For Client A, The QIDP has completed assessments of Client A's Social, functional and behavioral needs and has developed support plans based on the assessments, including but not limited to Client A's Safety. All facility staff been retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. All staff responsible for failing to report 3 incidents of Client A's evasion of staff supervision have received written corrective action.</p> <p>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 implement all training and behavior supports as written. The Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to participate in and monitor active treatment to</p>	

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 08/18/2015	
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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	to a small wooden table on the curb which had a stack of magazines, a shirt, a stuffed animal and two pairs of shoes. Client A indicated staff #1 was in the home and was working on paperwork in the basement. At 1:40 PM, a neighbor opened their garage door and began walking toward her vehicle. Client A indicated he wanted to speak to the neighbor and walked across the cul de sac to the neighbor's yard to initiate a conversation as she was in her vehicle backing out of her driveway. Client A returned to curb in front of the group home and indicated he needed to walk up the street to a friend's house. Client A indicated his friend was also having a yard sale and was selling a helmet for him. At 1:45 PM, the facility nurse pulled into the driveway. Client A observed the nurse arriving and then returned to the front door of the house, which was closed, and then entered the house. Client A returned outside with staff #1 to greet the nurse. Staff #1 introduced herself and indicated she was not aware of client A's yard sale and inquired as to how the surveyor was aware of the yard sale. Staff #1 was not monitoring client A and made no inquiry of the identification of the surveyor who was in the front of the house talking with client A from 1:30 PM through 1:45 PM.		assure all supports are implemented as written. The Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation. The QIDP has been retrained regarding the need to assure that all relevant assessments are obtained prior to admitting new clients to assure placement is appropriate and to facilitate the development of initial supports. After admission, additional assessment will occur for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will follow up with the QIDP no less twice weekly when clients are being considered for admission to the facility to assure appropriate assessments are obtained as required. Prior to admitting new clients, the Clinical Supervisor will assist the QIDP with developing appropriate initial supports. Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical				

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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>Staff #1 was interviewed on 8/13/15 at 2:00 PM. Staff #1 indicated she was the only staff present in the home at the time and was supervising client A and two housemates that had not gone to work. Staff #1 stated, "[Client A] likes to go out front. When I'm here by myself I have to keep an eye on the other clients too. That's why I keep the front door open and the curtains open so I can keep an eye on him from inside the house." Staff #1 indicated client would leave the property without permission and staff should supervise him while he is outside. Staff #1 indicated client A would walk to a nearby horse farm and spend time there helping the manager.</p> <p>Horse Barn Tenant (HBT) #1 was interviewed on 8/13/15 at 3:43 PM. HBT #1 stated, "Yea, I've seen [client A] up here. He will just show up and play with the kids who come here to ride their horses. [Client A] just makes me feel sort of uncomfortable. He looks like he's older but runs around playing with the 12 year olds. I see him watching the younger girls. They are like 12 or 13 and cute. I don't like the way he stares at them. As a mother, it just makes me feel uneasy. I don't really know him and there's nobody with him when he's here."</p> <p>Horse Barn Manager (HBM) #1 was</p>		<p>Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. The Executive Director or Program Manager will be on site for eight hours daily –observing active treatment and completing documentation reviews, Monday through Friday and complete additional observations at the facility on weekends until the Immediate Jeopardy status is resolved. When the Immediate Jeopardy is removed, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions and documentation reviews no less than five times weekly for the next 14 days, no less than three times weekly for an additional 30 days and twice weekly for an additional 60 days. The Program Manager will maintain a schedule for administrative monitoring and follow-up as needed. At the conclusion of this period of</p>		

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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>interviewed on 8/13/15 at 3:55 PM. HBM #1 indicated client A walked to the horse barn on a daily basis. HBM #1 stated, "[Client A] likes to come over and watch the horses and play with the kids. When he first started coming over the staff would come with him but now he just comes over by himself."</p> <p>Client A's record was reviewed on 8/13/15 at 2:30 PM. Client A's progress notes from 7/18/15 through 8/13/15 indicated the following narrative entries:</p> <p>- "8/4/15, [Client A] was riding a bike most of the time. Staff told him that he shouldn't left (sic) the staff's sight but he did and the staff told [TL (Team Leader) #1] and she told staff she should keep an eye on him."</p> <p>- "8/5/15, [Client A] ran off but he just came back a little bit ago so it's cool now."</p> <p>- "8/6/15, [Client A] ate breakfast, lunch and played outside. Left the house without permission."</p> <p>Client A's BSP (Behavior Support Plan) dated 8/10/15 indicated, "[Client A] is an 18 year old male with reported history of Attention Deficit/Hyper activity Disorder and Mild Intellectual Disability. Prior to</p>		<p>intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. 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, and visit the facility no less than monthly for the next 60 days. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will focus on:</p> <ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff. 2. Assuring adequate staffing is in place to ensure the safety of all clients. 3. Assuring staff implement support plans as written. 4. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. <p>Additionally, Administrative documentation audits will include review of assessment data for all clients. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>				

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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>his admission to the Avalon group home (7/18/15) [client A] lived at [agency]. Per his history, [client A] has previously engaged in many other problem behaviors including impulsivity, poor concentration, disrespect of authority figures, lack of regards for non-compliance and bullying. [Client A] displays these behaviors when he's attempting to execute dominance over his peers or in response to not being able to do something he wants to do. [Client A] does not show any interest in developing friendships or positive relationships since he has been admitted to ResCare. [Client A's] most common behaviors are property destruction. [Client A] is also likely to engage his peers in maladaptive behaviors by encouraging them to act out. [Client A] has engaged in self-injury by scratching on himself with a sharp object, the scratches are typically superficial. [Client A] is also prone to bullying his peers who are smaller/weaker and being rude and disrespectful to staff. At [client A's] previous placement, there was a total of 14 makeshift weapons found throughout his bedroom." Client A's BSP dated 8/10/15 indicated client A's targeted behaviors included but were not limited to verbal aggression, physical aggression, property destruction, threats to harm others, non-compliance, leaving assigned area and self-injurious behavior.</p>			

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	<p>Client A's BSP dated 8/10/15 indicated, "Leaving Assigned Area: Once [client A] walks away from the designated area, a staff will follow [client A] and initially keep a bit of distance between him and themselves (no more than 10 feet). If possible, the second staff will use the van to follow; the second or third staff will immediately notify the [TL #1] and follow their instructions; let [client A] know that you are there to talk to him and help him problem solve what is upsetting him; let [client A] know that once he returns to the home you and he will talk about what is upsetting him and help him come up with a solution; once [client A] returns to the home and he is calm, talk with him and help him problem solve; if [client A] is calm verbally redirect him to return to his original activity; if [client A] is threatening/attempting to run into the road or from the van, attempt to block him from exiting the home; if he opens the van door while the van is in motion, immediately pull to the side of the road and stop the van, attempt to redirect him from leaving the van; prior to him getting to the road staff will implement [physical management]."</p> <p>Client A's IDT (Interdisciplinary Team Meeting) form dated 8/11/15 indicated, "[Client A] will not leave Avalon home without staff. [Client A] does not have</p>			

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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>alone time and requires staffing while in the community. This is to ensure his safety. [Client A] will not accept or take alcohol. [Client A] understands the legal drinking age in Indiana is 21. [Client A] understand he can be arrested and go to jail if drinking under the age of 21. [Client A] will not make toys that look like guns and carry on him. This is very dangerous and can be views as weapons to members of the community resulting in calls to 911 and police being sent out. [Client A] could possibly be shot by police thinking he has a gun in his pants."</p> <p>Client A's admission papers included but were not limited to a Residential Safety Plan dated 4/7/15. Client A's Residential Safety Plan dated 4/7/15 indicated, "On Saturday, March 28, 2015, the following items were found in the [client A's] room as a result of a search after an incident in which [client A] stabbed/stuck/poked a staff with some type of tack or push pin: 1 pen wrapped in paper towels and shoe string, 2 or 3 pens wrapped in tape and paper, 2 or 3 pencils wrapped in vinyl gloves, rubber bands and rubber bracelets, 4 pieces of black plastic broken to have sharp edges and wrapped in socks, paper and string, 2 pieces of clear plastic broken to have sharp edges and wrapped in string and paper, a piece of a radio antenna wrapped in vinyl gloves</p>			

