

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00172392.</p> <p>Complaint #IN00172392: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W104, W154, W318, W331, W342 and W436.</p> <p>Survey dates: 5/13, 5/14, 5/18, 5/19, 5/20, 5/21 and 5/28/15.</p> <p>Facility Number: 001079 Provider Number: 15G565 AIM Number: 100245500</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<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 observation, interview and</p>	W 0104		06/27/2015

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: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility health care services met the health needs of clients it served in regard to monitoring and assessing a client's chronic/progressive health condition. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure its health care services developed appropriate risk plans for clients, obtained ordered medical treatments/evaluations, ensured facility staff were trained in regard to a client's illness/diseases, and to ensure a needed adaptive equipment was obtained for a health measure/need.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D) and for 1 additional client (H), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility had a Qualified Intellectual Disabilities Professional to monitor clients' programs in regard to data, assessments, addressing clients' identified needs, to ensure needed supports were added to clients' program plans, clients' program plans were implemented as</p>		<p>CORRECTION:</p> <p><i>The Governing body must exercise general policy, budget and operating direction over the facility. Specifically:</i></p> <p>The facility nurse will be retrained regarding the need to develop risk plans for all relevant medical conditions. Specifically for Client H, the nurse will develop a high risk plan that addresses weight loss including the use of adaptive equipment to compensate for tremors and provide staff with instructions for assisting Client H with eating and obtaining accurate weight. A review of current diagnostic information and risk plans indicated this deficient practice did not affect additional clients.</p> <p>The facility nurse will facilitate training of all staff regarding proper implementation of all Comprehensive High Risk Plans.</p> <p>The nurse will facilitate retraining of all staff regarding the operation's medication administration procedures which are consistent with Core A and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>written, and to ensure the facility's specially constituted committee reviewed and/or approved clients' restrictive plans.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility's governing body failed to exercise general policy and operating direction over the facility to ensure its health care services provided an appropriate wheelchair with leg rests, developed a high risk plan for Tubular Sclerosis (tumors which grow in brain and/or on other vital organs) for client A, assessed/monitored client A for complications of the disease and to monitor client A in regard to a secondary diagnosis of Anemia. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services ensured ordered tests and/or procedures were obtained, ensured facility staff obtained weekly weights as ordered, and failed to ensure a risk plan was developed for a client in regard to her weight/how the client should be weighed for consistency for client H. Please see W331. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure its health care services trained Group Home 		<p>Core B (Living in the Community), including but not limited to keeping the medication room locked and/or the medications secured in a locked cabinet when the medications are not being prepared or administered.</p> <p>The QIDP will direct the facility to pursue obtaining dentures for Client D.</p> <p>The QIDP has been retrained regarding the need to modify prioritized learning objectives whenever a client has completed the objective(s) successfully, whenever a client is regressing or losing skills already gained and whenever a client is failing to make progress. QIDP has also been retrained regarding the need to present summarized data to the interdisciplinary team in order to consider whether training toward new objectives is indicated. All prioritized learning objectives will be modified based on current progress and new objectives will be developed as needed through interdisciplinary team consensus.</p> <p>The QIDP has coordinated the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 to properly assess client A for complications of a disease including a secondary diagnosis of anemia. Please see W342.</p> <p>3. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure its health care services ensured facility staff kept the door to the medication room locked as well as keeping the lock box containing Narcotics secured when staff was not administering medications for clients B, C, D, E, F, G and H. Please see W382.</p> <p>4. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the group home had a Qualified Intellectual Disabilities Professional (QIDP) to monitor the clients' Individual Support Plan (ISP) objectives as there were no monthly summaries, revisions and/or monitoring of the clients' data for the entire year. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the group home had a QIDP to coordinate the clients' programs in regard to obtaining assessment of clients' needs, addressing a client's identified need, and to ensure needed supports were a part of the clients' program plans. The facility's</p>		<p>team's efforts to request diagnostic clarification from Client B's psychiatrist with regard to the use of Haldol and Clozaril. A review of Physician's Orders and support documents indicated that this deficient practice did not affect any additional clients</p> <p>The QIDP has guided the team in assisting Client H with obtaining updated assessments and providing Client H with additional adaptive equipment to assist her with coping with tremors.</p> <p>The QIDP has guided the interdisciplinary team in developing an objective for Client H to address refusals of health treatments and medical appointments that goes beyond the scope of her current desensitization plan and an objective to train Client G to arrange for her own privacy. Through observation the team determined that this deficient practice affected one additional individual and therefore the team will develop a privacy objective for Client F.</p> <p>The QIDP has coordinated with</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>governing body failed to exercise general policy and operating direction over the facility to ensure the group home had a QIDP to monitor the clients' programs for implementation of objectives to ensure active treatment/training, and to ensure the facility's Human Rights Committee reviewed and approved clients' restrictive programs. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the group home had a QIDP to ensure a client's interdisciplinary team met to review a dental recommendation. Please see W159.</p> <p>This federal tag relates to complaint #IN00172392.</p> <p>9-3-1(a)</p>		<p>the facility nurse to instruct staff to weigh Client H, at required intervals, using a seated scale. Additionally the interdisciplinary team has incorporated daily cleaning of Client C's mattress into her Individual Support Plan to facilitate the control of odors. Through observation the team has determined that this deficient practice also affected client F and G and daily mattress cleaning has been incorporated into their Individual Support Plans as well.</p> <p>The QIDP has coordinated retraining of all direct support staff regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Additionally, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning medication administration, morning hygiene and breakfast.</p> <p>PERVENTION:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis.</p> <p>The nurse, QIDP and Residential Manager will each conduct record reviews and face to face assessments to assure that staff display an appropriate level of competency with the implementation of Comprehensive High Risk Plans.</p> <p>The QIDP will turn in copies of monthly summaries to the Clinical Supervisor for review and follow-up to assure learning</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 are modified as required. Additionally, members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will documentation reviews as needed but no less than monthly to assure that the QIDP has modified learning objectives as required.</p> <p>The QIDP has been retrained regarding the need to assure that behavior controlling medications including but not limited to antipsychotic medications, are only administered as directed by a psychiatrist with an appropriate Axis I diagnosis. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will review Behavior Support Plans and Physician's Orders no less than monthly to assure that psychotropic medications are ordered with appropriate corresponding diagnoses.</p> <p>Professional staff have been retrained regarding the need to obtain prompt reassessments when the team observes changes in clients' physical, mental and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>developmental status. Members of the Operations Team comprised of Clinical Supervisors, the Program Manager, Nurse Manager and the Executive Director will review incident documentation, medical records and assessment documentation as needed but no less than monthly to assure that appropriate sensorimotor reassessment occurs as needed.</p> <p>The agency will retrain QIDP and facility nurse regarding the need to develop necessary supports and measureable objectives to support clients toward independence.</p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment and interdisciplinary input.</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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>training including but not limited to assuring the provision of continuous active treatment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. 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. 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,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>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> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include:</p> <ol style="list-style-type: none"> 1. Assuring that psychotropic medications are ordered with appropriate corresponding diagnoses. 2. Direct face to face assessment of clients to assure current sensorimotor needs are addressed with appropriate supports. 3. Assuring appropriate supports are included in each client’s support plan. 4. Direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate. 5. Assuring staff provide continuous active treatment during formal and informal opportunities. 6. Review of healthcare records and incident documentation to assure appropriate risk plans and nursing supports are in place. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 2 additional clients (F and G), the facility failed to protect the clients' privacy when dressing and/or bathing.</p> <p>Findings include:</p> <p>During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home, client G walked from her bedroom to the bathroom naked while staff #2 was at the front of the house. At 6:08 AM, staff #2 came to the back of the house and saw client G standing naked in her bedroom drying off. Staff #2 did not prompt and/or encourage client G to close her door. At 7:24 AM, staff #3 was</p>	W 0130	<p>7. Assuring staff demonstrate competency in the implementation of all Comprehensive High Risk Plans.</p> <p>8. Assuring staff secure medication per Living in the Community standards.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Operations Team</p> <p>COERRECTION <i>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Specifically, for Clients F and G, all facility staff have been retrained regarding the need to protect clients' privacy and to train clients toward providing for their own privacy during all skills training across environments. Although active treatment observations indicated this deficient practice did not affect any additional clients, the additional training stressed the need to provide for all clients' privacy. PREVENTION: The Residential Manager will be expected to observe no less than</i></p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>in the bathroom assisting client F to get ready to shower/bathe. Client F undressed with the door open. Staff #3 did not prompt and/or encourage client F to close the bathroom door to protect the client's privacy.</p> <p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP) on 5/19/15 at 3:10 PM indicated clients' doors should be closed when they are dressing and/or undressing.</p> <p>9-3-2(a)</p>		<p>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 protect clients' privacy. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to the protection of clients' privacy. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. 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. Active Treatment sessions to be monitored are defined as: 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS		<p>active treatment monitoring will include staff from both the day and overnight shifts. 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. 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. 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. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include assuring staff protect clients' privacy at all times, across environments.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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
Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 9 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure injuries of unknown source were thoroughly investigated for client A.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 5/13/15 at 2:19 PM. The facility's 4/19/15 IAR indicated "[Client A] had redish (sic) and black spot on the around of her right side/eye (sic). But staff noticed that she (sic) resting the right eye/side on the handle of the wheel-chair and staff redirected and putting towel on the wheelchair handle (sic). The staff notified the on call nurse. The facility's IAR and/or investigations since 10/14, did not indicate the facility conducted an investigation in regard to the client's bruising around the client's eye, and/or indicate how long client A was allowed to sit with her eye down on the handle of wheelchair to cause injury/bruising.</p> <p>Interview with Clinical Supervisor (CS)</p>	W 0154	<p>CORRECTION:</p> <p><i>The facility must have evidence that all alleged violations are thoroughly investigated.</i></p> <p>Specifically: the Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The training will also stress the importance of assuring the investigative process determines if discovered injuries occurred as a result of staff negligence. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>#1 on 5/13/15 at 3:11 PM indicated the facility did not conduct an investigation in regard to the client's bruising around her eye. CS #1 stated the facility staff "knew how the client got injured." CS #1 stated when "[Client A] laid down she did not have injury, had injury when she got up." CS #1 stated "She laid down all day on arm of chair." When asked if the facility had conducted an investigation for possible neglect, CS #1 indicated he did not look at the incident as an allegation of neglect in regard to allowing the client to rest her head on the arm of wheelchair all day until injured.</p> <p>9-3-2(a)</p>		<p>investigation process for the next 90 days.</p> <p>PREVENTION:</p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and the Executive Director. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0157 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 9 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to provide evidence of its recommended corrective actions for client H.</p> <p>Findings include: The facility's reportable incident reports, internal Incident/Accident Reports</p>	W 0157	<p>Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>If the alleged violation is verified, appropriate corrective action must be taken.</i> Specifically, for Client H, Staff have been retrained regarding proper implementation of her Comprehensive High Risk Plan for Falls. Additionally, facility supervisory staff have been retrained regarding the necessity to retain written documentation of all staff training. PREVENTION: When staff training needs are</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>(IARs) and/or investigations were reviewed on 5/13/15 at 2:19 PM. The facility's 2/9/15 reportable incident report indicated "While assisting [client H] (individual supported by ResCare) with engaging in leisure activities, staff noted a 2 inch diameter circular bruise on her forehead when she removed her hat. [Client H] was not able to describe how she received the bruise...."</p> <p>The facility's 2/9/15 investigation indicated "While in hallway another consumer was trying to get by in wheelchair which hit [client H's] walker which caused her to lose balance and fall. One staff was giving a shower (sic) the other staff was up front with other consumers cooking dinner. Staff have been inserviced to always hold [client H's] gait belt when she is up walking around and that she needs stand by assist with mobility at all times."</p> <p>Interview with Clinical Supervisor (CS) #1 and the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 5/19/15 at 11:40 AM indicated facility staff should have been retrained as recommended. The QIDP-D stated facility staff was retrained at a "monthly staff meeting." The QIDP-D and/or CS #1 did not provide any documentation facility staff had been</p>		<p>identified during the course of investigations, the QIDP or the clinical supervisor as appropriate will establish time frames for the prompt completion of required training. During weekly meetings with supervisors and the QIDP, the Clinical Supervisor will review documentation from the previous week to assure recommended training has occurred as directed. Training documentation will be turned in to the Program Manager monthly for further follow-up as needed. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0159 Bldg. 00	<p>retrained as recommended.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D) and for 1 additional client (H), the facility failed to ensure the group home had a Qualified Intellectual Disabilities Professional (QIDP) to monitor the clients' Individual Support Plan (ISP) objectives as there were no monthly summaries, revisions and/or monitoring of the clients' data for the entire year. The facility failed to ensure the group home had a QIDP to coordinate the clients' programs in regard to obtaining assessment of clients' needs, addressing a client's identified need, and to ensure needed supports were a part of the clients' program plans. The facility failed to ensure the group home had a QIDP to monitor the clients' programs for implementation of objectives to ensure active treatment/training, and to ensure the facility's Human Rights Committee reviewed and approved clients' restrictive programs. The facility failed to ensure</p>	W 0159	<p>CORRECTION:</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>The QIDP will direct the facility to pursue obtaining dentures for Client D.</p> <p>The QIDP has been retrained regarding the need to modify prioritized learning objectives whenever a client has completed the objective(s) successfully, whenever a client is regressing or losing skills already gained and whenever a client is failing to make progress. QIDP has also been retrained regarding the need to present summarized data to the interdisciplinary team in</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 group home had a QIDP to ensure a client's interdisciplinary team met to review a dental recommendation.</p> <p>Findings include:</p> <p>1. Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 10/28/14 Dental Summary Progress Report indicated client D was edentulous as the client's dental note indicated the client's "gingival health WNL (within normal limits)." Client D's dentist recommended the client receive dentures.</p> <p>Client D's 9/11/14 ISP and/or record indicated the client's interdisciplinary team (IDT) had not met to review the client's dental recommendation.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Clinical Supervisor (CS#1) on 5/19/15 at 1:40 PM indicated client D's IDT did not meet to address the client's 10/28/14 recommendation to get dentures.</p> <p>2. Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 7/1/14 Individual Support Plan (ISP) indicated the client had the following objectives:</p> <p>-To independently clean her room daily 75% of the time for 3 consecutive</p>		<p>order to consider whether training toward new objectives is indicated. All prioritized learning objectives will be modified based on current progress and new objectives will be developed as needed through interdisciplinary team consensus.</p> <p>The QIDP has coordinated the team's efforts to request diagnostic clarification from Client B's psychiatrist with regard to the use of Haldol and Clozaril. A review of Physician's Orders and support documents indicated that this deficient practice did not affect any additional clients</p> <p>The QIDP has guided the team in assisting Client H with obtaining updated assessments and providing Client H with additional adaptive equipment to assist her with coping with tremors.</p> <p>The QIDP has guided the interdisciplinary team in developing an objective for Client H to address refusals of health treatments and medical appointments that goes beyond the scope of her current desensitization plan and an</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>months.</p> <p>-To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months.</p> <p>-To name a side effect of her Risperidone (behavior) with 2 verbal prompts 50% of the time for 3 consecutive months.</p> <p>-To prepare side dish on the menu for that day with 2 verbal prompts 75% of the time for 3 consecutive months.</p> <p>-To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months.</p> <p>-To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months.</p> <p>-To dress herself properly for the weather with 2 verbal prompts for 90% of the time for 3 consecutive months.</p> <p>-To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time for 3 consecutive months.</p> <p>-To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months.</p>		<p>objective to train Client G to arrange for her own privacy. Through observation the team determined that this deficient practice affected one additional individual and therefore the team will develop a privacy objective for Client F.</p> <p>The QIDP has coordinated with the facility nurse to instruct staff to weigh Client H, at required intervals, using a seated scale. Additionally the interdisciplinary team has incorporated daily cleaning of Client C's mattress into her Individual Support Plan to facilitate the control of odors. Through observation the team has determined that this deficient practice also affected client F and G and daily mattress cleaning has been incorporated into their Individual Support Plans as well.</p> <p>The QIDP has coordinated retraining of all direct support staff regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Additionally, the Governing Body has directed the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>-To express her wants and needs and emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 9/11/14 ISP indicated client D had the following objectives:</p> <p>-To slow down and take her time speaking in a clear manner where people can understand with 50% accuracy for 3 consecutive months.</p> <p>-To hand 2 quarters to staff and practice counting the money before handing it to staff for accuracy with 3 verbal prompts 60% of the time for 3 consecutive months,</p> <p>-To name her medications with 3 verbal prompts and to know the purpose of the medication with 50% accuracy for 3 consecutive months.</p> <p>-To participate in laundry with 3 verbal prompts with 50% accuracy for 3 consecutive months.</p> <p>-To assist in meal preparation with 3 verbal prompts 50% if the time for 3 consecutive months.</p> <p>Client B's record was reviewed on</p>		<p>facility to modify the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning medication administration, morning hygiene and breakfast.</p> <p>PREVENTION:</p> <p>The QIDP will turn in copies of monthly summaries to the Clinical Supervisor for review and follow-up to assure learning objectives are modified as required. Additionally, members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will documentation reviews as needed but no less than monthly to assure that the QIDP has modified learning objectives as required.</p> <p>The QIDP has been retrained regarding the need to assure that behavior controlling medications including but not limited to antipsychotic medications, are only administered as directed by a psychiatrist with an appropriate Axis I diagnosis. Members of the Operations Team (including the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>5/18/15 at 3:49 PM. Client B's 6/2/14 ISP indicated client B had the following objectives:</p> <ul style="list-style-type: none"> -To independently clean her room daily 75% of the time for 3 consecutive months. -To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months. -To name a side effect of her Risperidone (behavior) with 2 verbal prompts 50% of the time for 3 consecutive months. -To prepare side dish on the menu for that day with 2 verbal prompts 75% of the time for 3 consecutive months. -To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months. -To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months. -To dress herself properly for the weather with 2 verbal prompts for 90% of the time for 3 consecutive months. -To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time 		<p>Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will review Behavior Support Plans and Physician's Orders no less than monthly to assure that psychotropic medications are ordered with appropriate corresponding diagnoses.</p> <p>Professional staff have been retrained regarding the need to obtain prompt reassessments when the team observes changes in clients' physical, mental and developmental status. Members of the Operations Team comprised of Clinical Supervisors, the Program Manager, Nurse Manager and the Executive Director will review incident documentation, medical records and assessment documentation as needed but no less than monthly to assure that appropriate sensorimotor reassessment occurs as needed.</p> <p>The agency will retrain QIDP and facility nurse regarding the need to develop necessary supports and measureable objectives to support clients toward independence.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>for 3 consecutive months.</p> <p>-To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months.</p> <p>-To express her wants and needs and emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client B, C and D's records indicated no monthly summaries had been completed in regard to progression, loss of skills, completion and consideration toward new objectives/skills for the entire year May 2014 to May 2015.</p> <p>Interview with the Qualified Intellectual Disabilities Professional Designee (QIDP-D) and the Clinical Supervisor (CS) #1 on 5/19/15 at 11:40 AM indicated the QIDP-D had not monitored/completed any monthly summaries for client B, C and D's ISP objectives since they were implemented to determine if the clients had achieved their objectives. CS #1 indicated he was the supervisor for the QIDP-D. CS #1 stated he had not been monitoring and/or "pushing" the QIDP-D to monitor the clients' objectives.