

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  10/05/2015
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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 PCR (Post Certification Revisit) to the investigation of complaints #IN00180086 and #IN00179268 which resulted in an Immediate Jeopardy on 8/18/15.</p> <p>Complaint #IN00180086: Not Corrected.</p> <p>Complaint #IN00179268: Not Corrected.</p> <p>Dates of Survey: 9/30/15, 10/1/15, 10/2/15 and 10/5/15</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. Quality Review of this report completed by #15068 on 10/9/15.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 3 sampled clients (A and B), the governing body failed to exercise general</p>	W 0104	<b>CORRECTION:</b>	11/04/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>policy, budget and operating direction over the facility to ensure client A's behavior promoted positive relations within the community and failed to ensure the home was clean and secure.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/30/15 at 1:25 PM. The review indicated the following:</p> <p>-BDDS report dated 9/21/15 indicated on 9/19/15 at 12:15 AM "[Client A] got upset and left the house, his one on one staff followed him in the van. [Client A] then went to three different homes in the neighborhood and knocked on the doors while staff attempted to redirect. The third door he knocked on opened and someone (unknown) called 911. Police arrived and talked to [client A], then encouraged him to return home without incident."</p> <p>Client A's record was reviewed on 9/30/15 at 2:00 PM. Client A's Daily Narrative Progress Notes from 9/3/15 through 9/30/15 indicated the following narrative notes:</p> <p>-9/20/15 narrative note, "[Client A] came back home to cut weeds at neighbor's</p>		<p><i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the governing body has facilitated the following:</i></p> <p>Based on incident review and analysis and ongoing interdisciplinary dialogue, the governing body has determined that the operation lacks the resources to guarantee an appropriate level of support for Client A in the current residential setting. To that end, on 10/16/15, the Executive Director and Program Manager served notice to the Bureau of Developmental Disability Services that ResCare – Indianapolis would need to discontinue ICF residential services for Client A. Until such time as BDDS can obtain alternate placement, the interdisciplinary team has implemented the following modifications to Client A's supports.</p> <p>Client A's Behavior Support Plan has been revised to include specific protocols and an approval process for community outings and additional reactive strategies for when Client A leaves the assigned area. All staff have been</p>	

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	<p>house across the street. Weed eater had some problem but he was determined to get it started and he did. [Client A] cut front and back weeds of house. He said he had permission to be on property. The house is vacant and up for sale. [Client A] says he get (sic) paid to do so. [Client A] came home and weed wacked (sic) the back yard."</p> <p>-9/24/15 narrative note, "[Client A] has been walking around the street cutting the grass. Peoples (sic) complained and tell (sic) staff to drive him around the town."</p> <p>CS (Clinical Supervisor) #1 was interviewed on 9/30/15 at 3:30 PM. CS #1 indicated the group home did not have a weed eater. CS #1 indicated he was not aware of how client A obtained a weed eater. CS #1 indicated he was not aware of the group home's neighbors giving client A permission to be on their property or weed eat their yards. CS #1 indicated staff working with client A should provide client A with supervision and redirection while in the community. CS #1 indicated staff working with client A should verify client A's claims to having permission to be on private property and cutting neighbor's grass.</p> <p>2. Observations were conducted at the group home on 9/30/15 from 12:30 PM</p>		<p>trained on the modified plan and retrained toward proper implementation of supports, supervision and behavior supports when working with Client A in the community. An enhanced supervisory and administrative presence in the home will continue to assure proper implementation of the current supports with emphasis on Client A's safety as well as developing and maintaining a positive relationship with neighbors and other community members, as described below.</p> <p><b>PREVENTION:</b></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 to cleanliness and security of the home and 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>	