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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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	and string, a staple remover that had string and yarn tied to the top and bottom in a large loop. On Friday, April 3, 2015, after a pen was found in [client A's] room on the floor the night before, another search was conducted. The following items were found in the vent in the ceiling in [client A's] room: 2 CD's broken in half to create sharp edges, 4 pieces of clear plastic CD case broken and fashioned into a shank or knife like pieces with sharp points, 1 belt buckle, 2 pieces of broken radio antenna. In the past, [client A] has been found to have a serving knife from the kitchen, a butcher knife from the dishwasher, a chisel and various screwdrivers either brought back from home visits or from maintenance/groundskeeper. It is believed that [client A] is picking things up as he attends school, works on campus doing trash removal and recycling, works with maintenance and the grounds crew and anytime he is off the unit and brining them back to his room. As a result, [client A] will be searched anytime he leaves the unit and returns by staff and/or managers. If he refuses, [response team] should be called immediately. If [client A] is found to be in possession of items a second time, he will lose the privilege of working for the rest of the week. In addition, staff responsible for supervision of [client A] need to be very aware of			

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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>what he is doing at all times."</p> <p>Client A's progress notes from 7/18/15 through 8/13/15 indicated client A was at the horse barn on 7/21/15, 7/22/15, 7/23/15, 7/29/15, 8/2/15, 8/3/15, 8/7/15 and 8/9/15. The review indicated documenting of staff supervision of client A at the horse barn on 7/22/15 and 8/3/15. Client A's progress notes from 7/18/15 through 8/13/15 and/or record did not indicate documentation of staff performing checks to ensure client A did not bring items that could be made into weapons into the home after being at the horse barn.</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 8/13/15 at 3:50 PM. The review indicated the following:</p> <p>-BDDS report dated 8/9/15 indicated, "[Client A] was caught drinking beer by staff. [Client A] stated that he got the beer from a neighbor."</p> <p>-BDDS report dated 8/11/15 indicated, "[Client A] left home without staff on 8/11/15. Staff on duty noticed [client A] had left the home during medication pass. One of the staff on duty found [client A] down the street. [Client A] told staff he was walking one of the neighborhood</p>			

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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>kids to the bus stop."</p> <p>The review did not indicate documentation of the 8/4/15, 8/5/15 or 8/6/15 incidents of client A leaving staff's sight/supervision.</p> <p>TL #1 was interviewed on 8/13/15 at 2:30 PM. TL #1 indicated client A should be supervised by staff when he is outside in the yard. TL #1 indicated client A would leave his designated area and walk or ride his bike through the community and to the nearby horse barn.</p> <p>Staff #2 was interviewed on 8/13/15 at 2:40 PM. Staff #2 indicated client A should be supervised while outside. Staff #2 indicated if client A attempts to leave the yard staff should follow him to ensure his safety. Staff #2 stated, "Sometimes if there are other clients here in the home we can't leave the house to follow him. Sometimes he takes off and leaves by himself."</p> <p>BDDS generalist #1 was interviewed on 8/13/15 at 3:45 PM. BDDS generalist #1 indicated client A had eloped from a family member's house while on a visit prior to being admitted to the group home. BDDS generalist #1 indicated client A was located 20 miles away from the family member's residence.</p>			

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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>Clinical Supervisor (CS) #1 was interviewed on 8/13/15 at 5:15 PM. CS #1 indicated client A had been admitted to the group home on 7/18/15. CS #1 indicated client A had not been at the group home for 30 days and had not yet been assessed to determine his community safety skills or if he was vulnerable in the community. CS #1 stated, "While he's in his first 30 days he should not be in the community alone." CS #1 indicated client A should be supervised and staff should be present with client A while he is outside. CS #1 indicated client A had recently been found with a bicycle that was not his, had used a knife to cut up some exercise equipment and had dug up wires in the yard. CS #1 indicated incidents of client A leaving his assigned area and staff's supervision should be reported to BDDS. CS #1 indicated client A's 8/4/15 and 8/5/15 incidents of being out of staff's supervision had not been reported to BDDS. CS #1 indicated the facility was actively investigating the 8/11/15 incident of client A's consumption of alcohol. CS #1 indicated the facility's abuse and neglect policy should be implemented. CS #1 indicated there was not currently a documented plan in place outlining client A's activities at the horse barn or how staff would ensure his safety</p>			

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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 0159 Bldg. 00	<p>while at the horse barn or upon his return.</p> <p>The facility's policy's and procedures were reviewed on 8/13/15 at 6:00 PM. The facility's Abuse and Neglect policy dated 2/26/11 indicated, "Program Intervention Neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan, inappropriate application of intervention without a qualified person notification/review."</p> <p>This federal tag relates to complaints #IN00180086 and #IN00179268.</p> <p>9-3-2(a)</p> <p>483.430(a) 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 1 of 3 sampled clients (A), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure sufficient staffing levels in the</p>	W 0159	<p>CORRECTION: <i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, The Governing Body has directed the facility to modify the staffing matrix to assure that one to one staffing is</i></p>	09/03/2015

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 08/18/2015
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	<p>home to implement client A's BSP (Behavior Support Plan) and ensure his safety, to ensure staff working with client A were competent to manage client A's inappropriate behavior and to ensure client A was assessed for behavioral, functional and social needs prior to admission to the group home.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QIDP failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure sufficient staffing levels in the home to implement client A's BSP and ensure his safety. Please see W186. 2. The QIDP failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure staff working with client A were competent to manage client A's inappropriate behavior. Please see W193. 3. The QIDP failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure client A was assessed for behavioral, functional and social needs prior to admission to the group home. Please see W200. <p>This federal tag relates to complaints</p>		<p>available for Client A during waking hours and that double staffing is in place on the overnight shift in case to provide one to one observation of Client A if he is awake and out of his bedroom and 15 minute checks when he is asleep. For Client A, the QIDP has facilitated training of all facility staff on appropriate implementation of enhanced supervision and behavior supports. An enhanced supervisory and administrative presence in the home has been established to assure proper implementation of the current supports with emphasis on Client A's safety, as described below. For Client A, The QIDP has completed assessments of Client A's Social, functional and behavioral needs and has developed support plans based on the assessments, including but not limited to Client A's Safety. The QIDP has facilitated training of all facility staff regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. All staff responsible for failing to report 3 incidents of Client A's evasion of staff supervision have received written</p>	

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 08/18/2015
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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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	#IN00180086 and #IN00179268. 9-3-3(a)		corrective action. 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 implement all training and behavior supports as written. The Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to participate in and monitor active treatment to assure all supports are implemented as written. The Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation. The QIDP has been retrained regarding the need to assure that all relevant assessments are obtained prior to admitting new clients to assure placement is appropriate and to facilitate the development of initial supports. After admission, additional assessment will occur for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will follow up with the QIDP no less twice weekly when clients	

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 08/18/2015
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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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			are being considered for admission to the facility to assure appropriate assessments are obtained as required. Prior to admitting new clients, the Clinical Supervisor will assist the QIDP with developing appropriate initial supports. Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. The Executive Director or Program Manager will be on site for eight hours daily –observing active treatment and completing documentation reviews, Monday through Friday and complete additional observations at the facility on weekends until the Immediate Jeopardy status is resolved.	