</p> <p>Review of the State Form 46318 (R2-9-08) Entitled Qualified Mental</p>		<p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment and interdisciplinary input.</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 assuring the provision of continuous active treatment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions no less than three times weekly for the next 30 days, and no less than</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>Retardation Professional (QMRP) on 5/20/15 at 5:12 PM indicated the QMRP for the group home was CS #1.</p> <p>2. The QIDP failed to re-assess the client's diagnosis in regard to the use of Clozaril (antipsychotic) and Haldol (antipsychotic) injections for client B. Please see W210.</p> <p>3. The QIDP failed to obtain a sensorimotor assessment in regard to client H's tremors. Please see W218.</p> <p>4. The QIDP failed to address the clients' identified training needs in regard to privacy and refusals of health treatments/exams for clients G and H. Please see W227.</p> <p>5. The QIDP failed to indicate how often client C's bed/mattress was to be cleaned to prevent odors, and to indicate how client H should be weighed for consistency of weights. Please see W240.</p> <p>6. The QIDP failed to implement the clients' Individual Support Plans (ISPs) when formal and/or informal training opportunities existed for clients B, C and D. Please see W249.</p> <p>9-3-3(a)</p>		<p>twice weekly for an additional 60 Days. 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. 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>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>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. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include:</p> <ol style="list-style-type: none"> 1. Assuring that psychotropic medications are ordered with appropriate corresponding diagnoses. 2. Direct face to face assessment of clients to assure current sensorimotor needs are addressed with appropriate supports. 3. Assuring appropriate supports are included in each client's support plan. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D) and for 4 additional clients (E, F, G and H), the facility failed to provide sufficient staffing to meet the needs of clients.</p>	W 0186	<p>4. Direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate.</p> <p>5. Assuring staff provide continuous active treatment during formal and informal opportunities.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Specifically, the Governing Body has directed the</i></p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205			
(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>During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home, there was one staff (staff #2) to six clients B, C, D, E, F and G. Client G walked from her bedroom to the bathroom naked while staff #2 was at the front of the house. At 6:08 AM, staff #2 came to the back of the house and saw client G standing naked in her bedroom drying off. Staff #2 did not prompt and/or encourage client G to close her door. Client H told staff #2 she was ready for her bath/shower. Staff #2 told client H she would need to wait until "[staff #3]" came in to assist client H with her shower. Staff #2 turned and stated "I don't do female personal care." Interview with staff #2 on 5/13/15 at 6:12 AM indicated the female staff assisted the clients with their shower/baths. Interview with staff #2 indicated client H normally waited for staff #3. Staff #2 assisted client H to the bathroom and left the client, who utilized a walker, to undress and bathe/shower herself. At 6:24 AM, while staff #2 was passing the medications in the office area (at the front of the house), clients E and H were in separate bathrooms located next to each other. Client H started yelling at client E to be quiet and client E started yelling back at client H. Clients E and H</p>		<p>facility to modify the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning medication administration, morning hygiene and breakfast.</p> <p>PREVENTION:</p> <p>The Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation.</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 during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. 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. Active Treatment sessions to be monitored are defined as:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>yelled and cursed at each other. At one point, staff #2 left the medication room and came to the back of the house to see what was going on. Staff #2 looked at the surveyor for an explanation. Staff #2 then turned around and went back to the medication room when staff #2 saw the clients were not together. Staff #2 did not stop and/or redirect the clients as clients E and H were in separate bathrooms. Once client E came out of the bathroom, client E dressed with her bedroom door open. Client E yelled for help. Client B came to the back of the house to see what client E wanted. Client B went to a closet and got out an adult diaper and handed it to client E. Client E then wanted help fastening her bra. Client E asked the surveyor to help her as staff #2 was in the office/medication room. Client C who was walking around, heard client E and fastened client E's bra. At 6:24 AM, staff #2 went into the kitchen and stirred the oatmeal on the stove and placed bread with butter on it in the oven. Staff #2 did not involve and/or assist clients B, C and D who were in the living room area, to prepare the breakfast items. Client B came into the kitchen and independently made the juice. Staff #2 then went to the back of the house to check on client H who was in her bedroom. Client B followed staff #2 to client H's bedroom. Client H</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>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>started yelling for client B to get out of her bedroom. Staff #2 placed a gait belt on client H. Client H indicated she wanted to put on a different gait belt. Staff #2 told client H she would need to wear the one she had on as the other gait belt was broken. Client F sat in her wheelchair in the hallway. Staff #2 told client F she would need to wait until the female staff came in to assist client F with her shower. At 6:45 AM, staff #2 had returned to the medication room. The group home phone started ringing and client B yelled "Phone is ringing" to staff #2 in the office area. Client H was walking down the hallway with her roller walker trying to go to the medication room. Client H's pants fell down off the client 3 different times. Client H stated "help me" as she attempted to maneuver her walker while trying to pull up and/or hold onto her pants. Client E stood in the kitchen area indicating she was ready to eat but they had to wait as staff #2 was passing medications. While staff #2 was passing medications, client F was at the back of the house waiting for staff #3 to come in, and clients C, B, D, E and/or G were in the living room area sitting without training and/or activities other than to watch the TV. During the 5/13/15 observation period, client C's bedroom smelled of urine. Client C's bed was unmade and an incontinent pad was</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. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring adequate direct support staff are on duty to meet the needs of all clients.</p> <p>The Clinical Supervisor will perform periodic spot checks of attendance records to assure ongoing compliance. Prior to each schedule period, the Operations Team will follow-up verbally and via email to assure that appropriate coverage has been arranged.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>laying on top of the client's bed sheet. Staff #2 did not encourage the client to clean her room and/or change her bed. At 7:09 AM, staff #3 (the second staff) arrived at the group home.</p> <p>Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 7/1/14 Individual Support Plan (ISP) indicated the client had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -To clean her room. -To prepare side dish on the menu for that day. -To combine various coins. -To stay on task with an activity of her choice. -To comb her hair daily. -To exercise for 5 minutes. <p>Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 9/11/14 ISP indicated client D had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -To slow down and take her time speaking in a clear manner where people can understand. -To hand 2 quarters to staff. -To assist in meal preparation. <p>Client B's record was reviewed on 5/18/15 at 3:49 PM. Client B's 6/2/14</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>ISP indicated client B had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -To clean her room daily. -To prepare a side dish on menu. -To combine various coins to equal \$1.00. -To stay on task with an activity of choice. -To exercise for 5 minutes. <p>Interview with staff #2 on 5/13/15 at 6:05 AM and 6:12 AM indicated he worked by himself until 7:00 AM when staff #3 came into work. Staff #2 indicated he would get clients up, get their medications and start breakfast before staff #3 arrived.</p> <p>Interview with Clinical Supervisor (CS) #1 on 5/19/15 at 11:40 AM indicated there was one staff who worked with 7 clients until 7:00 AM when a second staff person came in. CS #1 stated "One person cannot do active treatment for 7 clients." CS #1 indicated they would be changing the staffing hours at the group home. CS #1 indicated facility staff should be encouraging and assisting clients to cook their meals, and implement clients' ISP objectives throughout the day.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0210 Bldg. 00	<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 on interview and record review for 1 of 4 sampled clients (B), the facility failed to re-assess the client's diagnosis in regard to the use of Clozaril (antipsychotic) and Haldol (antipsychotic) injections.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 5/18/15 at 3:49 PM. Client B's 3/1/15 physician's orders indicated client B received Clozaril (used to treat severe schizophrenia) 100 milligrams for aggressive behavior. Client B's physician's order also indicated client B received Haloperidol (antipsychotic) Injection 100 milligrams every 28 days for behavior.</p> <p>Client B's 6/2/14 BSP (Behavior Support Plan) indicated client B received the Haldol Injection for Depression manifested by self injurious behavior (biting her wrist, hitting the table and walls with her fist). Client B's BSP indicated client B received Clozapine</p>	W 0210	<p>CORRECTION:</p> <p><i>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. Specifically, the team has requested diagnostic clarification from Client B's psychiatrist with regard to the use of Haldol and Clozaril. A review of Physician's Orders and support documents indicated that this deficient practice did not affect any additional clients.</i></p> <p>PERVENTION:</p> <p>The QIDP has been retrained regarding the need to assure that behavior controlling medications including but not limited to antipsychotic medications, are only administered as directed by a psychiatrist with an appropriate Axis I diagnosis. Members of the Operations Team (including the</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>(Clozaril) for "MR" (Mental Retardation) and ADHD (Attention Deficit Hyperactivity Disorder) demonstrated by verbal aggression (curse, yell and spit at others). Client B's 6/2/14 BSP indicated client B demonstrated the targeted behaviors of verbal aggression, property destruction, physical aggression and self-injurious behavior. Client B's 6/2/14 BSP indicated client B's diagnoses included, but were not limited to, Mental Retardation and Learning Disability.</p> <p>Client B's 3/18/15 Record Of Visit for the client's Quarterly Psychiatric assessment indicated client B's "mental status remains stable. Diagnosis: Major Depression & (and) mental retardation...Rationale for psychotropic medication Behavioral management."</p> <p>Client B's 1/13/15 Record Of Visit for a psychiatric appointment indicated "...mental status exam is normal baseline. Behaviors is unpredictable at times...." The Record Of Visit indicated client B's diagnoses included, but were not limited to, Major Depression and Mental Retardation." The form indicated client B received the psychotropic behavior medications for "Behavioral Management."</p> <p>Client B's 3/1/15 physician's order</p>		<p>Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will review Behavior Support Plans and Physician's Orders no less than monthly to assure that psychotropic medications are ordered with appropriate corresponding diagnoses.</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: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0218	<p>indicated client B required monthly labs of the client's white blood/cell count due to the effects of the Clozaril the client received.</p> <p>Client B's 6/2/14 BSP and/or 6/2/14 Individual Support Plan (ISP) did not indicate the client's interdisciplinary team conducted an accurate assessment in regard to client B's diagnosis to warrant the use of Clozaril and/or Haldol injections to address the client's behavioral/psychiatric needs.</p> <p>Interview with Clinical Supervisor (CS) #1 and LPN #1 on 5/19/15 at 1:53 PM indicated client B was admitted to the group home on Clozaril and Haldol injections. LPN #1 and CS #1 stated client B "has to take them for a MI (mental illness)." LPN #1 indicated client B's BSP indicated client B's MI diagnoses were "Attention Deficit and Depression." LPN #1 indicated client B had to have monthly lab work completed to be able to get the Clozaril/Clozapine refilled. CS #1 indicated they would need to re-assess why client B received the Haldol Injections and Clozaril.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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
