

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: March 31, April 1, 2 and 9, 2015.</p> <p>Facility number: 000842 Provider number: 15G324 AIM number: 100243860</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 136 Bldg. 00	<p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.</p> <p>Based upon record review and interview, the facility failed for 1 additional client (client #8), to ensure opportunities for religious services were provided.</p> <p>Findings included:</p>	W 136	<p>W136: The facility will ensure the rights of all clients. Therefore, the facility will ensure that all clients have the opportunity to participate in social, religious, and community group activities. Staff schedules have been changed so that the clients may attend social/religious/community group activities. The QIDP will</p>	05/09/2015

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Client #8 was interviewed on 4/1/15 at 10:50 AM. Client #8 indicated she would like to attend church, but was told by staff at the group home that in order to attend church there needed to be 4 clients who were interested in attending religious services. Client #8 indicated another nearby group home was contacted on at least one occasion for the interest of other clients to attend church, but the group home staff did not call back.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 4/1/15 at 4:30 PM. She indicated clients did not express an interest in church when asked to attend.</p> <p>Activity logs from January, February and March, 2015 for clients #1, #2, #3, #4, #5, #6, #7 and #8 were reviewed and failed to indicate clients had attended church during the period.</p> <p>The Clinical Supervisor indicated in an e-mail when asked for additional evidence of client #8's church attendance on 4/9/15 at 12:24 PM, client #8 had attended church in April, 2014.</p> <p>A review of the attached calendar of events, on 4/9/15 at 12:45 PM, indicated client #8 had attended church on 4/6/14.</p>		initially monitor client # 8's activities weekly for 2months, after which the QIDP will monitor activities monthly to ensure thatopportunities to participate in social/religious/community activities weregiven.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 210 Bldg. 00	<p>No other evidence of client #8 attending church or being provided opportunity to attend church was provided.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based upon observation, record review and interview, the facility failed to ensure for 2 of 4 sampled clients (clients #3 and #4) to ensure accurate assessments or reassessments were completed.</p> <p>Findings include:</p> <p>During observations at the group home on 3/31/15 from 7:08 PM until 8:22 PM and again on 4/1/15 from 6:33 AM until 8:10 AM, client #3 made loud vocalizations when asked to complete</p>	W 210	W210: Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Client # 3 will be scheduled for a speech/language reassessment to determine updated communication recommendations. Client # 4 will be scheduled for evaluations by speech/language therapy, occupational therapy and physical therapy to assess communication and sensorimotor skills. IDT will	05/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>tasks. During medication administration on 4/1/15 at 6:55 AM, client #3 was asked to state the time of his medication. His response was not understood by the surveyor. There was no evidence of a visual communication system in use for client #3 during the observations.</p> <p>1. Client #3's records were reviewed on 4/1/15 at 12:50 PM. A Functional Behavior Analysis dated 11/7/14 indicated "He has episodes of Agitated Outbursts, Repetitive Behavior and Grabbing. These generally occur when he is frustrated because others don't understand him or he doesn't like what another person is doing." Client #3's agitated outbursts were defined as "...will yell out very loudly and pound on things, it is a brief grunt many times repeated. He will do this when he is frustrated about communication issues." Client #3's plan indicated he received Mellaril (antipsychotic) 125 mg (milligrams) daily and Risperdal .25 mg (antipsychotic) to address behaviors of agitated outbursts, grabbing, repetitive behavior and non-compliance. An objective included in the ISP (Individual Support Plan) dated 11/7/14 indicated "Will improve his communication skills by repeating a situation appropriate two-word phrase." The objective indicated client #3 "has refused to use several other forms of</p>		<p>meet to discuss all recommendations and incorporate them in the consumer's plans. QIDP will monitor plans on a monthly basis.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>communication provided to him ([speech aid device] and pictures). There have been times in the past when he was willing to say more words." A speech evaluation dated 11/6/03 indicated client #3 was nonverbal except for "unintelligible vocal outbursts during the evaluation," and recommended "continuation of utilizing visual communication aides." There was no evidence of an updated speech evaluation/reassessment for client #3 to determine updated communication recommendations.