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 08/18/2015
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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>When the Immediate Jeopardy is removed, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions and documentation reviews no less than five times weekly for the next 14 days, no less than three times weekly for an additional 30 days and twice weekly for an additional 60 days. The Program Manager will maintain a schedule for administrative monitoring and follow-up as needed. 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. 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, and visit the facility no less than monthly for the next 60 days. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will focus on:</p> <ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff. 2. Assuring adequate staffing is 	

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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 0186 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 1 of 3 sampled clients (A), the facility failed to ensure sufficient staffing levels in the home to implement client A's BSP (Behavior Support Plan) and ensure his safety.</p> <p>Findings include:</p> <p>Confidential interview A stated, "There is</p>	W 0186	<p>in place to ensure the safety of all clients. 3. Assuring staff implement support plans as written. 4. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. Additionally, Administrative documentation audits will include review of assessment data for all clients. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</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 one to one staffing is available for Client A</i></p>	09/03/2015	

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 08/18/2015	
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>a new resident who looks to be about 12 years old called, [client A], who is not supervised and trespasses on neighbors' properties. [Client A] is home all day and walks all the way down the street and to a horse barn by himself, trespassing properties along the way." Confidential interview A stated, "On August 11, 2015, [client A] was not supervised and had a trimmer or weed whacker with a gas engine and trimmed another neighbor's grass down to the dirt. The neighbor is trying to sell her house and was upset that he did this." Confidential interview A stated, "... [client A] to ask him if he has supervision. [Client A] said yes, but there was no one around." Confidential interview A stated, "On August 9, 2015 two young boys showed up at the group home and were talking to [client A] through a window on the side of the house. [Client A] came out and was talking with them and then took off on his bike."</p> <p>Confidential interview A stated, "In the last 2 to 2 and 1/2 weeks, [client A] has been out on the street in the cul de sac entire days. In temperatures of humid, upper 80's, four inches of rain for four hours or more until dark. [Client A] in and out of front yard in all events, no one ever came after [client A] even in prolonged stays and inclement weather."</p>		<p>during waking hours and that double staffing is in place on the overnight shift in case to provide one to one observation of Client A if he is awake and out of his bedroom and 15 minute checks when he is asleep.</p> <p>PREVENTION:</p> <p>The Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation.</p> <p>The Executive Director or Program Manager will be on site for eight hours daily –observing active treatment and completing documentation reviews, Monday through Friday and complete additional observations at the facility on weekends until the Immediate Jeopardy status is resolved. When the Immediate Jeopardy is removed, 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 five times weekly for the next 14 days, no less than three</p>				

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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>Neighbor #1 was interviewed on 8/13/15 at 11:24 AM. Neighbor #1 indicated client A stays outside in the front yard of the home and in the cul de sac daily for extended periods of time. Neighbor #1 indicated staff are not seen and not supervising client A. Neighbor #1 indicated client A goes into neighbors' yards and tears things up. Neighbor #1 stated, "He is just getting to be a nuisance. Anytime anyone is outside, walking or working in their yard, [client A], comes over and bothers them. There is an elderly lady who is terminally ill who has stopped going outside for walks with her sister because [client A] won't leave them alone while they walk." Neighbor #1 stated, "[Client A] hangs around some younger kids in the neighborhood. Sometimes I hear them making fun of him, I don't think he realizes they are not really his friends."</p> <p>Observations were conducted at the group home on 8/13/15 from 1:30 PM to 2:45 PM. At 1:30 PM, upon arriving at the group home, client A was outside the group home walking up the driveway of the house. There were no staff present and the front door of the house was shut. Client A approached the surveyor, introduced himself and indicated he was having a yard sale. Client A then pointed</p>		<p>times weekly for an additional 30 days and twice weekly for an additional 60 days. The Program Manager will maintain a schedule for administrative monitoring and follow-up as needed. 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. Administrative monitoring will focus on adequate staffing and appropriate implementation of supports. 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</p>				

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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>to a small wooden table on the curb which had a stack of magazines, a shirt, a stuffed animal and two pairs of shoes. Client A indicated staff #1 was in the home and was working on paperwork in the basement. At 1:40 PM, a neighbor opened their garage door and began walking toward her vehicle. Client A indicated he wanted to speak to the neighbor and walked across the cul de sac to the neighbor's yard to initiate a conversation as she was in her vehicle backing out of her driveway. Client A returned to curb in front of the group home and indicated he needed to walk up the street to a friend's house. Client A indicated his friend was also having a yard sale and was selling a helmet for him. At 1:45 PM, the facility nurse pulled into the driveway. Client A observed the nurse arriving and then returned to the front door of the house, which was closed, and then entered the house. Client A returned outside with staff #1 to greet the nurse. Staff #1 introduced herself and indicated she was not aware of client A's yard sale and inquired as to how the surveyor was aware of the yard sale. Staff #1 was not monitoring client A and made no inquiry of the identification of the surveyor who was in the front of the house talking with client A from 1:30 PM through 1:45 PM.</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.</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, and visit the facility no less than monthly for the next 60 days. 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 adequate direct support staff are</p>	

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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>Staff #1 was interviewed on 8/13/15 at 2:00 PM. Staff #1 indicated she was the only staff present in the home at the time and was supervising client A and two housemates that had not gone to work. Staff #1 stated, "[Client A] likes to go out front. When I'm here by myself I have to keep an eye on the other clients too. That's why I keep the front door open and the curtains open so I can keep an eye on him from inside the house." Staff #1 indicated client would leave the property without permission and staff should supervise him while he is outside. Staff #1 indicated client A would walk to a nearby horse farm and spend time there helping the manager.</p> <p>Horse Barn Tenant (HBT) #1 was interviewed on 8/13/15 at 3:43 PM. HBT #1 stated, "Yea, I've seen [client A] up here. He will just show up and play with the kids who come here to ride their horses. [Client A] just makes me feel sort of uncomfortable. He looks like he's older but runs around playing with the 12 year olds. I see him watching the younger girls. They are like 12 or 13 and cute. I don't like the way he stares at them. As a mother, it just makes me feel uneasy. I don't really know him and there's nobody with him when he's here."</p> <p>Horse Barn Manager (HBM) #1 was</p>		<p>on duty to meet the safety and training 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> <p>RESPONSIBLE PARTIES:</p> <p>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 <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2015
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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>interviewed on 8/13/15 at 3:55 PM. HBM #1 indicated client A walked to the horse barn on a daily basis. HBM #1 stated, "[Client A] likes to come over and watch the horses and play with the kids. When he first started coming over the staff would come with him but now he just comes over by himself."</p> <p>Client A's record was reviewed on 8/13/15 at 2:30 PM. Client A's progress notes from 7/18/15 through 8/13/15 indicated the following narrative entries:</p> <p>- "8/4/15, [Client A] was riding a bike most of the time. Staff told him that he shouldn't left (sic) the staff's sight but he did and the staff told [TL (Team Leader) #1] and she told staff she should keep an eye on him."</p> <p>- "8/5/15, [Client A] ran off but he just came back a little bit ago so it's cool now."</p> <p>- "8/6/15, [Client A] ate breakfast, lunch and played outside. Left the house without permission."</p> <p>Client A's BSP (Behavior Support Plan) dated 8/10/15 indicated, "[Client A] is an 18 year old male with reported history of Attention Deficit/Hyper activity Disorder and Mild Intellectual Disability. Prior to</p>			