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	<p>to 1:40 PM. Client B's bedroom had a musty/pungent odor. Client B's mattress and box springs were not on a frame but were directly on the floor.</p> <p>CS #1 was interviewed on 9/30/15 at 1:15 PM. CS #1 indicated client B wets the bed at night and should be assisted in deodorizing his room. CS #1 indicated client B takes his bed apart and removes the metal frame.</p> <p>3. Observations were conducted at the group home on 9/30/15 from 12:30 PM to 1:40 PM. Upon arriving at the group home the front entry door was standing open. Surveyor rang the door bell and received no response. At 12:40 PM, the group home van returned to the residence with staff #1 and staff #2 and clients A and C.</p> <p>Staff #2 was interviewed on 9/30/15 at 12:45 PM. Staff #2 indicated there was no one in the home while they were on an outing. Staff #2 indicated client A had exited the home through the front door to board the van and indicated client A had left the door open. Staff #2 indicated the home should be secured while unoccupied.</p> <p>This deficiency was cited on 8/18/15. The facility failed to implement a systemic</p>		<p>assure all supports are implemented as written.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions no less than three times weekly for the next 14 days, no less than twice weekly for an additional 30 days and 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 appropriate implementation of supports, for all clients with emphasis on supports provided to client A While he is in the community. Additionally, administrative oversight will focus on the cleanliness and security of the home. Active Treatment sessions to be monitored are defined as:</p>		

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	<p>plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>		<p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p>	

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to implement its policy and procedures to prevent program intervention neglect of client A by failing to ensure staff working with client A provided competent supervision.</p> <p>Findings include:</p>	W 0149	<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 facility.</p> <p><b>RESPONSIBLE PARTIES:</b> Bureau of Developmental Disability Services Generalist, Bureau of Developmental Disabilities Central Office, QIDP, Residential Manager, Team Leader, Operations Team</p> <p><b>CORRECTION:</b></p> <p><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:</i></p>	11/04/2015

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	<p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/30/15 at 1:25 PM. The review indicated the following:</p> <p>-BDDS report dated 9/21/15 indicated on 9/19/15 at 12:15 AM "[Client A] got upset and left the house, his one on one staff followed him in the van. [Client A] then went to three different homes in the neighborhood and knocked on the doors while staff attempted to redirect. The third door he knocked on opened and someone (unknown) called 911. Police arrived and talked to [client A], then encouraged him to return home without incident."</p> <p>Client A's record was reviewed on 9/30/15 at 2:00 PM. Client A's Daily Narrative Progress Notes from 9/3/15 through 9/30/15 indicated the following narrative notes:</p> <p>-9/20/15 narrative note, "[Client A] came back home to cut weeds at neighbor's house across the street. Weed eater had some problem but he was determined to get it started and he did. [Client A] cut front and back weeds of house. He said he had permission to be on property. The house is vacant and up for sale. [Client A] says he get (sic) paid to do so. [Client</p>		<p>Client A's Behavior Support Plan has been revised to include specific protocols and an approval process for community outings and additional reactive strategies for when Client A leaves the assigned area. All staff have been trained on the modified plan and retrained toward proper implementation of supports, supervision and behavior supports when working with Client A in the community. An enhanced supervisory and administrative presence in the home will continue to assure proper implementation of the current supports with emphasis on Client A's safety as well as developing and maintaining a positive relationship with neighbors and other community members, as described below.</p> <p><b>PREVENTION:</b></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 to cleanliness and security of the home and assuring staff</p>	

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	<p>A] came home and weed wacked (sic) the back yard."</p> <p>-9/24/15 narrative note, "[Client A] has been walking around the street cutting the grass. Peoples (sic) complained and tell (sic) staff to drive him around the town."</p> <p>CS (Clinical Supervisor) #1 was interviewed on 9/30/15 at 3:30 PM. CS #1 indicated the group home did not have a weed eater. CS #1 indicated he was not aware of how client A obtained a weed eater. CS #1 indicated he was not aware of the group home's neighbors giving client A permission to be on their property or weed eat their yards. CS #1 indicated staff working with client A should provide client A with supervision and redirection while in the community. CS #1 indicated staff working with client A should verify client A's claims to having permission to be on private property and cutting neighbors grass. CS #1 indicated the facility's abuse and neglect policy should be implemented. CS #1 indicated staff working with client A should prevent client A from violating neighbors' boundaries and/or creating disturbances at 12:15 AM by knocking on neighbors' doors.</p> <p>The facility's policy's and procedures were reviewed on 10/2/15 at 12:12 PM.</p>		<p>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.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions no less than three times weekly for the next 14 days, no less than twice weekly for an additional 30 days and 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 appropriate implementation of supports, for all clients with emphasis on</p>	