Bldg. 00	<p>The comprehensive functional assessment must include sensorimotor development. Based on observation, interview and record review for 1 additional client (H), the facility failed to obtain a sensorimotor assessment in regard to the client's tremors.</p> <p>Findings include:</p> <p>During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home, client H walked with a roller walker to ambulate. Client H also wore a gait belt as she ambulated with her walker. Client H had tremors in her right hand when she walked causing her walker to jerk. At 7:33 AM, client H was sitting at the dining room table attempting to eat her breakfast which consisted of oatmeal and toast cut into small pieces. Client H was unable to get bites of food into her mouth as the client had tremors of her right hand while she attempt to eat. Client H would attempt to get the food to her mouth and the food would fall off the spoon. Client H stated "help me."</p> <p>Client H's record was reviewed on 5/19/15 at 10:45 AM. The 3/1/15 Physician's orders indicated client H's diagnosis included, but was not limited to, Extrapyrimal Symptoms (EPS)</p>	W 0218	<p>CORRECTION:</p> <p><i>The comprehensive functional assessment must include sensorimotor development.</i> Specifically, the team has assisted Client H with obtaining updated assessments and has provided Client H with additional adaptive equipment to assist her with coping with tremors.</p> <p>PREVENTION:</p> <p>Professional staff have been retrained regarding the need to obtain prompt reassessments when the team observes changes in clients' physical, mental and developmental status. Members of the Operations Team comprised of Clinical Supervisors, the Program Manager, Nurse Manager and the Executive Director will review incident documentation, medical records and assessment documentation as needed but no less than monthly to assure that appropriate sensorimotor reassessment occurs as needed.</p> <p>Members of the Operations Team and the QIDP will conduct</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>(drug induced movements).</p> <p>Client H's 12/17/14 Record Of Visit indicated client H saw her Neurologist for "F/U (follow up) MR (Mental Retardation) Tremor" in the client's right hand. The record of visit indicated "med (medication) induced tremor."</p> <p>Client H's record indicated the client's last Occupational Therapy (OT) assessment was dated 8/6/08 and the client's last Physical Therapy (PT) assessment was completed on 7/8/14. Client H's PT assessment was in regard to the use of walker for the client's unsteady gait. Client H's 7/29/14 Individual Support Plan, OT and/or PT assessments did not address the client's tremors.</p> <p>Interview with Clinical Supervisor and LPN #1 on 5/19/15 at 1:53 PM indicated client H had EPS. CS #1 indicated when he was at the home on 5/13/15, he observed client H's tremors. CS #1 stated "I did not know they were that severe." CS #1 indicated client H would need to be assessed. LPN #1 stated "I have it written down to get orders (PT and OT assessment)."</p> <p>9-3-4(a)</p>		<p>observations during active treatment sessions no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. 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. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>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. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include direct face to face assessment of clients to assure current sensorimotor needs are addressed with appropriate supports.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0227 Bldg. 00	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview and record review for 2 additional clients (G and H), the facility failed to address the clients' identified training needs in regard to privacy and refusals of health treatments/exams.</p> <p>Findings include:</p> <p>1. During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home, client G walked from her bedroom to the bathroom naked while staff #2 was at the front of the house. At 6:08 AM, client G was standing naked in her bedroom drying off with the door open.</p> <p>Client G's record was reviewed on 5/19/15 at 3:10 PM. Client G's 2/21/15 Individual Support Plan (ISP) indicated client G's identified training need in regard to privacy had not been addressed.</p> <p>Interview with the Qualified Intellectual Disabilities Professional Designee (QIDP-D) on 5/19/15 at 3:10 PM indicated client G's 2/21/15 ISP did not</p>	W 0227	<p>CORRECTION: <i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.</i></p> <p>Specifically, the interdisciplinary team will develop an objective for Client H to address refusals of health treatments and medical appointments that goes beyond the scope of her current desensitization plan and an objective to train Client G to arrange for her own privacy. Through observation the team determined that this deficient practice affected one additional individual and therefore the team will develop a privacy objective for Client F. PERVENTION: The agency will retrain QIDP and facility nurse regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days to</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>address the client's identified training need in regard to privacy.</p> <p>2. Client H's record was reviewed on 5/19/15 at 10:45 AM. Client H's 9/24/14 Quarterly Nursing Assessment indicated "assessment (sic) complete. [Client H] was screaming the entire time...."</p> <p>Client H's 3/31/15 Nursing Quarterly Assessment indicated "B/P (blood pressure) & (and) weight was not obtain (sic) during assessment. Pt (patient) refused x's (times) 2, for the weight she would not step on the scale and she would not sit still for the B/P to read on auto cuff."</p> <p>Client H's April 2015 Medication Administration Record (MAR) indicated client H was to be weighed weekly and the client's vitals were to be obtained weekly. Client H's April 2015 MAR indicated client H refused to be weighed and/or have her vitals (B/P, pulse respirations and temperature) taken on 4/15/15. The April 2015 MAR also indicated staff were to trim client H's fingernails and toenails weekly. The April 2015 MAR indicated client H refused to let staff trim her nails on 4/23 and 4/30/15.</p> <p>Client H's Record Of Visits (ROV)</p>		<p>assure appropriate supports are included in each client's support plan. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>indicated the following (not all inclusive):</p> <p>-10/9/14 Client H went to have a mammogram done. The ROV sheet indicated "Attempted to do exam pt refused after multiple attempts."</p> <p>-8/5/14 Client H went to her doctor for her annual physical examination. The 8/5/14 ROV sheet indicated "nl (normal) exam as far as I can tell. Pt is very hard to examine...."</p> <p>Client H's 11/12/13 fax note indicated "[Client H] will not attend any appts (appointments) or is very combative once @ (at) appt. Can we get an order for a pre-med (medication) for all appts?" The note indicated client H could receive Valium 10 milligrams one hour prior to appointments for sedation.</p> <p>Client H's 7/29/14 Desensitization Plan indicated client H was to receive the Valium 1 hour prior to "OB/GYN (obstetrics/gynecological) appointments. Client H's objective indicated "Given desensitization training, [client H] will tolerate OB/GYN exams with Valium 10 mg (milligrams) tab or less at one scheduled appointment by 07/29/2015."</p> <p>Client H's 7/29/14 Behavior Support Plan</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>(BSP) indicated client H had a targeted behavior of Non-Cooperation defined as "This usually occurs when [client H] is asked to participate in a functional activity. [Client H] will frequently refuse to participate...." Client H's BSP indicated facility staff were to "Verbally redirect if [client H] refuses to participate, when given choices of activities to participate in. Let her know the importance of the activity she is doing...." Client H's 7/29/14 Desensitization Plan, BSP and/or 7/29/14 ISP did not include a specific objective/plan which addressed client H's identified training need in regard to participating in medical/health treatments/examinations other than OB/GYN appointments.</p> <p>Interview with Clinical Supervisor (CS) #1 and the QIDP-D on 5/19/15 at 11:40 AM stated client H's refusals for health and medical treatments were addressed "Just through the Desensitization Plan." QIDP-D stated "We keep trying to talk to her." QIDP-D and CS #1 indicated client H did not have any formal training/program in place to address the client's identified training need in regard to refusals for medical and health treatments/examinations.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0240 Bldg. 00	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (C) and for 1 additional client (H), the clients' Individual Support Plans (ISPs) failed to indicate how often a client's bed/mattress was to be cleaned to prevent odors, and to indicate how a client should be weighed for consistency of weights.</p> <p>Findings include:</p> <p>1. During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home, client C's bedroom smelled of urine. Client C's bed was unmade and an incontinent pad was laying on top of the client's bed sheet.</p> <p>Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 7/1/14 ISP did not indicate how often and/or when client's C bed/mattress was to be cleaned to prevent odors.</p> <p>Interview with the Qualified Intellectual Disabilities Professional-Designee (QIDP-D) on 5/19/15 at 3:10 PM stated client C had "incontinent issues." The</p>	W 0240	<p>CORRECTION:</p> <p><i>The individual program plan must describe relevant interventions to support the individual toward independence. Specifically, the facility nurse has instructed staff to weigh Client H, at required intervals, using a seated scale. Additionally the interdisciplinary team has incorporated daily cleaning of Client C's mattress into her Individual Support Plan to facilitate the control of odors. Through observation the team has determined that this deficient practice also affected client F and G and daily mattress cleaning has been incorporated into their Individual Support Plans as well.</i></p> <p>PREVENTION:</p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment and interdisciplinary input. Members of the Operations Team and the QIDP will conduct observations during active</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>QIDP-D stated client C's mattress/bed should be cleaned "whenever she is incontinent." The QIDP-D indicated client C's ISP did not indicate when/how often client H's mattress/bed should be cleaned.</p> <p>2. During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home, client H was small in size with a bony prominence seen in the client's upper arms/shoulder areas. During the 5/13/15 observation period, client H's pants fell off the client 3 different times as client H tried to walk from the back of the house to the medication room to get her morning medication. Client H had a belt on when her pants fell down. At 7:33 AM, client H was sitting at the dining room table attempting to eat her breakfast which consisted of oatmeal and toast cut into small pieces. Client H was unable to get bites of food into her mouth as the client's hand shook while she was attempting to eat. Client H stated "help me."</p> <p>Interview with client H on 5/19/15 at 11:06 AM indicated client H was losing weight. When asked why, client H stated "I don't know. Sometimes I do not want to eat. I don't like toast and oats."</p>		<p>treatment sessions no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. 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. 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>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 H's record was reviewed on 5/19/15 at 10:45 AM. Client H's 3/1/15 physician's order indicated client H was to be weighed weekly "...on Wednesday call nurse for 5# (pounds) gain or loss in 1 month."</p> <p>Client H's 12/29/14 Group Home Quarterly Nutrition Assessment indicated the following weights:</p> <p>5/14 110 pounds 6/14 109 pounds 7/14 111.4 pounds 8/14 no weight documented 9/14 121 pounds 10/14 no weight documented 11/14 122 pounds 12/14 125.4 pounds. Client H's nutritional assessment indicated client H had a "history of low weights." Client H's nutritional assessment indicated client H's ideal body weight was between 122 to 149 pounds.</p> <p>Client H's nursing Monthly Summaries indicated the following weights:</p> <p>1/15 125 pounds 2/15 121 pounds 3/15 126 pounds</p> <p>Client H's April 2015 MAR indicated the following weights:</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. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Health Services Team,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>4/1/15 112 pounds 4/8/15 110.2 pounds 4/15/15 Refused 4/22/15 116.5 pounds 4/29/15 119.8 pounds</p> <p>Client H's 2/12/15 risk plans and/or 7/29/14 ISP did not indicate how client H was to be weighed (standing scale or sitting scale) to ensure accurate/consistency in weights to determine if client H was losing and/or gaining weight.</p> <p>Confidential interview A indicated they were concerned about client H's weight loss. Confidential interview A stated "[Client H] is getting awful thin."</p> <p>Interview with Clinical Supervisor (CS) #1 and the QIDP-D on 5/19/15 at 11:40 AM indicated they were not sure how client H was being weighed. The QIDP-D indicated staff could be holding the client's hands while she was on the scale and/or client H could be sitting in the scale with a chair. The QIDP-D and CS #1 indicated client H's ISP did not indicate how client H should be weighed for accuracy and/or consistency with weights.</p> <p>Interview with LPN #1 on 5/19/15 at 1:53 PM indicated she did not know how</p>		Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205			