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	<p>his admission to the Avalon group home (7/18/15) [client A] lived at [agency]. Per his history, [client A] has previously engaged in many other problem behaviors including impulsivity, poor concentration, disrespect of authority figures, lack of regards for non-compliance and bullying. [Client A] displays these behaviors when he's attempting to execute dominance over his peers or in response to not being able to do something he wants to do. [Client A] does not show any interest in developing friendships or positive relationships since he has been admitted to ResCare. [Client A's] most common behaviors are property destruction. [Client A] is also likely to engage his peers in maladaptive behaviors by encouraging them to act out. [Client A] has engaged in self-injury by scratching on himself with a sharp object, the scratches are typically superficial. [Client A] is also prone to bullying his peers who are smaller/weaker and being rude and disrespectful to staff. At [client A's] previous placement, there was a total of 14 makeshift weapons found throughout his bedroom." Client A's BSP dated 8/10/15 indicated client A's targeted behaviors included but were not limited to verbal aggression, physical aggression, property destruction, threats to harm others, non-compliance, leaving assigned area and self-injurious behavior.</p>			

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	<p>Client A's BSP dated 8/10/15 indicated, "Leaving Assigned Area: Once [client A] walks away from the designated area, a staff will follow [client A] and initially keep a bit of distance between him and themselves (no more than 10 feet). If possible, the second staff will use the van to follow; the second or third staff will immediately notify the [TL #1] and follow their instructions; let [client A] know that you are there to talk to him and help him problem solve what is upsetting him; let [client A] know that once he returns to the home you and he will talk about what is upsetting him and help him come up with a solution; once [client A] returns to the home and he is calm, talk with him and help him problem solve; if [client A] is calm verbally redirect him to return to his original activity; if [client A] is threatening/attempting to run into the road or from the van, attempt to block him from exiting the home; if he opens the van door while the van is in motion, immediately pull to the side of the road and stop the van, attempt to redirect him from leaving the van; prior to him getting to the road staff will implement [physical management]."</p> <p>Client A's IDT (Interdisciplinary Team Meeting) form dated 8/11/15 indicated, "[Client A] will not leave Avalon home without staff. [Client A] does not have</p>			

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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>alone time and requires staffing while in the community. This is to ensure his safety. [Client A] will not accept or take alcohol. [Client A] understands the legal drinking age in Indiana is 21. [Client A] understand he can be arrested and go to jail if drinking under the age of 21. [Client A] will not make toys that look like guns and carry on him. This is very dangerous and can be views as weapons to members of the community resulting in calls to 911 and police being sent out. [Client A] could possibly be shot by police thinking he has a gun in his pants."</p> <p>Client A's admission papers included but were not limited to a Residential Safety Plan dated 4/7/15. Client A's Residential Safety Plan dated 4/7/15 indicated, "On Saturday, March 28, 2015, the following items were found in the [client A's] room as a result of a search after an incident in which [client A] stabbed/stuck/poked a staff with some type of tack or push pin: 1 pen wrapped in paper towels and shoe string, 2 or 3 pens wrapped in tape and paper, 2 or 3 pencils wrapped in vinyl gloves, rubber bands and rubber bracelets, 4 pieces of black plastic broken to have sharp edges and wrapped in socks, paper and string, 2 pieces of clear plastic broken to have sharp edges and wrapped in string and paper, a piece of a radio antenna wrapped in vinyl gloves</p>			

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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>and string, a staple remover that had string and yarn tied to the top and bottom in a large loop. On Friday, April 3, 2015, after a pen was found in [client A's] room on the floor the night before, another search was conducted. The following items were found in the vent in the ceiling in [client A's] room: 2 CD's broken in half to create sharp edges, 4 pieces of clear plastic CD case broken and fashioned into a shank or knife like pieces with sharp points, 1 belt buckle, 2 pieces of broken radio antenna. In the past, [client A] has been found to have a serving knife from the kitchen, a butcher knife from the dishwasher, a chisel and various screwdrivers either brought back from home visits or from maintenance/groundskeeper. It is believed that [client A] is picking things up as he attends school, works on campus doing trash removal and recycling, works with maintenance and the grounds crew and anytime he is off the unit and brining them back to his room. As a result, [client A] will be searched anytime he leaves the unit and returns by staff and/or managers. If he refuses, [response team] should be called immediately. If [client A] is found to be in possession of items a second time, he will lose the privilege of working for the rest of the week. In addition, staff responsible for supervision of [client A] need to be very aware of</p>			

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	<p>what he is doing at all times."</p> <p>Client A's progress notes from 7/18/15 through 8/13/15 indicated client A was at the horse barn on 7/21/15, 7/22/15, 7/23/15, 7/29/15, 8/2/15, 8/3/15, 8/7/15 and 8/9/15. The review indicated documenting of staff supervision of client A at the horse barn on 7/22/15 and 8/3/15. Client A's progress notes from 7/18/15 through 8/13/15 and/or record did not indicate documentation of staff performing checks to ensure client A did not bring items that could be made into weapons into the home after being at the horse barn.</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 8/13/15 at 3:50 PM. The review indicated the following:</p> <p>-BDDS report dated 8/9/15 indicated, "[Client A] was caught drinking beer by staff. [Client A] stated that he got the beer from a neighbor."</p> <p>-BDDS report dated 8/11/15 indicated, "[Client A] left home without staff on 8/11/15. Staff on duty noticed [client A] had left the home during medication pass. One of the staff on duty found [client A] down the street. [Client A] told staff he was walking one of the neighborhood</p>			

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	<p>kids to the bus stop."</p> <p>TL #1 was interviewed on 8/13/15 at 2:30 PM. TL #1 indicated client A should be supervised by staff when he is outside in the yard. TL #1 indicated client A would leave his designated area and walk or ride his bike through the community and to the nearby horse barn.</p> <p>Staff #2 was interviewed on 8/13/15 at 2:40 PM. Staff #2 indicated client A should be supervised while outside. Staff #2 indicated if client A attempts to leave the yard staff should follow him to ensure his safety. Staff #2 stated, "Sometimes if there are other clients here in the home we can't leave the house to follow him. Sometimes he takes off and leaves by himself."</p> <p>Clinical Supervisor (CS) #1 was interviewed on 8/13/15 at 5:15 PM. CS #1 stated, "While he's in his first 30 days he should not be in the community alone." CS #1 indicated client A should be supervised and staff should be present with client A while he is outside.</p> <p>This federal tag relates to complaints #IN00180086 and #IN00179268.</p> <p>9-3-3(a)</p>			

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W 0193 Bldg. 00	<p>483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure staff working with client A were competent to manage client A's inappropriate behavior.</p> <p>Findings include:</p> <p>Confidential interview A stated, "There is a new resident who looks to be about 12 years old called, [client A], who is not supervised and trespasses on neighbors' properties. [Client A] is home all day and walks all the way down the street and to a horse barn by himself, trespassing properties along the way." Confidential interview A stated, "On August 11, 2015, [client A] was not supervised and had a trimmer or weed whacker with a gas engine and trimmed another neighbor's grass down to the dirt. The neighbor is trying to sell her house and was upset that he did this." Confidential interview A stated, "... [client A] to ask him if he has supervision. [Client A] said yes, but there was no one around." Confidential interview A stated, "On August 9, 2015 two young boys showed up at the group home and were talking to [client A]"</p>	W 0193	<p>CORRECTON:</p> <p><i>Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. Specifically for Client A, all staff have been trained on appropriate implementation of enhanced supervision and behavior supports. An enhanced supervisory and administrative presence in the home has been established to assure proper implementation of the current supports with emphasis on Client A's safety, as described below.</i></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 assuring staff implement all</p>	09/03/2015
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	<p>through a window on the side of the house. [Client A] came out and was talking with them and then took off on his bike."</p> <p>Confidential interview A stated, "In the last 2 to 2 and 1/2 weeks, [client A] has been out on the street in the cul de sac entire days. In temperatures of humid, upper 80's, four inches of rain for four hours or more until dark. [Client A] in and out of front yard in all events, no one ever came after [client A] even in prolonged stays and inclement weather."</p> <p>Neighbor #1 was interviewed on 8/13/15 at 11:24 AM. Neighbor #1 indicated client A stays outside in the front yard of the home and in the cul de sac daily for extended periods of time. Neighbor #1 indicated staff are not seen and not supervising client A. Neighbor #1 indicated client A goes into neighbors' yards and tears things up. Neighbor #1 stated, "He is just getting to be a nuisance. Anytime anyone is outside, walking or working in their yard, [client A], comes over and bothers them. There is an elderly lady who is terminally ill who has stopped going outside for walks with her sister because [client A] won't leave them alone while they walk." Neighbor #1 stated, "[Client A] hangs around some younger kids in the</p>		<p>training and behavior supports as written. The Team Lead will be present, supervising active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to participate in and monitor active treatment to assure all supports are implemented as written.</p> <p>The Executive Director or Program Manager will be on site for eight hours daily –observing active treatment and completing documentation reviews, Monday through Friday and complete additional observations at the facility on weekends until the Immediate Jeopardy status is resolved. When the Immediate Jeopardy is removed, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions and documentation reviews no less than five times weekly for the next 14 days, no less than three times weekly for an additional 30 days and twice weekly for an additional 60 days. The Program Manager will maintain a schedule for administrative monitoring and</p>	

