

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 05/30/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000000	<p>This visit was for an investigation of complaint #IN00128993.</p> <p>Complaint #IN00128993. Unsubstantiated, due to lack of sufficient evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: May 21, 22 and 30, 2013</p> <p>Facility Number: 000911 Provider Number: 15G397 AIM Number: 100244420</p> <p>Surveyor: Vickie Kolb, RN</p> <p>The deficiencies in this report reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/6/13 by Ruth Shackelford, QIDP.</p>	W000000					

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: 15G397	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250		
(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	
W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 3 of 4 sampled clients (A, B and D) and for 3 additional clients (E, H and G), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to ensure the facility had a reproducible system and/or conducted thorough investigations in regard to client to client abuse and reported all incidents of client to client abuse to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult Protective Services).</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of client to client abuse were thoroughly investigated with a reproducible system of investigation and were reported to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult Protective Services) for clients A, B, D, E, H and G. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction</p>	W000104	<p>CORRECTION:</p> <p><i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically,</i></p> <p>1. The governing body has directed the facility to complete BDDS Incident reports for incidents of physical aggression that occurred between Client A and Client B on 4/29/13 and 5/2/13.</p> <p>2. The governing body has directed facility to investigate incidents of physical aggression between Client A and Client B on 2/4/13 and 5/17/13, between Client A and Client G on 2/23/13 and 5/2/13, between Client B and Client G on 3/9/13 and between Client E and Client H on 4/5/13.</p> <p>PREVENTION:</p> <p>1. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs.</p> <p>2. Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's</p>	06/23/2013	

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 05/30/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250		
(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>over the facility to ensure all incidents of client to client abuse were reported to BDDS (Bureau of Developmental Disabilities Services) and to Adult Protective Services (APS) for clients A and B. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure all incidents of client to client abuse were thoroughly investigated for clients A, B, D, E, H and G. Please see W154.</p> <p>9-3-1(a)</p>		<p>incident-investigation tracking spreadsheet no less than to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</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 05/30/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250		
(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	
W000149	<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 interview and record review for 9 of 12 incidents of client to client abuse reviewed for clients A, B, D, E, H and G, the facility neglected to implement its policy and procedures to ensure all incidents of client to client abuse were thoroughly investigated with a reproducible system of investigation and were reported to BDDS (Bureau of Developmental Disabilities Services) and to APS (Adult Protective Services).</p> <p>Findings include:</p> <p>The facility records were reviewed on 5/21/13 at 2 PM.</p> <p>The BDDS (Bureau of Developmental Disabilities Services) reports indicated: __On 2/4/13 at 6 PM client A became upset with one of his housemates about the use of the telephone. Client A called 911 and reported the housemate had grabbed him at the wrist areas. "Police arrived and determined that house mate had not grabbed [client A] as he had described." The facility records did not indicate the facility had conducted an investigation in regard to client A's allegations.</p>	W000149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically,</i></p> <ol style="list-style-type: none"> The facility will complete BDDS Incident reports for incidents of physical aggression that occurred between Client A and Client B on 4/29/13 and 5/2/13. The facility will investigate incidents of physical aggression between Client A and Client B on 2/4/13 and 5/17/13, between Client A and Client G on 2/23/13 and 5/2/13, between Client B and Client G on 3/9/13 and between Client E and Client H on 4/5/13. <p>PREVENTION:</p> <ol style="list-style-type: none"> Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs. Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking 	06/23/2013	