(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 0249 Bldg. 00	<p>client H's weight was doing but she would check. LPN #1 indicated the facility had a standing scale and a sitting scale at the group home. LPN #1 indicated client H's ISP and/or risk plans did not indicate how client H was to be weighed for consistency to ensure the accuracy of the client's weights.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D), the facility failed to implement the clients' Individual Support Plans (ISPs) when formal and/or informal training opportunities existed.</p> <p>Findings include:</p> <p>1. During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home, client C walked around the group home, spoke with other clients and/or sat in the living room without</p>	W 0249	<p>CORRECTION:</p> <p><i>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically, all direct support staff will be retrained and receive ongoing face to face coaching</i></p>	06/27/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>activity and/or training. During the 5/13/15 observation period, staff #2 custodially prepared the oatmeal and toast for the breakfast meal. Staff #2 did not encourage and/or assist client C to prepare the food items.</p> <p>Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 7/1/14 Individual Support Plan (ISP) indicated the client had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -To clean her room. -To prepare side dish on the menu for that day. -To combine various coins. -To stay on task with an activity of her choice. -To comb her hair daily. -To exercise for 5 minutes which facility staff #2 and #3 did not implement when formal and/or informal opportunities for training existed. <p>Interview with Clinical Supervisor (CS) #1 on 5/19/15 at 1:53 PM indicated facility staff should be encouraging and assisting clients to cook their meals, and implement clients' ISP objectives throughout the day.</p> <p>2. During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the</p>		<p>from supervisors regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Additionally, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning medication administration, morning hygiene and breakfast.</p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring the provision of continuous active treatment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>group home, client D sat in the living room and/or walked around the house to see what others were doing. Client D was not redirected to participate in an alternate activity and/or training. During the above observation period, staff #2 custodially prepared the oatmeal and toast for the breakfast meal. Staff #2 did not involve client D in the meal preparation.</p> <p>Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 9/11/14 ISP indicated client D had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -To slow down and take her time speaking in a clear manner where people can understand. -To hand 2 quarters to staff. -To assist in meal preparation which staff #2 and staff #3 did not implement client D's objectives when formal and/or informal opportunities for training existed. <p>Interview with Clinical Supervisor (CS) #1 on 5/19/15 at 1:53 PM indicated facility staff should be encouraging and assisting clients to cook their meals, and implement clients' ISP objectives throughout the day.</p> <p>3. During the 5/13/15 observation period</p>		<p>preparation, family style dining, other domestic skills and meaningful leisure activities. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. 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. 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>between 5:40 AM and 8:00 AM, at the group home, client B sat and watched TV, assisted to help client G while staff #2 was in the office area and independently made juice for the breakfast meal while staff #2 prepared the oatmeal and toast in the oven. Staff #2 did not involve client B in preparing the breakfast food items.</p> <p>Client B's record was reviewed on 5/18/15 at 3:49 PM. Client B's 6/2/14 ISP indicated client B had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -To clean her room daily. -To prepare a side dish on menu. -To combine various coins to equal \$1.00. -To stay on task with an activity of choice. -To exercise for 5 minutes which staff #2 and/or staff #3 did not implement when formal and/or informal opportunities for training existed. <p>Interview with Clinical Supervisor (CS) #1 on 5/19/15 at 1:53 PM indicated facility staff should be encouraging and assisting clients to cook their meals, and implement clients' ISP objectives throughout the day.</p> <p>9-3-4(a)</p>		<p>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. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0255 Bldg. 00	<p>483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D), the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor/revise the clients' Individual Support Plan objectives when the clients achieved their objectives.</p> <p>Findings include:</p> <p>1. Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 7/1/14 Individual Support Plan (ISP) indicated the client had the following objectives:</p> <p>-To independently clean her room daily 75% of the time for 3 consecutive months.</p>	W 0255	<p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The individual program plan must be reviewed at, least by the qualified mental retardation, professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. Through review of facility documentation, the governing body has determined that in addition to Clients B – D, this deficient practice affected four additional clients (E – H). Specifically, The QIDP has been retrained regarding the need to modify prioritized learning objectives whenever a client has</i></p>	06/27/2015
--------------------	---	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>-To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months.</p> <p>-To name a side effect of her Risperidone (behavior) with 2 verbal prompts 50% of the time for 3 consecutive months.</p> <p>-To prepare side dish on the menu for that day with 2 verbal prompts 75% of the time for 3 consecutive months.</p> <p>-To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months.</p> <p>-To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months.</p> <p>-To dress herself properly for the weather with 2 verbal prompts for 90% of the time for 3 consecutive months.</p> <p>-To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time for 3 consecutive months.</p> <p>-To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months.</p> <p>-To express her wants and needs and</p>		<p>completed the objective(s) successfully. All prioritized learning objectives will be modified based on current progress.</p> <p>PREVENTION:</p> <p>The QIDP will turn in copies of monthly summaries to the Clinical Supervisor for review and follow-up to assure learning objectives are modified as required. Additionally, members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will documentation reviews as needed but no less than monthly to assure that the QIDP has modified learning objectives as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client C's record indicated the QIDP failed to monitor the client's 7/1/14 ISP objectives to determine if the client had successfully completed the objective as there were no monthly summaries/reviews of the client's objectives since the implementation of the client's 6/2/14 ISP.</p> <p>2. Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 9/11/14 ISP indicated client D had the following objectives:</p> <ul style="list-style-type: none"> -To slow down and take her time speaking in a clear manner where people can understand with 50% accuracy for 3 consecutive months. -To hand 2 quarters to staff and practice counting the money before handing it to staff for accuracy with 3 verbal prompts 60% of the time for 3 consecutive months, -To name her medications with 3 verbal prompts and to know the purpose of the medication with 50% accuracy for 3 consecutive months. -To participate in laundry with 3 verbal 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>prompts with 50% accuracy for 3 consecutive months.</p> <p>-To assist in meal preparation with 3 verbal prompts 50% if the time for 3 consecutive months.</p> <p>Client D's record indicated the QIDP failed to monitor the client's 9/11/14 ISP objectives to determine if the client had successfully completed the objective as there were no monthly summaries/reviews of the implementation of the client's 9/11/14 ISP.</p> <p>3. Client B's record was reviewed on 5/18/15 at 3:49 PM. Client B's 6/2/14 ISP indicated client B had the following objectives:</p> <p>-To independently clean her room daily 75% of the time for 3 consecutive months.</p> <p>-To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months.</p> <p>-To name a side effect of her Risperidone (behavior) with 2 verbal prompts 50% of the time for 3 consecutive months.</p> <p>-To prepare side dish on the menu for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>that day with 2 verbal prompts 75% of the time for 3 consecutive months.</p> <p>-To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months.</p> <p>-To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months.</p> <p>-To dress herself properly for the weather with 2 verbal prompts for 90% of the time for 3 consecutive months.</p> <p>-To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time for 3 consecutive months.</p> <p>-To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months.</p> <p>-To express her wants and needs and emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client B's record indicated the QIDP failed to monitor the client's 6/2/14 ISP objectives to determine if the client had successfully completed the objective as there were no monthly summaries/reviews of the client's objectives since the implementation of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0256 Bldg. 00	<p>the client's 6/2/14 ISP.</p> <p>Interview with the Qualified Intellectual Disabilities Professional Designee (QIDP-D) and the Clinical Supervisor (CS) #1 on 5/19/15 at 11:40 AM indicated the QIDP-D had not monitored/completed any monthly summaries for client B, C and D's ISP objectives since they were implemented to determine if the clients had achieved their objectives.</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(ii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D), the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor/revise the clients' Individual Support Plan objectives when the clients regressed and/or lost skills they had.</p> <p>Findings include:</p> <p>1. Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 7/1/14</p>	W 0256	<p>CORRECTION:</p> <p><i>The individual program plan must be reviewed at, least by the qualified mental retardation, professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. Through review of facility documentation, the</i></p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>Individual Support Plan (ISP) indicated the client had the following objectives:</p> <ul style="list-style-type: none"> -To independently clean her room daily 75% of the time for 3 consecutive months. -To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months. -To name a side effect of her Risperidone (behavior) with 2 verbal prompts 50% of the time for 3 consecutive months. -To prepare side dish on the menu for that day with 2 verbal prompts 75% of the time for 3 consecutive months. -To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months. -To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months. -To dress herself properly for the weather with 2 verbal prompts for 90% of the time for 3 consecutive months. -To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time for 3 consecutive months. 		<p>governing body has determined that in addition to Clients B – D, this deficient practice affected four additional clients (E – H). Specifically, The QIDP has been retrained regarding the need to modify prioritized learning objectives whenever a client has completed the objective(s) successfully. All prioritized learning objectives will be modified based on current progress.</p> <p>PREVENTION:</p> <p>The QIDP will turn in copies of monthly summaries to the Clinical Supervisor for review and follow-up to assure learning objectives are modified as required. Additionally, members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will documentation reviews as needed but no less than monthly to assure that the QIDP has modified learning objectives as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>-To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months.</p> <p>-To express her wants and needs and emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client C's record indicated the QIDP failed to monitor the client's 7/1/14 ISP objectives to determine if the client had regressed and/or lost skills as there were no monthly summaries/reviews of the client's objectives since the implementation of the client's 6/2/14 ISP.</p> <p>2. Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 9/11/14 ISP indicated client D had the following objectives:</p> <p>-To slow down and take her time speaking in a clear manner where people can understand with 50% accuracy for 3 consecutive months.</p> <p>-To hand 2 quarters to staff and practice counting the money before handing it to staff for accuracy with 3 verbal prompts 60% of the time for 3 consecutive months,</p> <p>-To name her medications with 3 verbal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>prompts and to know the purpose of the medication with 50% accuracy for 3 consecutive months.</p> <p>-To participate in laundry with 3 verbal prompts with 50% accuracy for 3 consecutive months.</p> <p>-To assist in meal preparation with 3 verbal prompts 50% if the time for 3 consecutive months.