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) and the group home nurse were interviewed on 4/1/15 at 4:30 PM. The QIDP and the nurse indicated there had not been an updated speech evaluation for client #3.</p> <p>2. Client #4's record was reviewed on 4/1/15 at 3:10 PM and indicated she had been admitted to the group home on 4/29/14. Client #4's record failed to indicate evaluations of her communication and sensorimotor skills.</p> <p>The QIDP was interviewed on 4/1/15 at 4:30 PM. The QIDP indicated client #4 had not had evaluations of communication and sensorimotor skills after admission because her doctor did</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 278 Bldg. 00	<p>not recommend the evaluations as previous assessments had been completed at a former placement. She indicated she would look for documentation of previous assessments and of the IDT (interdisciplinary team) review of the assessments to determine their appropriateness. No additional information was provided regarding the assessments for client #4.</p> <p>9-3-4(a)</p> <p>483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Based on record review and interview, for 1 of 4 sampled clients (client #4), the facility failed to ensure the use of less restrictive techniques had been previously used and proved unsuccessful prior to the implementation of physical interventions in client #4's behavior support plan (BSP).</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 3/31/15 at 4:35 PM and included the following:</p> <p>A BDDS report dated 1/19/15 indicated the Program Manager for SGL (supported group living) was notified by a staff member that on 1/18/15, client #4 had been pushed down by two staff members. The report indicated staff had been suspended and an investigation completed. A follow up report dated 1/28/15 indicated the investigation had been completed and indicated the initial report should have stated "[client #4] said she had been pushed down by two staff members." The allegation was unsubstantiated (that staff had pushed client #4 down) and "staff who were involved in the incident received disciplinary action and were retrained on company policy and procedures,</p>	W 278	<p>W278: Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. Any inclusion of physical redirection to client's plan will be based on data collected and documentation provided that demonstrates the necessity of the physical redirection. Previously tried least restrictive techniques will be noted. Client #4's plan will be reviewed and revised as necessary based on her behavior data. The QIDP will review plans and behavior data on a monthly basis. The clinical supervisor will review any plan that adds restrictive measures to assure that the intervention has documentation to support the more restrictive technique.</p>	05/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>involving documentation, individual rights and the use of physical interventions. All staff in the group home will be retrained on the preceding issues at their monthly staff meeting."</p> <p>An investigative summary into the incident dated 1/19/15-1/22/15 was reviewed on 3/31/15 at 4:45 PM. "Factual Findings" indicated "When [client #4] engaged in self-injurious behavior, staff implemented appropriate physical escort to her bedroom. [Staff #5 and staff #7] engaged in a power struggle with [client #4] over cake/chores/hygiene, and then violated [client #4's] rights by not letting her receive a piece of cake...."</p> <p>An Incident Report dated 2/22/15, written by staff #5, was reviewed on 3/31/15 at 4:50 PM and indicated client #4 was throwing picture frames along with salt and pepper shakers. "Client was asked to stop multiple times. She continued, so she was escorted to her room."</p> <p>Client #4's record was reviewed on 4/1/15 at 3:10 PM. A Behavior Support Plan (BSP) dated 5/28/14 included targeted behaviors of physical aggression, non-compliance, inappropriate communications, fabrications and AWOL (leaving without notice). A note dated 1/25/15 indicated a modification of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>physical redirection was added as an intervention to address physical aggression. An IDT (interdisciplinary team) meeting dated 1/25/15 indicated "Addition of physical redirect to BSP for physical aggression." A note at the bottom of the signatures indicated "Due to intensity of physical aggression in past." There was no evidence of a description of client #4's physical aggression in the record. There was no evidence in the record of attempts of less restrictive interventions prior to the addition of physical redirection to her plan.