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	<p>neighborhood. Sometimes I hear them making fun of him, I don't think he realizes they are not really his friends."</p> <p>Observations were conducted at the group home on 8/13/15 from 1:30 PM to 2:45 PM. At 1:30 PM, upon arriving at the group home, client A was outside the group home walking up the driveway of the house. There were no staff present and the front door of the house was shut. Client A approached the surveyor, introduced himself and indicated he was having a yard sale. Client A then pointed to a small wooden table on the curb which had a stack of magazines, a shirt, a stuffed animal and two pairs of shoes. Client A indicated staff #1 was in the home and was working on paperwork in the basement. At 1:40 PM, a neighbor opened their garage door and began walking toward her vehicle. Client A indicated he wanted to speak to the neighbor and walked across the cul de sac to the neighbor's yard to initiate a conversation as she was in her vehicle backing out of her driveway. Client A returned to curb in front of the group home and indicated he needed to walk up the street to a friend's house. Client A indicated his friend was also having a yard sale and was selling a helmet for him. At 1:45 PM, the facility nurse pulled into the driveway. Client A observed the</p>		<p>follow-up as needed. 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. Administrative monitoring will focus on adequate staffing and appropriate implementation of supports. 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</p>	

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	<p>nurse arriving and then returned to the front door of the house, which was closed, and then entered the house. Client A returned outside with staff #1 to greet the nurse. Staff #1 introduced herself and indicated she was not aware of client A's yard sale and inquired as to how the surveyor was aware of the yard sale. Staff #1 was not monitoring client A and made no inquiry of the identification of the surveyor who was in the front of the house talking with client A from 1:30 PM through 1:45 PM.</p> <p>Staff #1 was interviewed on 8/13/15 at 2:00 PM. Staff #1 indicated she was the only staff present in the home at the time and was supervising client A and two housemates that had not gone to work. Staff #1 stated, "[Client A] likes to go out front. When I'm here by myself I have to keep an eye on the other clients too. That's why I keep the front door open and the curtains open so I can keep an eye on him from inside the house." Staff #1 indicated client would leave the property without permission and staff should supervise him while he is outside. Staff #1 indicated client A would walk to a nearby horse farm and spend time there helping the manager.</p> <p>Horse Barn Tenant (HBT) #1 was interviewed on 8/13/15 at 3:43 PM. HBT</p>		<p>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, and visit the facility no less than monthly for the next 60 days. 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 adequate direct support staff are on duty to meet the safety and training needs of all clients.</p>	

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	<p>#1 stated, "Yea, I've seen [client A] up here. He will just show up and play with the kids who come here to ride their horses. [Client A] just makes me feel sort of uncomfortable. He looks like he's older but runs around playing with the 12 year olds. I see him watching the younger girls. They are like 12 or 13 and cute. I don't like the way he stares at them. As a mother, it just makes me feel uneasy. I don't really know him and there's nobody with him when he's here."</p> <p>Horse Barn Manager (HBM) #1 was interviewed on 8/13/15 at 3:55 PM. HBM #1 indicated client A walked to the horse barn on a daily basis. HBM #1 stated, "[Client A] likes to come over and watch the horses and play with the kids. When he first started coming over the staff would come with him but now he just comes over by himself."</p> <p>Client A's record was reviewed on 8/13/15 at 2:30 PM. Client A's progress notes from 7/18/15 through 8/13/15 indicated the following narrative entries:</p> <p>-"8/4/15, [Client A] was riding a bike most of the time. Staff told him that he shouldn't left (sic) the staff's sight but he did and the staff told [TL (Team Leader) #1] and she told staff she should keep an eye on him."</p>		<p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	
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	<p>- "8/5/15, [Client A] ran off but he just came back a little bit ago so it's cool now."</p> <p>- "8/6/15, [Client A] ate breakfast, lunch and played outside. Left the house without permission."</p> <p>Client A's BSP (Behavior Support Plan) dated 8/10/15 indicated, "[Client A] is an 18 year old male with reported history of Attention Deficit/Hyper activity Disorder and Mild Intellectual Disability. Prior to his admission to the Avalon group home (7/18/15) [client A] lived at [agency]. Per his history, [client A] has previously engaged in many other problem behaviors including impulsivity, poor concentration, disrespect of authority figures, lack of regards for non-compliance and bullying. [Client A] displays these behaviors when he's attempting to execute dominance over his peers or in response to not being able to do something he wants to do. [Client A] does not show any interest in developing friendships or positive relationships since he has been admitted to ResCare. [Client A's] most common behaviors are property destruction. [Client A] is also likely to engage his peers in maladaptive behaviors by encouraging them to act out. [Client A] has engaged in self-injury by</p>			

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	scratching on himself with a sharp object, the scratches are typically superficial. [Client A] is also prone to bullying his peers who are smaller/weaker and being rude and disrespectful to staff. At [client A's] previous placement, there was a total of 14 makeshift weapons found throughout his bedroom." Client A's BSP dated 8/10/15 indicated client A's targeted behaviors included but were not limited to verbal aggression, physical aggression, property destruction, threats to harm others, non-compliance, leaving assigned area and self-injurious behavior. Client A's BSP dated 8/10/15 indicated, "Leaving Assigned Area: Once [client A] walks away from the designated area, a staff will follow [client A] and initially keep a bit of distance between him and themselves (no more than 10 feet). If possible, the second staff will use the van to follow; the second or third staff will immediately notify the [TL #1] and follow their instructions; let [client A] know that you are there to talk to him and help him problem solve what is upsetting him; let [client A] know that once he returns to the home you and he will talk about what is upsetting him and help him come up with a solution; once [client A] returns to the home and he is calm, talk with him and help him problem solve; if [client A] is calm verbally redirect him to return to his original activity; if [client A]			

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	<p>is threatening/attempting to run into the road or from the van, attempt to block him from exiting the home; if he opens the van door while the van is in motion, immediately pull to the side of the road and stop the van, attempt to redirect him from leaving the van; prior to him getting to the road staff will implement [physical management]."</p> <p>Client A's IDT (Interdisciplinary Team Meeting) form dated 8/11/15 indicated, "[Client A] will not leave Avalon home without staff. [Client A] does not have alone time and requires staffing while in the community. This is to ensure his safety. [Client A] will not accept or take alcohol. [Client A] understands the legal drinking age in Indiana is 21. [Client A] understand he can be arrested and go to jail if drinking under the age of 21. [Client A] will not make toys that look like guns and carry on him. This is very dangerous and can be views as weapons to members of the community resulting in calls to 911 and police being sent out. [Client A] could possibly be shot by police thinking he has a gun in his pants."</p> <p>Client A's admission papers included but were not limited to a Residential Safety Plan dated 4/7/15. Client A's Residential Safety Plan dated 4/7/15 indicated, "On Saturday, March 28, 2015, the following</p>			