</p> <p>Client D's record indicated the QIDP failed to monitor the client's 9/11/14 ISP objectives to determine if the client had regressed and/or lost skills as there were no monthly summaries/reviews of the implementation of the client's 9/11/14 ISP.</p> <p>3. Client B's record was reviewed on 5/18/15 at 3:49 PM. Client B's 6/2/14 ISP indicated client B had the following objectives:</p> <p>-To independently clean her room daily 75% of the time for 3 consecutive months.</p> <p>-To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months.</p> <p>-To name a side effect of her Risperidone</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>(behavior) with 2 verbal prompts 50% of the time for 3 consecutive months.</p> <p>-To prepare side dish on the menu for that day with 2 verbal prompts 75% of the time for 3 consecutive months.</p> <p>-To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months.</p> <p>-To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months.</p> <p>-To dress herself properly for the weather with 2 verbal prompts for 90% of the time for 3 consecutive months.</p> <p>-To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time for 3 consecutive months.</p> <p>-To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months.</p> <p>-To express her wants and needs and emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client B's record indicated the QIDP failed to monitor the client's 6/2/14 ISP objectives to determine if the client had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0257 Bldg. 00	<p>regressed and/or lost skills as there were no monthly summaries/reviews of the client's objectives since the implementation of the client's 6/2/14 ISP.</p> <p>Interview with the Qualified Intellectual Disabilities Professional Designee (QIDP-D) and the Clinical Supervisor (CS) #1 on 5/19/15 at 11:40 AM indicated the QIDP-D had not monitored/completed any monthly summaries for client B, C and D's ISP objectives since they were implemented to determine if the clients had regressed and/or lost skills.</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D), the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor/revise the clients' Individual Support Plan objectives when the clients failed to make progress after 3 months.</p>	W 0257	<p>CORRECTION:</p> <p><i>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the</i></p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 7/1/14 Individual Support Plan (ISP) indicated the client had the following objectives:</p> <ul style="list-style-type: none"> -To independently clean her room daily 75% of the time for 3 consecutive months. -To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months. -To name a side effect of her Risperidone (behavior) with 2 verbal prompts 50% of the time for 3 consecutive months. -To prepare side dish on the menu for that day with 2 verbal prompts 75% of the time for 3 consecutive months. -To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months. -To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months. -To dress herself properly for the weather with 2 verbal prompts for 90% of the 		<p><i>client is failing to progress toward identified objectives after reasonable efforts have been made.</i> Through review of facility documentation, the governing body has determined that in addition to Clients B – D, this deficient practice affected four additional clients (E – H). Specifically, The QIDP has been retrained regarding the need to modify prioritized learning objectives whenever a client is failing to make progress. All prioritized learning objectives will be modified based on current progress.</p> <p>PREVENTION:</p> <p>The QIDP will turn in copies of monthly summaries to the Clinical Supervisor for review and follow-up to assure learning objectives are modified as required. Additionally, members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will documentation reviews as needed but no less than monthly to assure that the QIDP has modified learning objectives as required.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>time for 3 consecutive months.</p> <p>-To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time for 3 consecutive months.</p> <p>-To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months.</p> <p>-To express her wants and needs and emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client C's record indicated the QIDP failed to monitor the client's 7/1/14 ISP objectives to determine if the client had failed to make progress after 3 consecutive months as there were no monthly summaries/reviews of the client's objectives since the implementation of the client's 6/2/14 ISP.</p> <p>2. Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 9/11/14 ISP indicated client D had the following objectives:</p> <p>-To slow down and take her time speaking in a clear manner where people can understand with 50% accuracy for 3 consecutive months.</p> <p>-To hand 2 quarters to staff and practice</p>		<p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>counting the money before handing it to staff for accuracy with 3 verbal prompts 60% of the time for 3 consecutive months,</p> <p>-To name her medications with 3 verbal prompts and to know the purpose of the medication with 50% accuracy for 3 consecutive months.</p> <p>-To participate in laundry with 3 verbal prompts with 50% accuracy for 3 consecutive months.</p> <p>-To assist in meal preparation with 3 verbal prompts 50% if the time for 3 consecutive months.</p> <p>Client D's record indicated the QIDP failed to monitor the client's 9/11/14 ISP objectives to determine if the client had failed to make progress after 3 consecutive months as there were no monthly summaries/reviews of the implementation of the client's 9/11/14 ISP.</p> <p>3. Client B's record was reviewed on 5/18/15 at 3:49 PM. Client B's 6/2/14 ISP indicated client B had the following objectives:</p> <p>-To independently clean her room daily 75% of the time for 3 consecutive</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>months.</p> <ul style="list-style-type: none"> -To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months. -To name a side effect of her Risperidone (behavior) with 2 verbal prompts 50% of the time for 3 consecutive months. -To prepare side dish on the menu for that day with 2 verbal prompts 75% of the time for 3 consecutive months. -To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months. -To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months. -To dress herself properly for the weather with 2 verbal prompts for 90% of the time for 3 consecutive months. -To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time for 3 consecutive months. -To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months. 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0258 Bldg. 00	<p>-To express her wants and needs and emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client B's record indicated the QIDP failed to monitor the client's 6/2/14 ISP objectives to determine if the client had failed to make progress after 3 consecutive months as there were no monthly summaries/reviews of the client's objectives since the implementation of the client's 6/2/14 ISP.</p> <p>Interview with the Qualified Intellectual Disabilities Professional Designee (QIDP-D) and the Clinical Supervisor (CS) #1 on 5/19/15 at 11:40 AM indicated the QIDP-D had not monitored/completed any monthly summaries for client B, C and D's ISP objectives since they were implemented to determine if the clients had failed to make progress after 3 consecutive months.</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>considered for training towards new objectives.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D), the Qualified Intellectual Disabilities Professional (QIDP) failed to revise the clients' Individual Support Plan objectives to see if the clients could be considered for training toward new objectives.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 7/1/14 Individual Support Plan (ISP) indicated the client had the following objectives: <ul style="list-style-type: none"> -To independently clean her room daily 75% of the time for 3 consecutive months. -To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months. -To name a side effect of her Risperidone (behavior) with 2 verbal prompts 50% of the time for 3 consecutive months. -To prepare side dish on the menu for that day with 2 verbal prompts 75% of the time for 3 consecutive months. 	W 0258	<p>CORRECTION:</p> <p><i>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives.</i></p> <p>Through review of facility documentation, the governing body has determined that in addition to Clients B – D, this deficient practice affected four additional clients (E – H). Specifically, The QIDP has been retrained regarding the need to present summarized data to the interdisciplinary team in order to consider whether training toward new objectives is indicated. All prioritized learning objectives will be modified based on current progress and new objectives will be developed as needed through interdisciplinary team consensus.</p> <p>PREVENTION:</p> <p>The QIDP will turn in copies of monthly summaries to the Clinical Supervisor for review and follow-up to assure learning objectives are modified as</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>-To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months.</p> <p>-To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months.</p> <p>-To dress herself properly for the weather with 2 verbal prompts for 90% of the time for 3 consecutive months.</p> <p>-To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time for 3 consecutive months.</p> <p>-To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months.</p> <p>-To express her wants and needs and emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client C's record indicated the QIDP failed to monitor the client's 7/1/14 ISP objectives to determine if the client could be considered for training toward new objectives as there were no monthly summaries/reviews of the client's objectives since the implementation of the client's 6/2/14 ISP.</p> <p>2. Client D's record was reviewed on</p>		<p>required. Additionally, members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will documentation reviews as needed but no less than monthly to assure that the QIDP has modified learning objectives as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>5/18/15 at 3:30 PM. Client D's 9/11/14 ISP indicated client D had the following objectives:</p> <ul style="list-style-type: none"> -To slow down and take her time speaking in a clear manner where people can understand with 50% accuracy for 3 consecutive months. -To hand 2 quarters to staff and practice counting the money before handing it to staff for accuracy with 3 verbal prompts 60% of the time for 3 consecutive months, -To name her medications with 3 verbal prompts and to know the purpose of the medication with 50% accuracy for 3 consecutive months. -To participate in laundry with 3 verbal prompts with 50% accuracy for 3 consecutive months. -To assist in meal preparation with 3 verbal prompts 50% if the time for 3 consecutive months. <p>Client D's record indicated the QIDP failed to monitor the client's 9/11/14 ISP objectives to determine if the client could be considered for training toward new objectives as there were no monthly summaries/reviews of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>implementation of the client's 9/11/14 ISP.</p> <p>3. Client B's record was reviewed on 5/18/15 at 3:49 PM. Client B's 6/2/14 ISP indicated client B had the following objectives:</p> <ul style="list-style-type: none"> -To independently clean her room daily 75% of the time for 3 consecutive months. -To speak to others in a "pleasant tone of voice" with 1 verbal prompt 85% of the time for 3 consecutive months. -To name a side effect of her Risperidone (behavior) with 2 verbal prompts 50% of the time for 3 consecutive months. -To prepare side dish on the menu for that day with 2 verbal prompts 75% of the time for 3 consecutive months. -To combine various coins to equal \$1.00 with 1 verbal prompt 50% of the time for 3 consecutive months. -To stay on task with an activity of her choice 85% of the time with 2 verbal prompts for 3 consecutive months. -To dress herself properly for the weather with 2 verbal prompts for 90% of the 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>time for 3 consecutive months.</p> <p>-To comb her hair daily with 2 verbal prompts at bedtime for 65% of the time for 3 consecutive months.</p> <p>-To exercise for 5 minutes with 4 verbal prompts 60% of the time for 3 consecutive months.</p> <p>-To express her wants and needs and emotions with 3 verbal prompts 85% of the time for 3 consecutive months.</p> <p>Client B's record indicated the QIDP failed to monitor the client's 6/2/14 ISP objectives to determine if the client could be considered for training toward new objectives as there were no monthly summaries/reviews of the client's objectives since the implementation of the client's 6/2/14 ISP.</p> <p>Interview with the Qualified Intellectual Disabilities Professional Designee (QIDP-D) and the Clinical Supervisor (CS) #1 on 5/19/15 at 11:40 AM indicated the QIDP-D had not monitored/completed any monthly summaries for client B, C and D's ISP objectives since they were implemented to determine if the clients could be considered for training toward new objectives.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0262 Bldg. 00	<p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on interview and record review for 3 of 4 sampled clients (B, C and D), with restrictive programs, the facility failed to have its Human Rights Committee (HRC) review and/or approve the clients' restrictive programs.