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 4/1/15 at 4:30 PM and indicated physical redirection was added to client #4's plan as a result of physical aggression incidents in the past and including the incident on 1/18/15.</p> <p>Behavior rates for client #4's physical aggression were reviewed on 4/9/15 at 12:30 PM and indicated the following incidents of physical aggression: June, 2014 (12), July, 2014 (2), August, 2014 (5), September, 2014 (0), October, 2014 (6), November, 2014 (2), December, 2014 (4), January, 2015 (4). There was no description of the intensity of client #4's behavior or of less restrictive</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 286 Bldg. 00	<p>interventions attempted in the data provided.</p> <p>The Clinical Supervisor was interviewed on 4/9/15 at 3:38 PM and indicated she would look for additional documentation or IDT meetings for evidence of less restrictive interventions attempted prior to the implementation of physical redirection in client #4's plan. No additional documentation was provided.</p> <p>9-3-5(a)</p> <p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for disciplinary purposes. Based upon record review and interview, for 1 of 4 sampled clients (client #4), the facility failed to ensure techniques to address property destruction were not used as retribution.</p> <p>Findings include:</p>	W 286	W286: Techniques to manage inappropriate client behavior must never be used for disciplinary purposes. All staff will be retrained on Client #4's behavior plan. Staff will be trained that at no time will techniques to manage inappropriate behavior be used as retribution for the behavior. The	05/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 3/31/15 at 4:35 PM and included the following:</p> <p>A BDDS report dated 1/19/15 indicated the Program Manager of SGL (supported group living) was notified by a staff member that on 1/18/15, client #4 had been pushed down by two staff members. The report indicated staff had been suspended and an investigation completed. A follow up report dated 1/28/15 indicated the investigation had been completed and indicated the initial report should have stated "[client #4] said she had been pushed down by two staff members." The allegation was unsubstantiated (that staff had pushed client #4 down) and "staff who were involved in the incident received disciplinary action and were retrained on company policy and procedures, involving documentation, individual rights and the use of physical interventions. All staff in the group home will be retrained on the preceding issues at their monthly staff meeting."</p> <p>An investigative summary into the incident dated 1/19/15-1/22/15 was reviewed on 3/31/15 at 4:45 PM. Staff #5 indicated client #4 "had refused to take a</p>		<p>QIDP will review any behavior incident where physical redirection is implemented and submit thereview to the Clinical Supervisor. Additionally the QIDP will conduct weeklyhabilitation observations and the RM will conduct twice weekly observations toinclude observing client behavior and staff response to that behavior, assuringthat there is no retribution for any behavior displayed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>shower, was noncompliant for most routine requests throughout the day and was being verbally aggressive to her peers and staff." Staff #5 reported "after dinner, [client #4] was yelling and screaming, and [client #4] threw half the cake on the floor, which upset her peers because the cake was going to be packed in their lunches for the next day. When this happened, [client #4] was physically escorted to her bedroom using a two-person escort technique." Staff #5 reported "the two person escort was used because [client #4] was yelling/screaming, pounding her fist on the counter, getting her peers upset which in turn caused them to begin to display behaviors...." Staff #5 denied pushing client #4. Staff #7 indicated "the only time that [client #4] had gotten up that day was to eat breakfast and lunch. [Client #4] refused to take her medications. [Staff #7] reported [client #4] refused to shower and was displaying inappropriate behaviors in front of her peers. Those behaviors consisted of scratching herself, including her private parts, while at the dining room table. [Staff #7] reported that she told [client #4] that the consequences of not taking her shower or cleaning herself up was that she would get no cake....."</p> <p>The Program Manager for SGL was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G324	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/09/2015
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 4516 W WALDEN DR MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	interviewed on 3/31/15 at 4:55 PM and indicated staff had been disciplined and retrained for the incident involving withholding cake from client #4 as a consequence for her noncompliance. 9-3-5(a)				