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	<p>items were found in the [client A's] room as a result of a search after an incident in which [client A] stabbed/stuck/poked a staff with some type of tack or push pin: 1 pen wrapped in paper towels and shoe string, 2 or 3 pens wrapped in tape and paper, 2 or 3 pencils wrapped in vinyl gloves, rubber bands and rubber bracelets, 4 pieces of black plastic broken to have sharp edges and wrapped in socks, paper and string, 2 pieces of clear plastic broken to have sharp edges and wrapped in string and paper, a piece of a radio antenna wrapped in vinyl gloves and string, a staple remover that had string and yarn tied to the top and bottom in a large loop. On Friday, April 3, 2015, after a pen was found in [client A's] room on the floor the night before, another search was conducted. The following items were found in the vent in the ceiling in [client A's] room: 2 CD's broken in half to create sharp edges, 4 pieces of clear plastic CD case broken and fashioned into a shank or knife like pieces with sharp points, 1 belt buckle, 2 pieces of broken radio antenna. In the past, [client A] has been found to have a serving knife from the kitchen, a butcher knife from the dishwasher, a chisel and various screwdrivers either brought back from home visits or from maintenance/groundskeeper. It is believed that [client A] is picking things</p>			

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	<p>up as he attends school, works on campus doing trash removal and recycling, works with maintenance and the grounds crew and anytime he is off the unit and brining them back to his room. As a result, [client A] will be searched anytime he leaves the unit and returns by staff and/or managers. If he refuses, [response team] should be called immediately. If [client A] is found to be in possession of items a second time, he will lose the privilege of working for the rest of the week. In addition, staff responsible for supervision of [client A] need to be very aware of what he is doing at all times."</p> <p>Client A's progress notes from 7/18/15 through 8/13/15 indicated client A was at the horse barn on 7/21/15, 7/22/15, 7/23/15, 7/29/15, 8/2/15, 8/3/15, 8/7/15 and 8/9/15. The review indicated documenting of staff supervision of client A at the horse barn on 7/22/15 and 8/3/15. Client A's progress notes from 7/18/15 through 8/13/15 and/or record did not indicate documentation of staff performing checks to ensure client A did not bring items that could be made into weapons into the home after being at the horse barn.</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 8/13/15 at 3:50</p>			

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 08/18/2015
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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>PM. The review indicated the following:</p> <p>-BDDS report dated 8/9/15 indicated, "[Client A] was caught drinking beer by staff. [Client A] stated that he got the beer from a neighbor."</p> <p>-BDDS report dated 8/11/15 indicated, "[Client A] left home without staff on 8/11/15. Staff on duty noticed [client A] had left the home during medication pass. One of the staff on duty found [client A] down the street. [Client A] told staff he was walking one of the neighborhood kids to the bus stop."</p> <p>TL #1 was interviewed on 8/13/15 at 2:30 PM. TL #1 indicated client A should be supervised by staff when he is outside in the yard. TL #1 indicated client A would leave his designated area and walk or ride his bike through the community and to the nearby horse barn.</p> <p>Staff #2 was interviewed on 8/13/15 at 2:40 PM. Staff #2 indicated client A should be supervised while outside. Staff #2 indicated if client A attempts to leave the yard staff should follow him to ensure his safety. Staff #2 stated, "Sometimes if there are other clients here in the home we can't leave the house to follow him. Sometimes he takes off and leaves by himself."</p>			

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W 0200 Bldg. 00	<p>Clinical Supervisor (CS) #1 was interviewed on 8/13/15 at 5:15 PM. CS #1 stated, "While he's in his first 30 days he should not be in the community alone." CS #1 indicated client A should be supervised and staff should be present with client A while he is outside.</p> <p>This federal tag relates to complaints #IN00180086 and #IN00179268.</p> <p>9-3-3(a)</p> <p>483.440(b)(3) ADMISSIONS, TRANSFERS, DISCHARGE A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility. Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A was assessed for behavioral, functional and social needs prior to admission to the group home.</p> <p>Findings include: Confidential interview A stated, "There is</p>	W 0200	<p>CORRECTON:</p> <p><i>A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit</i></p>	09/03/2015

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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>a new resident who looks to be about 12 years old called, [client A], who is not supervised and trespasses on neighbors' properties. [Client A] is home all day and walks all the way down the street and to a horse barn by himself, trespassing properties along the way." Confidential interview A stated, "On August 11, 2015, [client A] was not supervised and had a trimmer or weed whacker with a gas engine and trimmed another neighbor's grass down to the dirt. The neighbor is trying to sell her house and was upset that he did this." Confidential interview A stated, "... [client A] to ask him if he has supervision. [Client A] said yes, but there was no one around." Confidential interview A stated, "On August 9, 2015 two young boys showed up at the group home and were talking to [client A] through a window on the side of the house. [Client A] came out and was talking with them and then took off on his bike."</p> <p>Confidential interview A stated, "In the last 2 to 2 and 1/2 weeks, [client A] has been out on the street in the cul de sac entire days. In temperatures of humid, upper 80's, four inches of rain for four hours or more until dark. [Client A] in and out of front yard in all events, no one ever came after [client A] even in prolonged stays and inclement weather."</p>		<p><i>from placement in the facility.</i> Specifically for Client A, The QIDP has completed assessments of Client A's Social, functional and behavioral needs and has developed support plans based on the assessments, including but not limited to Client A's Safety.</p> <p>PREVENTION:</p> <p>The QIDP has been retrained regarding the need to assure that all relevant assessments are obtained prior to admitting new clients to assure placement is appropriate and to facilitate the development of initial supports. After admission, additional assessment will occur for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will follow up with the QIDP no less twice weekly when clients are being considered for admission to the facility to assure appropriate assessments are obtained as required. Prior to admitting new clients, the Clinical Supervisor will assist the QIDP with developing appropriate initial supports.</p>	

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	<p>Neighbor #1 was interviewed on 8/13/15 at 11:24 AM. Neighbor #1 indicated client A stays outside in the front yard of the home and in the cul de sac daily for extended periods of time. Neighbor #1 indicated staff are not seen and not supervising client A. Neighbor #1 indicated client A goes into neighbors' yards and tears things up. Neighbor #1 stated, "He is just getting to be a nuisance. Anytime anyone is outside, walking or working in their yard, [client A], comes over and bothers them. There is an elderly lady who is terminally ill who has stopped going outside for walks with her sister because [client A] won't leave them alone while they walk." Neighbor #1 stated, "[Client A] hangs around some younger kids in the neighborhood. Sometimes I hear them making fun of him, I don't think he realizes they are not really his friends."</p> <p>Observations were conducted at the group home on 8/13/15 from 1:30 PM to 2:45 PM. At 1:30 PM, upon arriving at the group home, client A was outside the group home walking up the driveway of the house. There were no staff present and the front door of the house was shut. Client A approached the surveyor, introduced himself and indicated he was having a yard sale. Client A then pointed</p>		<p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>to a small wooden table on the curb which had a stack of magazines, a shirt, a stuffed animal and two pairs of shoes. Client A indicated staff #1 was in the home and was working on paperwork in the basement. At 1:40 PM, a neighbor opened their garage door and began walking toward her vehicle. Client A indicated he wanted to speak to the neighbor and walked across the cul de sac to the neighbor's yard to initiate a conversation as she was in her vehicle backing out of her driveway. Client A returned to curb in front of the group home and indicated he needed to walk up the street to a friend's house. Client A indicated his friend was also having a yard sale and was selling a helmet for him. At 1:45 PM, the facility nurse pulled into the driveway. Client A observed the nurse arriving and then returned to the front door of the house, which was closed, and then entered the house. Client A returned outside with staff #1 to greet the nurse. Staff #1 introduced herself and indicated she was not aware of client A's yard sale and inquired as to how the surveyor was aware of the yard sale. Staff #1 was not monitoring client A and made no inquiry of the identification of the surveyor who was in the front of the house talking with client A from 1:30 PM through 1:45 PM.</p>			

