

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for the PCR (Post Certification Revisit) to the extended annual recertification and state licensure survey completed on 9/24/14.</p> <p>This visit was done in conjunction with the investigation of complaint #IN00158247.</p> <p>Dates of Survey: 11/12/14 and 11/13/14</p> <p>Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/20/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p>			

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: 15G494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/13/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
(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 3 of 3 sampled clients (#1, #2 and #3), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2 and #3's active treatment programs by failing to ensure clients #1 and #2 participated in the development of their ISPs (Individual Support Plans) and ensure clients #1, #2 and #3's training objectives were documented/tracked to measure accomplishment of specified ISP objectives.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QIDP failed to ensure clients #1 and #2 participated in the development of their ISPs. Please see W209. 2. The QIDP failed to ensure clients #1, #2 and #3's training objectives were documented/tracked to measure accomplishment of specified ISP objectives. Please see W252. <p>This deficiency was cited on 9/24/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-3(a)</p>	W000159	<p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</i></p> <p>Specifically, the QIDP has assisted the interdisciplinary team in reviewing current individual support plans with Clients #1 and #2 and they have signed indicating their agreement.</p> <p>Additionally, the QIDP has placed current prioritized objective data collection grids in place in all clients' Individual Support Plan binders. All staff will be trained toward proper implementation of the current objectives.</p> <p>PERVENTION:</p> <p>The QIDP will assure that clients who have emancipated status participate fully in the development of their support plans. The Program Manager and Clinical supervisor will in turn follow-up to assure that documentation of client participation and agreement with the ISP development process.</p>	12/13/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/13/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(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	
W000209	<p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Based on record review and interview for 2 of 3 sampled clients (#1 and #2), the facility failed to ensure clients #1 and #2 participated in the development of their ISPs (Individual Support Plans).</p>	W000209	<p>Administrative level document reviews will occur no less than monthly.</p> <p>The QIDP will assume responsibility for assuring that current prioritized objective data collection grids are in place for all clients at all times. Along with the QIDP, members of the Operations Team will conduct active treatment observations and reviews of support documents, to assure data is collected as required at the facility on a twice monthly basis. Administrative level document reviews to assure that current prioritized objective data collection grids are in place will occur no less than monthly.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>Participation by the client, his or her parent (if the client is a minor), or the client's legal</i></p>	12/13/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/13/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
(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>Findings include:</p> <p>1. Client #1's record was reviewed on 11/12/14 at 9:30 AM. Client #1's ISP dated 7/22/14 indicated client #1 was an emancipated adult. Client #1's ISP did not indicate documentation of client #1's signature/participation in completing client #1's ISP. Client #1's PCP (Person Centered Planning) form dated 7/22/14 did not indicate documentation of client #1's signature/participation in the planning of client #1's ISP.</p> <p>2. Client #2's record was reviewed on 11/13/14 at 10:32 AM. Client #2's ISP dated 7/11/14 indicated client #2 was an emancipated adult. Client #2's ISP did not indicate documentation of client #2's signature/participation in completing client #2's ISP. Client #2's PCP form dated 7/11/14 did not indicate documentation of client #2's signature/participation in the planning of client #2's ISP.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 11/13/14 at 11:45 AM. QIDP #1 indicated clients #1 and #2's ISP quarterly review meetings had been scheduled. QIDP #1 indicated clients #1 and #2 would participate in the ISP</p>		<p><i>guardian is required unless the participation is unobtainable or inappropriate.</i> Specifically, the interdisciplinary team has reviewed current individual support plans with Clients #1 and #2 and they have signed indicating their agreement. A review of facility documentation indicated that this deficient practice did not affect any additional clients.</p> <p>PERVENTION:</p> <p>The QIDP will assure that clients who have emancipated status participate fully in the development of their support plans. The Program Manager and Clinical supervisor will in turn follow-up to assure that documentation of client participation and agreement with the ISP development process. Administrative level document reviews will occur no less than monthly.</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: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000252	<p>process at their upcoming reviews. QIDP #1 indicated there was not currently documentation of clients #1 or #2's participation in their ISP's.</p> <p>This deficiency was cited on 9/24/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure clients #1, #2 and #3's training objectives were documented/tracked to measure accomplishment of specified ISP (Individual Support Plan) objectives.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 11/12/14 at 9:30 AM. Client #1's ISP dated 7/22/14 included but was not limited to the following formal training objectives:</p>	W000252	<p>CORRECTION:</p> <p><i>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Specifically, the QIDP has placed current prioritized objective data collection grids in place in all clients' Individual Support Plan binders. All staff will be trained toward proper implementation of the current objectives. A review of facility documentation indicated that this deficient practice did not affect any additional clients.</i></p>	12/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(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>-"Given skills training, two VP (Verbal Prompts), [client #1] will independently state the use of his Depakote (seizures), 60% of the time for TCMs (Three Consecutive Months)."</p> <p>-"Given skills training and one VP, [client #1] will give examples of proper choices, 70% of the time for TCMs."</p> <p>Client #1's record did not indicate documentation of data collection regarding his identification of Depakote or proper choices training objectives.</p> <p>2. Client #2's record was reviewed on 11/13/14 at 10:32 AM. Client #2's ISP dated 8/11/14 included but was not limited to the following formal training objectives:</p> <p>-"Given skills training and three VPs, [client #2] will participate in a leisure activity of his choice, 60% of the time for TCMs."</p> <p>-"Given skills training and three VPs, [client #2] will state the side effects of his Risperdal (bipolar) independently, 50% of the time for TCMs."</p> <p>-"Given skills training and three VPs, [client #2] will count change from a \$10.00 bill, 50% of the time for TCMs."</p>		<p>PREVENTION:</p> <p>The QIDP will assume responsibility for assuring that current prioritized objective data collection grids are in place for all clients at all times. Along with the QIDP, members of the Operations Team will conduct active treatment observations and reviews of support documents, to assure data is collected as required at the facility on a twice monthly basis. Administrative level document reviews to assure that current prioritized objective data collection grids are in place will occur no less than monthly.</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: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(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>-"Given skills training and three VPs, [client #2] will complete his daily hygiene on a daily basis, 70% of the time for TCMs"</p> <p>Client #2's record did not indicate documentation of data collection regarding client #2's leisure activity, medication, money management or daily hygiene formal training objectives.</p> <p>3. Client #3's record was reviewed on 11/13/14 at 11:06 AM. Client #3's ISP dated 9/11/14 included but was not limited to the following formal training objectives:</p> <p>-"Given skills training and three VPs, [client #3] will count change from \$10.00 bill, 50% of the time for TCMs."</p> <p>Client #3's record did not indicate documentation of data collection regarding client #3's money management formal training objective.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 11/13/14 at 11:45 AM. QIDP #1 indicated clients #1, #2 and #3's ISP objectives data should be documented/tracked to measure accomplishment of specified ISP</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/13/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(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>objectives.</p> <p>This deficiency was cited on 9/24/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-4(a)</p>				