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	<p>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 deficiency was cited on 8/18/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		<p>supports provided to client A While he is in the community. Additionally, administrative oversight will focus on the cleanliness and security of the home. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team</p>		

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W 0159  Bldg. 00	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	W 0159	Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.  The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate, 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 facility.  <b>RESPONSIBLE PARTIES:</b>  QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team  <b>CORRECTION:</b>	11/04/2015	

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	<p>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 staff working with client A was competent to provide supervision and intervention while in the community and by failing to ensure client A had an active treatment schedule/outline of his active treatment program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The QIDP failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure staff working with client A was competent to provide supervision and intervention while in the community. Please see W193.</li> <li>2. The QIDP failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure client A had an active treatment schedule/outline of his active treatment program. Please see W250.</li> </ol> <p>This deficiency was cited on 8/18/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>		<p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically,</i></p> <p>Client A's Behavior Support Plan has been revised to include specific protocols and an approval process for community outings and additional reactive strategies for when Client A leaves the assigned area. All staff have been trained on the modified plan and retrained toward proper implementation of supports, supervision and behavior supports when working with Client A in the community. An enhanced supervisory and administrative presence in the home will continue to assure proper implementation of the current supports with emphasis on Client A's safety as well as developing and maintaining a positive relationship with neighbors and other community members, as described below.</p> <p>The QIDP has worked with the interdisciplinary team to develop an Active Treatment Schedules for Client A that reflects current support needs, including but not</p>		

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			<p>limited to structured activities on weekdays, during the day. A review of facility support documents indicated this deficient practice did not affect any additional clients.</p> <p><b>PREVENTION:</b></p> <p>The QIDP will assure that the Residential Manager observes 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. Additionally, 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>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</p>	

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			<p>active Treatment sessions no less than three times weekly for the next 14 days, no less than twice weekly for an additional 30 days and 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 appropriate implementation of supports, for all clients with emphasis on supports provided to client A While he is in the community. 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>	

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  10/05/2015
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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>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and 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 facility.</p>	

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W 0193	483.430(e)(3) STAFF TRAINING PROGRAM		Professional staff will be trained regarding the need to provide Active Treatment Schedules for all clients that reflect current support needs including but not limited to appropriate training and leisure activities on days that the client(s) are not at work or participating in formal day programming. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director will review support documents during routine visits to the facility which will occur no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days and no less than monthly thereafter, as part of the agency's formal internal audit process to assure active treatment schedules are in place and reflect the training and support needs of all clients.  <b>RESPONSIBLE PARTIES:</b>  QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team		

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Bldg. 00	<p>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 record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure staff working with client A was competent to provide supervision and intervention while in the community.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 9/30/15 at 2:00 PM. Client A's Daily Narrative Progress Notes from 9/3/15 through 9/30/15 indicated the following narrative notes:</p> <p>-9/20/15 narrative note, "[Client A] came back home to cut weeds at neighbor's house across the street. Weed eater had some problem but he was determined to get it started and he did. [Client A] cut front and back weeds of house. He said he had permission to be on property. The house is vacant and up for sale. [Client A] says he get (sic) paid to do so. [Client A] came home and weed wacked (sic) the back yard."</p> <p>-9/24/15 narrative note, "[Client A] has been walking around the street cutting the grass. Peoples (sic) complained and tell (sic) staff to drive him around the town."</p>	W 0193	<p><b>CORRECTON:</b></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, Client A's Behavior Support Plan has been revised to include specific protocols and an approval process for community outings and additional reactive strategies for when Client A leaves the assigned area. All staff have been trained on the modified plan and retrained toward proper implementation of supports, supervision and behavior supports when working with Client A in the community. An enhanced supervisory and administrative presence in the home will continue to assure proper implementation of the current supports with emphasis on Client A's safety as well as developing and maintaining a positive relationship with neighbors and other community members, as described below.</i></p> <p><b>PREVENTION:</b></p>	11/04/2015	