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 05/30/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250			
(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>__ On 2/23/13 at 6:30 PM client A "began to yell and curse and get into [client G's] Faced (sic) who then punched [client A] in his face above his right eye.... [Client A] had a small 2 cm (centimeter) cut above his right eye and he was (sic) treated...."</p> <p>__ On 3/9/13 at 10:30 PM Client B was "agitated from a previous incident and believed that [client G] was laughing at him and teasing him so he charged at [client G] who returned (sic) hit [client B] in the back.... [Client A] called 911 because [client B] was trying to attack [client G]...."</p> <p>__ On 3/16/13 at 7:22 PM client A "was upset because he didn't want chicken and did not want to wait on staff to prepare alternative. He went into [client D's] room and began yelling. When [client D] came out [client A] was agitating [client D] and thre (sic) paper towel at [client A]. [Client A] began to close fit hit [client D] in the head (sic)...."</p> <p>__ On 4/5/13 at 3:15 PM client H was being loaded onto the transport van when he began "harassing" client E, pushing him and hitting him in the face. The staff tried to intervene, "but at this point it was too late" and they began to fight in the parking lot.</p> <p>__ On 5/2/13 at 6 PM client B reported to the staff client G had spit at him after an argument. "Staff intervned and stopped.</p>		<p>spreadsheet no less than to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</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 05/30/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250			
(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>Staff looked in the area where [client B] told them this happened but was unable to see anything." ___ On 5/17/13 at 4:30 PM client B was on the van being transported to his site when clients G and A began to harass client B, calling him names and telling him that he was "gay." Client G threw "a foreign object" at client B, striking him in the back of the neck.</p> <p>The facility records indicated no investigative records in regard to the incidents of client to client abuse reported on 2/4/13, 2/23/13, 3/9/13, 3/16/13, 4/5/13, 4/29/13, 5/2/13 and 5/17/13 for clients A, B, D, E, H and G.</p> <p>The facility Incident/Accident Reports indicated: ___ On 4/29/13 at 8:30 PM client B was sitting at the table eating a snack when he started getting "harassed" by client A. Client B continued to eat his snack and ignore client A. Client A kept giving verbal taunts and escalation the situation. Client B's glasses were slapped off of his face by client A and client A threw a notebook at client B. ___ On 5/2/13 at 9:10 PM "The phone in the basement began to ring and another client [client A] answered the phone first and [client B] ran up and attempted to snatch the receiver out of the other</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 05/30/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250			
(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>consumer's hand. In the process of attempting to snatch the phone he [client B] pushed the other consumer [client A]."</p> <p>The facility records did not indicate the incidents of client to client abuse on 4/29/13 and 5/2/13 had been reported to BDDS and/or APS.</p> <p>Interview with Adm (Administrative staff) #1 on 5/22/13 at 4 PM indicated all incidents of client to client abuse were to be reported to BDDS and to APS and were to be thoroughly investigated. Adm staff #1 indicated he was not able to locate any investigative records in regard to the client to client abuse reported on 2/4/13, 2/23/13, 3/9/13, 3/16/13, 4/5/13, 4/29/13, 5/2/13 and 5/17/13 for clients A, B, D, E, H and G. Adm staff #1 indicated the incidents of client to client abuse on 4/29/13 and 5/2/13 had not been reported to BDDS and/or APS.</p> <p>The facility's policies and procedures were reviewed on 5/21/13 at 1 PM. The revised 2/26/11 facility policy entitled "Abuse, Neglect, and Exploitation" indicated "Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, or mistreatment shall be reported to the appropriate authorities</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 05/30/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250		
(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>through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, and local, state and federal guidelines." The policy indicated: ___ "Physical abuse: the act or failure to act that results or could result in physical injury to an individual. Non-accidental injury inflicted by another person or persons." ___ "Intimidation/emotional abuse: the act of failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation. Discouraging or inhibiting behavior by threatening both actual or implied. Attitude or acts that interfere with the psychological and social well being of an individual."</p> <p>9-3-2(a)</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 05/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250
---	--

(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
--------------------	--	---------------	---	----------------------

W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 2 of 12 incidents of client to client abuse reviewed, the facility failed to report all incidents of client to client abuse to BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for clients A and B.</p> <p>Findings include:</p> <p>The facility records were reviewed on 5/21/13 at 2 PM. The facility Incident/Accident Reports indicated: __ On 4/29/13 at 8:30 PM client B was sitting at the table eating a snack when he started getting "harassed" by client A. Client B continued to eat his snack and ignore client A. Client A kept giving verbal taunts and escalation the situation. Client B's glasses were slapped off of his face by client A and client A threw a notebook at client B. __ On 5/2/13 at 9:10 PM "The phone in the basement began to ring and another client [client A] answered the phone first and [client B] ran up and attempted to</p>	W000153	<p>CORRECTION: <i>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, the facility will complete BDDS Incident reports for incidents of physical aggression that occurred between Client A and Client B on 4/29/13 and 5/2/13.</i></p> <p>PREVENTION: Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Quality Assurance Manager who will in turn coordinate and follow-up with the facility Clinical Supervisor to assure appropriate follow-up occurs.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	06/23/2013
---------	---	---------	--	------------

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 05/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250
---	--