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	<p>Staff #1 was interviewed on 8/13/15 at 2:00 PM. Staff #1 indicated she was the only staff present in the home at the time and was supervising client A and two housemates that had not gone to work. Staff #1 stated, "[Client A] likes to go out front. When I'm here by myself I have to keep an eye on the other clients too. That's why I keep the front door open and the curtains open so I can keep an eye on him from inside the house." Staff #1 indicated client would leave the property without permission and staff should supervise him while he is outside. Staff #1 indicated client A would walk to a nearby horse farm and spend time there helping the manager.</p> <p>Horse Barn Tenant (HBT) #1 was interviewed on 8/13/15 at 3:43 PM. HBT #1 stated, "Yea, I've seen [client A] up here. He will just show up and play with the kids who come here to ride their horses. [Client A] just makes me feel sort of uncomfortable. He looks like he's older but runs around playing with the 12 year olds. I see him watching the younger girls. They are like 12 or 13 and cute. I don't like the way he stares at them. As a mother, it just makes me feel uneasy. I don't really know him and there's nobody with him when he's here."</p> <p>Horse Barn Manager (HBM) #1 was</p>			

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	<p>interviewed on 8/13/15 at 3:55 PM. HBM #1 indicated client A walked to the horse barn on a daily basis. HBM #1 stated, "[Client A] likes to come over and watch the horses and play with the kids. When he first started coming over the staff would come with him but now he just comes over by himself."</p> <p>Client A's record was reviewed on 8/13/15 at 2:30 PM. Client A's progress notes from 7/18/15 through 8/13/15 indicated the following narrative entries:</p> <p>- "8/4/15, [Client A] was riding a bike most of the time. Staff told him that he shouldn't left (sic) the staff's sight but he did and the staff told [TL (Team Leader) #1] and she told staff she should keep an eye on him."</p> <p>- "8/5/15, [Client A] ran off but he just came back a little bit ago so it's cool now."</p> <p>- "8/6/15, [Client A] ate breakfast, lunch and played outside. Left the house without permission."</p> <p>Client A's BSP (Behavior Support Plan) dated 8/10/15 indicated, "[Client A] is an 18 year old male with reported history of Attention Deficit/Hyper activity Disorder and Mild Intellectual Disability. Prior to</p>			

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	<p>his admission to the Avalon group home (7/18/15) [client A] lived at [agency]. Per his history, [client A] has previously engaged in many other problem behaviors including impulsivity, poor concentration, disrespect of authority figures, lack of regards for non-compliance and bullying. [Client A] displays these behaviors when he's attempting to execute dominance over his peers or in response to not being able to do something he wants to do. [Client A] does not show any interest in developing friendships or positive relationships since he has been admitted to ResCare. [Client A's] most common behaviors are property destruction. [Client A] is also likely to engage his peers in maladaptive behaviors by encouraging them to act out. [Client A] has engaged in self-injury by scratching on himself with a sharp object, the scratches are typically superficial. [Client A] is also prone to bullying his peers who are smaller/weaker and being rude and disrespectful to staff. At [client A's] previous placement, there was a total of 14 makeshift weapons found throughout his bedroom." Client A's BSP dated 8/10/15 indicated client A's targeted behaviors included but were not limited to verbal aggression, physical aggression, property destruction, threats to harm others, non-compliance, leaving assigned area and self-injurious behavior.</p>			
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	<p>Client A's BSP dated 8/10/15 indicated, "Leaving Assigned Area: Once [client A] walks away from the designated area, a staff will follow [client A] and initially keep a bit of distance between him and themselves (no more than 10 feet). If possible, the second staff will use the van to follow; the second or third staff will immediately notify the [TL #1] and follow their instructions; let [client A] know that you are there to talk to him and help him problem solve what is upsetting him; let [client A] know that once he returns to the home you and he will talk about what is upsetting him and help him come up with a solution; once [client A] returns to the home and he is calm, talk with him and help him problem solve; if [client A] is calm verbally redirect him to return to his original activity; if [client A] is threatening/attempting to run into the road or from the van, attempt to block him from exiting the home; if he opens the van door while the van is in motion, immediately pull to the side of the road and stop the van, attempt to redirect him from leaving the van; prior to him getting to the road staff will implement [physical management]."</p> <p>Client A's IDT (Interdisciplinary Team Meeting) form dated 8/11/15 indicated, "[Client A] will not leave Avalon home without staff. [Client A] does not have</p>			

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	<p>alone time and requires staffing while in the community. This is to ensure his safety. [Client A] will not accept or take alcohol. [Client A] understands the legal drinking age in Indiana is 21. [Client A] understand he can be arrested and go to jail if drinking under the age of 21. [Client A] will not make toys that look like guns and carry on him. This is very dangerous and can be views as weapons to members of the community resulting in calls to 911 and police being sent out. [Client A] could possibly be shot by police thinking he has a gun in his pants."</p> <p>Client A's admission papers included but were not limited to a Residential Safety Plan dated 4/7/15. Client A's Residential Safety Plan dated 4/7/15 indicated, "On Saturday, March 28, 2015, the following items were found in the [client A's] room as a result of a search after an incident in which [client A] stabbed/stuck/poked a staff with some type of tack or push pin: 1 pen wrapped in paper towels and shoe string, 2 or 3 pens wrapped in tape and paper, 2 or 3 pencils wrapped in vinyl gloves, rubber bands and rubber bracelets, 4 pieces of black plastic broken to have sharp edges and wrapped in socks, paper and string, 2 pieces of clear plastic broken to have sharp edges and wrapped in string and paper, a piece of a radio antenna wrapped in vinyl gloves</p>			

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	and string, a staple remover that had string and yarn tied to the top and bottom in a large loop. On Friday, April 3, 2015, after a pen was found in [client A's] room on the floor the night before, another search was conducted. The following items were found in the vent in the ceiling in [client A's] room: 2 CD's broken in half to create sharp edges, 4 pieces of clear plastic CD case broken and fashioned into a shank or knife like pieces with sharp points, 1 belt buckle, 2 pieces of broken radio antenna. In the past, [client A] has been found to have a serving knife from the kitchen, a butcher knife from the dishwasher, a chisel and various screwdrivers either brought back from home visits or from maintenance/groundskeeper. It is believed that [client A] is picking things up as he attends school, works on campus doing trash removal and recycling, works with maintenance and the grounds crew and anytime he is off the unit and brining them back to his room. As a result, [client A] will be searched anytime he leaves the unit and returns by staff and/or managers. If he refuses, [response team] should be called immediately. If [client A] is found to be in possession of items a second time, he will lose the privilege of working for the rest of the week. In addition, staff responsible for supervision of [client A] need to be very aware of			

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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>what he is doing at all times."</p> <p>Client A's progress notes from 7/18/15 through 8/13/15 indicated client A was at the horse barn on 7/21/15, 7/22/15, 7/23/15, 7/29/15, 8/2/15, 8/3/15, 8/7/15 and 8/9/15. The review indicated documenting of staff supervision of client A at the horse barn on 7/22/15 and 8/3/15. Client A's progress notes from 7/18/15 through 8/13/15 and/or record did not indicate documentation of staff performing checks to ensure client A did not bring items that could be made into weapons into the home after being at the horse barn.</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 8/13/15 at 3:50 PM. The review indicated the following:</p> <p>-BDDS report dated 8/9/15 indicated, "[Client A] was caught drinking beer by staff. [Client A] stated that he got the beer from a neighbor."</p> <p>-BDDS report dated 8/11/15 indicated, "[Client A] left home without staff on 8/11/15. Staff on duty noticed [client A] had left the home during medication pass. One of the staff on duty found [client A] down the street. [Client A] told staff he was walking one of the neighborhood</p>			