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 3/1/15 physician's order indicated client C received Melatonin 5 milligrams at bedtime for sleep, Concerta 36 milligrams 2 tablets in the morning for Attention Deficit Hyperactivity Disorder (ADHD), Risperdal 1 milligram at bedtime and Risperdal 2 milligrams in the morning for aggressive behaviors. Client C's 3/1/15 physician's orders also indicated client C received Halcion 0.25 milligrams 1 hour before appointments as a presedation. 	W 0262	<p>CORRECTION:</p> <p><i>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</i></p> <p>Through review of facility documentation, the governing body has determined that in addition to Clients B – D, this deficient practice affected four additional clients (E – H). Specifically, the QIDP will obtain Human rights Committee Approval for all restrictive programs for all clients who reside at the facility.</p> <p>PREVENTION:</p> <p>The QIDP will be retrained regarding the need to assure that</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 C's 7/31/14 Behavior Action Plan (BAP) indicated client C wore a helmet due to the client's self-injurious behavior of head banging. Client C's BAP indicated a 1 person and/or 2 person standing and/or sitting restraint could be utilized when client C became self-injurious, physically aggressive, disrobed and/or demonstrated behaviors of "sexual boundaries." Client C's 7/31/14 BAP also indicated "Calling for emergency Police assistance should be the absolute last resort when helping [client C] learns (sic) to control her behavior. This option is only used with the approval of the QIDP (Qualified Intellectual Disabilities Professional)...." Client C's 7/31/14 BAP indicated the facility's HRC had not reviewed and/or approved the restrictive behavior plan.</p> <p>Interview with Clinical Supervisor (CS) #1 and the QIDP-D (QIDP-designee) on 5/19/15 at 11:40 AM indicated the facility's HRC had not reviewed and/or approved the client's restrictive program. CS #1 indicated he was aware the facility's HRC would need to review the client C's behavior plan when he audited the home.</p> <p>2. Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 3/1/15 physician's orders indicated client D</p>		<p>the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The QIDP, facility nurse and Human Rights Committee liaison will each maintain copies of Human rights Committee approval forms to assure the ability to reproduce copies of HRC records for surveyors upon request. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of Human Rights Committee records to assure appropriate approvals have been obtained.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>received Desyrel 50 milligrams at bedtime for "sleep aid" and Sertraline 100 milligrams in the morning for Depression.</p> <p>Client D's 9/11/14 Behavior Support Plan (BSP) indicated client D's restrictive behavior plan/use of the Desyrel and Sertraline had not been approved by the facility's HRC committee.</p> <p>Interview with CS #1 and the QIDP-D on 5/19/15 at 11:40 AM indicated the facility's HRC had not reviewed and/or approved the client's restrictive program. CS #1 indicated he was aware the facility's HRC would need to review client D's behavior plan when he audited the home.</p> <p>3. Client B's record was reviewed on 5/18/15 at 3:49 PM. Client B's 3/1/15 physician's orders indicated client B received Clozaril 100 milligrams for aggressive behavior. Client B's physician's order also indicated client B received Haloperidol Injection 100 milligrams every 28 days for behavior.</p> <p>Client B's 6/2/14 BSP indicated client B received the Haldol Injection for Depression manifested by self injurious behavior. Client B's BSP indicated client B received Clozapine (Clozaril) for "MR"</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: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0312 Bldg. 00	<p>(Mental Retardation) and ADHD demonstrated by verbal aggression. Client B's restrictive BSP indicated facility staff could utilize restraints with 1 or 2 person holds if the client demonstrated self injurious behavior and/or physical aggression. Client B's 6/2/14 restrictive program and/or record indicated the facility's HRC had not reviewed and/or approved the client's restrictive program.</p> <p>Interview with CS #1 and the QIDP-D on 5/19/15 at 11:40 AM indicated the facility's HRC had not reviewed and/or approved the client's restrictive program. CS #1 indicated he was aware the facility's HRC would need to review the client B's behavior plan when he audited the home.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 2 of 3 sampled clients (C and D) on behavior controlling medications, the facility failed to ensure each client had an</p>	W 0312	<p>CORRECTION:</p> <p><i>Drugs used for control of inappropriate behavior must be</i></p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205			
(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>active treatment program for each medication which were prescribed, and to ensure each behavior controlling medication was included/part of the client's behavior plan.</p> <p>Findings include:</p> <p>1. Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 3/1/15 physician's order indicated client C received Melatonin 5 milligrams at bedtime for sleep and Concerta 36 milligrams 2 tablets in the morning for Attention Deficit Hyperactivity Disorder (ADHD).</p> <p>Client C's 7/31/14 Behavior Action Plan (BAP) indicated C's Concerta for ADHD was not part of the client's Behavior Support Plan (BSP). Client C's 7/31/14 BSP indicated the client's ADHD was not clearly defined. Also, client C's 7/31/14 BSP did not include the use of Melatonin for sleep and/or indicate client C had an active treatment program for sleep.</p> <p>Interview with Clinical Supervisor (CS) #1 and the Qualified Intellectual Disabilities Professional-Designee (QIDP-D designee) on 5/19/15 at 11:40 AM indicated the use of the Melatonin was not part of the BAP, and the BAP did not include an active treatment program</p>		<p><i>used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</i> Specifically the team will incorporate the use of Melatonin into Client C's Behavior Support Plan (BSP) including an active treatment program that monitors and tracks Client C's sleep. Additionally the team will incorporate the use of Desyrel into Client D's BSP, including an active treatment program that monitors and tracks Client C's sleep. A review of facility support documents indicated that this deficient practice did not affect any additional clients.</p> <p>PERVENTION:</p> <p>The QIDP has been retrained regarding the need to assure that active treatment programs are in place to support the reduction and eventual elimination of all currently prescribed psychotropic medications. Additionally, members of the Operations Team (including Clinical Supervisor, the Program Manager, Nurse Manager and Executive Director) will review facility Behavior Support Plans no less than monthly and to assure the plans</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205			
(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 0318 Bldg. 00	<p>which monitored/tracked client C's sleep.</p> <p>2. Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 3/1/15 physician's orders indicated client D received Desyrel 50 milligrams at bedtime for "sleep aid."</p> <p>Client D's 9/11/14 Behavior Support Plan (BSP) indicated client D's restrictive behavior plan did not include the use of Desyrel for a sleep aid. Client D's BSP did not include an active treatment program for client D's sleeplessness.</p> <p>Interview with CS #1 and the QIDP-D on 5/18/15 at 11:40 AM indicated client D's Desyrel was not part of the client's BSP and the client did not have an active treatment program for the client's sleep.</p> <p>9-3-5(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for clients A, B, C, D, E, F, G and H. The facility's health care services failed to ensure its nursing services met the health needs for clients it</p>			W 0318	<p>include active treatment programs designed to reduce and eventually eliminate the use of behavior controlling medications.</p> <p>RESPONSIBLE PARTIES: Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>The facility must ensure that specific health care services requirements are met. Specifically:</i></p>		06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>served in regard to monitoring and assessing a client's chronic/progressive health condition. The facility's health care services failed to ensure its nursing services developed appropriate risk plans for clients, obtained ordered medical treatments/evaluations, ensured facility staff were trained in regard to a client's illness/diseases, and to ensure a needed adaptive equipment was obtained for a health measure/need.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility's health care services failed to ensure its nursing services provided an appropriate wheelchair with leg rests, developed a high risk plan for Tubular Sclerosis (rare genetic disorder where tumors grow on vital organs) for client A, assessed/monitored client A for complications of the disease and to monitor client A in regard to a secondary diagnosis of Anemia. The facility's health care services failed to ensure ordered tests and/or procedures were obtained, to ensure facility staff obtained weekly weights as ordered, and failed to ensure a risk plan was developed for a client in regard to her weight/how the client should be weighed for consistency for client H. Please see W331. The facility's health care services 		<p>The facility nurse will be retrained regarding the need to develop risk plans for all relevant medical conditions. Specifically for Client H, the nurse will develop a high risk plan that addresses weight loss including the use of adaptive equipment to compensate for tremors and provide staff with instructions for assisting Client H with eating and obtaining accurate weight. A review of current diagnostic information and risk plans indicated this deficient practice did not affect additional clients.</p> <p>The facility nurse will facilitate training of all staff regarding proper implementation of all Comprehensive High Risk Plans.</p> <p>The nurse will facilitate retraining of all staff regarding the operation's medication administration procedures which are consistent with Core A and Core B (Living in the Community), including but not limited to keeping the medication room locked and/or the medications secured in a locked cabinet when the medications are not being prepared or administered.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>failed to train the Group Home staff to properly assess client A for complications of a disease including a secondary diagnosis of anemia. Please see W342.</p> <p>3. The facility's health care services failed to keep the door to the medication room locked as well as keeping the lock box containing Narcotics secured when staff was not administering medications for clients B, C, D, E, F, G and H. Please see W382.</p> <p>This federal tag relates to complaint #IN00172392.</p> <p>9-3-6(a)</p>		<p>PREVENTION:</p> <p>The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis.</p> <p>The nurse, QIDP and Residential Manager will each conduct record reviews and face to face assessments to assure that staff display an appropriate level of competency with the implementation of Comprehensive High Risk Plans.</p> <p>The Residential Manager will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>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 assuring the provision of continuous active treatment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring staff demonstrate competency in the implementation of all Comprehensive High Risk Plans and assuring staff secure medication per Living in the Community standards.</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 during active treatment sessions no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>Operations Team will determine the level of ongoing support needed at the facility. 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 Members and/or the Residential Manager will perform spot checks</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>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. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>.</p> <p>Administrative support at the home will include</p> <ol style="list-style-type: none"> 1. Review of healthcare records and incident documentation to assure appropriate risk plans and nursing supports are in place. 2. Assuring staff demonstrate competency in the implementation of all Comprehensive High Risk Plans. 3. Assuring staff secure medication per Living in the Community standards. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 2 of 4 sampled clients (A and D) and for 1 additional client (H), the facility's nursing services failed to provide an appropriate wheelchair with leg rests. The facility's nursing services also failed to develop a high risk plan for Tubular Sclerosis (rare genetic disorder where tumors grow on vital organs) for client A, and failed to assess/monitor client A for complications of the disease. The facility's nursing services also failed to monitor client A in regard to a secondary diagnosis of Anemia. The facility's nursing services failed to ensure ordered tests and/or procedures were obtained, to ensure facility staff obtained weekly weights as ordered, and failed to ensure a risk plan was developed for a client in regard to her weight/how the client should be weighed for consistency.</p> <p>Findings include:</p>	W 0331	<p>RESPONSIBLE PARTIES:</p> <p>QIDP, Health Services Team, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically: The facility nurse will be retrained regarding the need to develop risk plans for all relevant medical conditions. Specifically for Client H, the nurse will develop a high risk plan that addresses weight loss including the use of adaptive equipment to compensate for tremors and provide staff with instructions for assisting Client H with eating and obtaining accurate weight. A review of current diagnostic information and risk plans indicated this deficient practice did not affect additional clients.</i></p> <p>PERVENTION:</p> <p>The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to</p>	06/27/2015