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  10/05/2015
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>CS (Clinical Supervisor) #1 was interviewed on 9/30/15 at 3:30 PM. CS #1 indicated the group home did not have a weed eater. CS #1 indicated he was not aware of how client A obtained a weed eater. CS #1 indicated he was not aware of the group home's neighbors giving client A permission to be on their property or weed eat their yards. CS #1 indicated staff working with client A should provide client A with supervision and redirection while in the community. CS #1 indicated staff working with client A should verify client A's claims to having permission to be on private property and cutting neighbor's grass.</p> <p>This deficiency was cited on 8/18/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</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 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>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 no less than three times weekly for the next 14 days, no less than twice weekly for an additional 30 days and 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</p>		

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			<p>monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative monitoring will focus on appropriate implementation of supports, for all clients with emphasis on supports provided to client A While he is in the community. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p>	

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W 0250  Bldg. 00	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active		<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 facility.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>treatment program and that is readily available for review by relevant staff.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A had an active treatment schedule/outline of his active treatment program.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/30/15 from 12:30 PM through 1:40 PM. At 12:40 PM, client A returned to the group home from being in the community. Upon returning to the home, client A ate his lunch before sitting on the home's couch while listening to music on a set of headphones. Client A did not attend a day services or have a community based job.</p> <p>Client A's record was reviewed on 9/30/15 at 2:00 PM. Client A's Active Treatment Schedule form, undated, did not indicate documentation of scheduled activity for weekdays during the hours of 9:00 AM through 3:30 PM.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 9/30/15 at 3:30 PM. CS #1 indicated client A did not attend a day services or have a community job during the day. CS #1 indicated client A did volunteer work and went into the</p>	W 0250	<p><b>CORRECTION:</b></p> <p><i>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Specifically, the interdisciplinary team will develop Active Treatment Schedules for Client A that reflects current support needs, including but not limited to structured activities on weekdays, during the day. A review of facility support documents indicated this deficient practice did not affect any additional clients.</i></p> <p><b>PREVENTION:</b></p> <p>Professional staff will be trained regarding the need to provide Active Treatment Schedules for all clients that reflect current support needs including but not limited to appropriate training and leisure activities on days that the client(s) are not at work or participating in formal day programming. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director will review</p>	11/04/2015

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W 9999 Bldg. 00	community during the day. CS #1 indicated client A's active treatment schedule did not specify or outline client A's active treatment program.  9-3-4(a)  State Findings  The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.  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: (11.) An emergency intervention for the	W 9999	support documents during routine visits to the facility which will occur no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days and no less than monthly thereafter, as part of the agency's formal internal audit process to assure active treatment schedules are in place and reflect the training and support needs of all clients.  <b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team  <b>CORRECTION:</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.	11/04/2015	

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	<p>individual resulting from: (a.) a physical symptom; (b.) a medical or psychiatric condition; (c.) any other event.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 1 incident of emergency interventions reviewed, the facility failed to ensure an incident of police intervention regarding client A was immediately reported to BDDS (Bureau of Developmental Disabilities Services).</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/30/15 at 1:25 PM. The review indicated the following:</p> <p>-BDDS report dated 9/21/15 indicated on 9/19/15 at 12:15 AM "[Client A] got upset and left the house, his one on one staff followed him in the van. [Client A] then went to three different homes in the neighborhood and knocked on the doors while staff attempted to redirect. The third door he knocked on opened and someone (unknown) called 911. Police arrived and talked to [client A], then encouraged him to return home without incident."</p>		<p>Specifically, all facility staff have 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. The staff responsible for failing to report the incident involving Client A harassing neighbors which resulted in police intervention has received written corrective action.</p> <p><b>PREVENTION:</b></p> <p>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>CS (Clinical Supervisor) #1 was interviewed on 9/30/15 at 3:30 PM. CS #1 indicated staff working with client A on 9/19/15 documented the incident in the daily narrative progress notes but failed to report the incident to professional staff. CS #1 indicated the narrative note/incident was discovered during a weekly review of the progress notes by professional staff in the home. CS #1 indicated client A's 9/19/15 incident involving the police should have been reported to BDDS within 24 hours.</p> <p>This state rule was cited on 8/18/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(b)</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. 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 a no less than three times weekly for the next 14 days, no less than twice weekly for an additional 30 days and 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. 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</p>	

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			incidents are reported in a timely manner.  <b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team		