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	<p>kids to the bus stop."</p> <p>TL #1 was interviewed on 8/13/15 at 2:30 PM. TL #1 indicated client A should be supervised by staff when he is outside in the yard. TL #1 indicated client A would leave his designated area and walk or ride his bike through the community and to the nearby horse barn.</p> <p>Staff #2 was interviewed on 8/13/15 at 2:40 PM. Staff #2 indicated client A should be supervised while outside. Staff #2 indicated if client A attempts to leave the yard staff should follow him to ensure his safety. Staff #2 stated, "Sometimes if there are other clients here in the home we can't leave the house to follow him. Sometimes he takes off and leaves by himself."</p> <p>BDDS generalist #1 was interviewed on 8/13/15 at 3:45 PM. BDDS generalist #1 indicated client A had eloped from a family member's house while on a visit prior to being admitted to the group home. BDDS generalist #1 indicated client A was located 20 miles away from the family member's residence.</p> <p>Clinical Supervisor (CS) #1 was interviewed on 8/13/15 at 5:15 PM. CS #1 indicated client A had been admitted to the group home on 7/18/15. CS #1</p>			

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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 9999 Bldg. 00	<p>indicated client A had not been at the group home for 30 days and had not yet been assessed to determine his community safety skills or if he was vulnerable in the community. CS #1 stated, "While he's in his first 30 days he should not be in the community alone." CS #1 indicated client A should be supervised and staff should be present with client A while he is outside. CS #1 indicated the facility had limited information about client A prior to his admission and was still assessing client A's behavioral, functional and social needs.</p> <p>RM (Residential Manager) #1 was interviewed on 8/14/15 at 1:15 PM. RM #1 stated, "We really didn't get a lot of information about him before he got here. We've been trying to get his plan together."</p> <p>This federal tag relates to complaints #IN00180086 and #IN00179268.</p> <p>9-3-4(a)</p> <p>State Findings</p>	W 9999	CORRECTION: The residential provider shall report the following	09/03/2015

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	<p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division: (8.) "Elopement of an individual that results in the evasion of required supervision as described in the ISP (Individual Support Plan) as necessary for the individuals health and welfare."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 3 of 5 incidents of elopement reviewed, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) regarding 3 separate incidents of client A's evasion of required supervision.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 8/13/15 at 2:30 PM. Client A's progress notes from 7/18/15 through 8/13/15</p>		<p>circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division: (8.) "Elopement of an individual that results in the evasion of required supervision as described in the ISP (Individual Support Plan) as necessary for the individuals health and welfare. Specifically, all facility staff been retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. All staff responsible for failing to report 3 incidents of Client A's evasion of staff supervision have received written corrective action.</p> <p>PREVENTION: Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn</p>	

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	<p>indicated the following narrative entries:</p> <p>- "8/4/15, [Client A] was riding a bike most of the time. Staff told him that he shouldn't left (sic) the staff's sight but he did and the staff told [TL (Team Leader) #1] and she told staff she should keep an eye on him."</p> <p>- "8/5/15, [Client A] ran off but he just came back a little bit ago so it's cool now."</p> <p>- "8/6/15, [Client A] ate breakfast, lunch and played outside. Left the house without permission."</p> <p>Client A's BSP (Behavior Support Plan) dated 8/10/15 indicated, "[Client A] is an 18 year old male with reported history of Attention Deficit/Hyper activity Disorder and Mild Intellectual Disability. Prior to his admission to the Avalon group home (7/18/15) [client A] lived at [agency]. Per his history, [client A] has previously engaged in many other problem behaviors including impulsivity, poor concentration, disrespect of authority figures, lack of regards for non-compliance and bullying. [Client A] displays these behaviors when he's attempting to execute dominance over his peers or in response to not being able to do something he wants to do. [Client A]</p>		<p>coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. The Executive Director or Program Manager will be on site for eight hours daily –observing active treatment and completing documentation reviews, Monday through Friday and complete additional observations at the facility on weekends until the Immediate Jeopardy status is resolved. When the Immediate Jeopardy is removed, members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions and documentation reviews no less than five times weekly for the next 14 days, no less than three times weekly for an additional 30 days and twice weekly for an additional 60 days. The Program Manager will maintain a schedule for administrative monitoring and follow-up as needed. At the conclusion of this period of intensive administrative monitoring and support, the</p>		

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	<p>does not show any interest in developing friendships or positive relationships since he has been admitted to ResCare. [Client A's] most common behaviors are property destruction. [Client A] is also likely to engage his peers in maladaptive behaviors by encouraging them to act out. [Client A] has engaged in self-injury by scratching on himself with a sharp object, the scratches are typically superficial. [Client A] is also prone to bullying his peers who are smaller/weaker and being rude and disrespectful to staff. At [client A's] previous placement, there was a total of 14 makeshift weapons found throughout his bedroom." Client A's BSP dated 8/10/15 indicated client A's targeted behaviors included but were not limited to verbal aggression, physical aggression, property destruction, threats to harm others, non-compliance, leaving assigned area and self-injurious behavior. Client A's BSP dated 8/10/15 indicated, "Leaving Assigned Area: Once [client A] walks away from the designated area, a staff will follow [client A] and initially keep a bit of distance between him and themselves (no more than 10 feet). If possible, the second staff will use the van to follow; the second or third staff will immediately notify the [TL #1] and follow their instructions; let [client A] know that you are there to talk to him and help him problem solve what is upsetting</p>		<p>Operations Team will determine the level of ongoing support needed at the facility. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>him; let [client A] know that once he returns to the home you and he will talk about what is upsetting him and help him come up with a solution; once [client A] returns to the home and he is calm, talk with him and help him problem solve; if [client A] is calm verbally redirect him to return to his original activity; if [client A] is threatening/attempting to run into the road or from the van, attempt to block him from exiting the home; if he opens the van door while the van is in motion, immediately pull to the side of the road and stop the van, attempt to redirect him from leaving the van; prior to him getting to the road staff will implement [physical management]."</p> <p>Client A's IDT (Interdisciplinary Team Meeting) form dated 8/11/15 indicated, "[Client A] will not leave Avalon home without staff. [Client A] does not have alone time and requires staffing while in the community. This is to ensure his safety."</p> <p>The facility's BDDS reports were reviewed on 8/13/15 at 3:50 PM. The review did not indicate documentation of the 8/4/15, 8/5/15 or 8/6/15 incidents of client A leaving staff's sight/supervision.</p> <p>TL #1 was interviewed on 8/13/15 at 2:30 PM. TL #1 indicated client A should</p>			

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	<p>be supervised by staff when he is outside in the yard.</p> <p>Staff #2 was interviewed on 8/13/15 at 2:40 PM. Staff #2 indicated client A should be supervised while outside. Staff #2 indicated if client A attempts to leave the yard staff should follow him to ensure his safety.</p> <p>Clinical Supervisor (CS) #1 was interviewed on 8/13/15 at 5:15 PM. CS #1 indicated client A had been admitted to the group home on 7/18/15. CS #1 stated, "While he's in his first 30 days he should not be in the community alone." CS #1 indicated client A should be supervised and staff should be present with client A while he is outside. CS #1 indicated incidents of client A leaving his assigned area and staff's supervision should be reported to BDDS. CS #1 indicated client A's 8/4/15 and 8/5/15 incidents of being out of staff's supervision had not been reported to BDDS.</p> <p>This federal tag relates to complaints #IN00180086 and #IN00179268.</p> <p>9-3-1(b)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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