(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>snatch the receiver out of the other consumer's hand. In the process of attempting to snatch the phone he [client B] pushed the other consumer [client A]."</p> <p>Interview with Adm (Administrative staff) #1 on 5/22/13 at 4 PM indicated all incidents of client to client abuse were to be reported to BDDS and to APS. Adm staff #1 indicated the incidents of client to client abuse on 4/29/13 and 5/2/13 had not been reported to BDDS and/or APS.</p> <p>9-3-2(a)</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 05/30/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250			
(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			
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 9 of 12 incidents of client to client abuse reviewed, the facility failed to provide evidence an investigation had been conducted for clients A, B, D, E, H and G.</p> <p>Findings include:</p> <p>The facility records were reviewed on 5/21/13 at 2 PM.</p> <p>The BDDS (Bureau of Developmental Disabilities Services) reports indicated: __ On 2/4/13 at 6 PM client A became upset with one of his housemates about the use of the telephone. Client A called 911 and reported the housemate had grabbed him at the wrist areas. "Police arrived and determined that house mate had not grabbed [client A] as he had described." The facility records did not indicate the facility had conducted an investigation in regard to client A's allegations. __ On 2/23/13 at 6:30 PM client A "began to yell and curse and get into [client G's] Faced (sic) who then punched [client A] in his face above his right eye.... [Client A] had a small 2 cm (centimeter) cut</p>	W000154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, the facility will investigate incidents of physical aggression between Client A and Client B on 2/4/13 and 5/17/13, between Client A and Client G on 2/23/13 and 5/2/13, between Client B and Client G on 3/9/13 and between Client E and Client H on 4/5/13.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as</p>	06/23/2013			

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 05/30/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250		
(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>above his right eye and he was (sic) treated...."</p> <p>__ On 3/9/13 at 10:30 PM Client B was "agitated from a previous incident and believed that [client G] was laughing at him and teasing him so he charged at [client G] who returned (sic) hit [client B] in the back.... [Client A] called 911 because [client B] was trying to attack [client G]...."</p> <p>__ On 3/16/13 at 7:22 PM client A "was upset because he didn't want chicken and did not want to wait on staff to prepare alternative. He went into [client D's] room and began yelling. When [client D] came out [client A] was agitating [client D] and thre (sic) paper towel at [client A]. [Client A] began to close fit hit [client D] in the head (sic)...."</p> <p>__ On 4/5/13 at 3:15 PM client H was being loaded onto the transport van when he began "harassing" client E, pushing him and hitting him in the face. The staff tried to intervene, "but at this point it was too late" and they began to fight in the parking lot.</p> <p>__ On 5/2/13 at 6 PM client B reported to the staff client G had spit at him after an argument. "Staff intervned and stopped. Staff looked in the area where [client B] told them this happened but was unable to see anything."</p> <p>__ On 5/17/13 at 4:30 PM client B was on the van being transported to his site when</p>		<p>needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</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 05/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250
---	--

(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>clients G and A began to harass client B, calling him names and telling him that he was "gay." Client G threw "a foreign object" at client B, striking him in the back of the neck.</p> <p>The facility Incident/Accident Reports indicated: __ On 4/29/13 at 8:30 PM client B was sitting at the table eating a snack when he started getting "harassed" by client A. Client B continued to eat his snack and ignore client A. Client A kept giving verbal taunts and escalation the situation. Client B's glasses were slapped off of his face by client A and client A threw a notebook at client B. __ On 5/2/13 at 9:10 PM "The phone in the basement began to ring and another client [client A] answered the phone first and [client B] ran up and attempted to snatch the receiver out of the other consumer's hand. In the process of attempting to snatch the phone he [client B] pushed the other consumer [client A]."</p> <p>The facility records indicated no investigative records in regard to the incidents of client to client abuse reported on 2/4/13, 2/23/13, 3/9/13, 3/16/13, 4/5/13, 4/29/13, 5/2/13 and 5/17/13 for clients A, B, D, E, H and G.</p> <p>Interview with Adm (Administrative</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 05/30/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 AVALON FOREST DR INDIANAPOLIS, IN 46250
---	--

(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>staff) #1 on 5/22/13 at 4 PM indicated all allegations of client to client abuse were to be thoroughly investigated. Adm staff #1 indicated he was not able to locate any investigative records in regard to the client to client abuse reported on 2/4/13, 2/23/13, 3/9/13, 3/16/13, 4/5/13, 4/29/13, 5/2/13 and 5/17/13 for clients A, B, D, E, H and G.</p> <p>9-3-2(a)</p>			