--------------------	--	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>1. Review of the facility's reportables, internal incident reports and/or investigations were completed on 5/13/15 at 12:10 pm. A report to BDDS (Bureau of Developmental Disabilities Services) dated 4/21/2015 indicated "[client A] was taken to [name of Hospital] on 4/21/2015 because she was very sluggish and was not acting quite herself. RME (Residential Manager) of home called nurse and was instructed to take her to the ER (Emergency Room). [Client A] was treated and diagnosed with dehydration and was given 500 units of saline. RME of home spoke with doctors and nurse about [client A] being on a honey thickened liquid for all liquids consumed. Doctor informed me to give more than the 8 - 8 ounce cups a day to help her take in more fluids. [Client A] is looking better the following morning, all staff are continuing to push fluids throughout day but she still seems to be weak. [Client A] will be kept home the rest of the week to push fluids and monitor her recovery. RME will make follow up appointment with doctors as requested. Staff and RME will continue to monitor [client A] and report any changes as needed. Team will continue to give emotional support and comfort. Administration team, facility nurse and guardian have been notified of incident."</p>		<p>Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis.</p> <p>Members of the Operations Team (including Clinical Supervisors, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility three times weekly for the next 30 days and twice weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include review of healthcare records and incident documentation to assure</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>A facility's Incident/Accident report dated 5/5/2015 at 8:20 am indicated "This morning while bathing [client A] she had brown dark brown blood (sic) on her. It was so dark I thought it was a bowel movement. I wiped her and it became lighter like reddish. This continued throughout [client A's] day. It smelled bad - it had an odor to it." The facility Incident/Accident report did not indicate the facility's nurse was contacted in regard to the client's health status change.</p> <p>Client A's hospital records were reviewed on 5/13/15 at 2:30 pm. The 5/5/15 progress note signed by the Emergency Room physician indicated "the patient (client A) will be admitted to the hospital for GI bleeding, vaginal bleeding, dehydration and hypokalemia (low potassium)."</p> <p>Review of client A's record was completed on 5/13/15 at 10:15 AM. The Group Home Progress Note dated 5/5/15 indicated the 8 am - 4 pm staff had written "[client A] did not go to day service this morning. She ate at noon and watched some TV. Afterwards, she slept the remaining time." The Progress Note indicated "[client A] was taken to the hospital ER (Emergency Room) via ambulance at 4:00 pm per nurse instructions."</p>		<p>appropriate risk plans and nursing supports are in place.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 Physicians orders dated 4/1/15 - 4/30/15 indicated client A had the following diagnoses included, but were not limited to, Normacytic Normochronic Anemia (decrease in number of red blood cells) and Tubular Sclerosis.</p> <p>A Record of Visit dated 4/3/15 from client A's primary care physician indicated "patient with bilateral angiomyolipoma (tumor in the kidney), probably renal cell carcinoma - hospitalized 2 times over past month. Last hospitalization was to ER and Lasix (diuretic) 40 mg (milligrams) bid (twice daily) was ordered. ER evaluation was for hemorrhoids. Legs are 3 - 4 pitting edema. Diagnosis: 1) Bilateral Angiomyolipoma, 2) Probable Renal Cell Cancer, 3) Hemorrhoids and 4) Edema of legs - keep Lasix and TED/support hose. BMP (Basic Metabolic Panel) to be done every two weeks."</p> <p>A Record of Visit form dated 4/9/14 indicated client A's physician wrote an order for client A to be evaluated for appropriateness of a wheelchair. A recommendation dated 8/13/14 was faxed to the facility from the Physical Therapist on 8/13/14 and again on 8/18/14. It indicated "based on the Physical Therapy/Mobility evaluation performed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 4/9/14, [client A] is in need of a standard wheelchair with leg rests for elevation of the legs."</p> <p>A Record of Visit dated 4/23/15 from client A's Neurologist indicated "Sz (seizure), 1st in years. Diagnosis - Seizure, Tubular Sclerosis. Recommendations for treatment EEG (Electroencephalogram), CT (Computed Tomography) of the head. D/C (discontinue) Dilantin, start Vimpat 200 mg x 1 dose, then 50 mg bid (twice daily) for one week, then 100 mg twice daily." A Record of visit dated 4/23/15 at client A's Oncologist indicated "referral for liposarcoma, recommended surgery biopsy to confirm diagnosis. Depending on biopsy will determine chemotherapy or palliative care. Family must make decision."</p> <p>The Nursing Notes for April 2015 indicated the following (not all inclusive):</p> <p>4/1/15 - "received ROV (Record of Visit) from ER visit, sent out an email to inform the team of the dx and plan of treatment." 4/6/15 - "Labs were faxed to doctors that follows [client A's] care. [Name of client A's primary care doctor] sent an order to start Vitamin C 500 mg daily. Called the medication into back up and completed a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>MAR (Medication Administration Record), sent an email out to inform the team."</p> <p>4/8/15 - "Dilantin was decreased to 100 mg twice daily due to high Dilantin levels, sent out an email to inform the team."</p> <p>4/21/15 - "[Name of Group Home Manager] called me at around 8:40 am to say [client A] didn't look well - she was not acting normal (sic). I advised her to take her to the ER."</p> <p>4/22/15 - "Sent out an email that states what doctors [client A] needs to follow up with and that the diagnosis during her recent hospitalization was dehydration with no medication changes."</p> <p>4/23/15 - "Face to face with [client A], check on her eye and just wanted to see how she was doing, follow her ER visit while at the home I reviewed the ROV from the Neurologist - [client A] had changes to discontinue Dilantin and start Vimpat."</p> <p>4/28/15 - "Requested ROV for [client A's] Oncology appointment on 4/24/15 to be faxed to me."</p> <p>4/29/15 - "Face to face with [client A]. She was sitting in wheelchair."</p> <p>4/29/15 - "Called [Name of Oncologist] office to request dictations of notes from her visit on 4/23/15." The facility's nursing services failed to monitor, assess and document any information in regard</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>to the client's diagnosis of Tubular Sclerosis and/or Anemia.</p> <p>Client A's 2/13/15 and 4/13/15 Comprehensive High Risk Health Plans indicated the following health problems for the Direct Care Staff to be aware of: constipation, chronic lower extremity edema, choking, skin breakdown secondary to urinary incontinence, and anemia. The anemia 4/13/15 care plan indicated "Triggers to notify the nurse - fatigue, increased sleeping, increased need for rest during normal task or activities of daily living, changes in balance, muscle weakness, shortness of breath." It also indicated staff should notify the nurse when changes in the client's condition are noted and to record the observation in a progress note. The facility's 4/13/15 High Risk Plan for anemia did not instruct staff to notify the nurse of any evidence of bleeding or to take the client's vital signs, such as blood pressure, to check for change in cognition, the presence of dizziness, chest pain, shortness of breath, and/or pale skin. Included in client A's Comprehensive High Risk Plan was one for Edema (swelling in the lower legs). The risk plan for edema indicated "have [client A] utilize the leg rests on wheelchair when wheelchair is used for extended periods." Client A's record</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>indicated the facility's nursing services failed to develop a high risk plan for the client's Tubular Sclerosis.</p> <p>Review of the Group Home Staff training was reviewed on 5/21/15 at 8:47 am. The facility's 1/3/14, 5/7/14, 5/19/14, 1/28/15, 2/16/15, 3/27/15, 4/20/15 and 5/1/15 Consumer Specific Training records did not specifically indicate the facility trained staff on when to call the nurse nor did it include specialized training in regard to the client's diagnosis of Tubular Sclerosis.</p> <p>Interview with the facility nurse was completed on 5/13/15 at 10:30 am. She stated "I have been trying to get an appropriate wheelchair with the recommended leg rests for [client A] since I started here at the facility over a year ago. I keep sending requests to the purchasing department but it has never been ordered." She indicated client A did have a wheelchair but it did not have any leg rests.</p> <p>Interview with LPN #1 on 5/19/15 and Clinical Supervisor (CS) #1 at 1:53 pm stated on 5/5/15 LPN #1 had gone to the group home to do "a nursing audit" of the Group Home clients' medical charts. LPN #1 stated staff at the group home advised her client A had been "experiencing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>significant bleeding either from the vagina or rectum all day." The LPN stated "staff thought [client A] was having her monthly period even though the client was 68 years old." The LPN indicated Group Home staff had been trained on client A's High Risk Plan for anemia and should have notified her during the morning of 5/5/15 of the abnormal bleeding so the client could be assessed by the nurse at that time. CS #1 stated "[client A's] Physical Therapist recommended a wheelchair with leg rests, but the client was using an older wheelchair without leg rests." CS #1 and LPN #1 indicated the facility had not developed a Risk Plan for the Tubular Sclerosis and therefore, staff had not been trained on what complications and signs and symptoms to monitor client A for.</p> <p>2. During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home, client H was small in size with a bony prominence seen in the client's upper arms/shoulder areas. During the 5/13/15 observation period, client H's pants fell off the client 3 different times as client H tried to walk from the back of the house to the medication room to get her morning medication. Client H had a belt on when her pants fell down. At 7:33 AM, client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>H was sitting at the dining room table attempting to eat her breakfast which consisted of oatmeal and toast cut into small pieces. Client H was unable to get bites of food into her mouth as the client's hand shook while she was attempting to eat. Client H stated "help me."</p> <p>Interview with client H on 5/19/15 at 11:06 AM indicated client H was losing weight. When asked why, client H stated "I don't know. Sometimes I do not want to eat. I don't like toast and oats."</p> <p>Client H's record was reviewed on 5/19/15 at 10:45 AM. Client H's 3/1/15 physician's order indicated client H was to be weighed weekly "...on Wednesday call nurse for 5# (pounds) gain or loss in 1 month."</p> <p>Client H's 12/29/14 Group Home Quarterly Nutrition Assessment indicated the following weights:</p> <p>5/14 110 pounds 6/14 109 pounds 7/14 111.4 pounds 8/14 no weight documented 9/14 121 pounds 10/14 no weight documented 11/14 122 pounds 12/14 125.4 pounds. Client H's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>nutritional assessment indicated client H had a "history of low weights." Client H's nutritional assessment indicated client H's ideal body weight was between 122 to 149 pounds.</p> <p>Client H's nursing Monthly Summaries indicated the following weights: 1/15 125 pounds 2/15 121 pounds 3/15 126 pounds</p> <p>Client H's April 2015 MAR indicated the following weights: 4/1/15 112 pounds 4/8/15 110.2 pounds 4/15/15 Refused 4/22/15 116.5 pounds 4/29/15 119.8 pounds</p> <p>Client H's 2/12/15 risk plans did not indicate client H had a risk plan in regard to the client's low weight and/or indicate how client H was to be weighed (standing scale or sitting scale) to ensure accurate/consistency in weights to determine if client H was losing and/or gaining weight.</p> <p>Confidential interview A indicated they were concerned about client H's weight loss. Confidential interview A stated "[Client H] is getting awful thin."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>Interview with Clinical Supervisor (CS) #1 and the QIDP-D on 5/19/15 at 11:40 AM indicated they were not sure how client H was being weighed. The QIDP-D indicated staff could be holding the client's hands while she was on the scale and/or client H could be sitting in the scale with a chair. The QIDP-D and CS #1 indicated client #1's ISP did not indicate how client H should be weighed for accuracy and/or consistency with weights.</p> <p>Interview with LPN #1 on 5/19/15 at 1:53 PM indicated she did not know how client H's weight was doing but she would check. LPN #1 indicated the facility had a standing scale and a sitting scale at the group home. LPN #1 indicated client H's ISP and/or risk plans did not indicate how client H was to be weighed for consistency to ensure the accuracy of the client's weights.</p> <p>3. Client H's record was reviewed on 5/19/15 at 10:45 AM. Client H's Record Of Visits indicated the following (not all inclusive):</p> <p>-8/5/14 Client H saw her doctor for a physical examination. The form indicated "...Please do a hemocult (checking for blood in stool) & (and)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>send me a copy of results. Send me a copy of recent mammogram results."</p> <p>-10/9/14 Client H went to have her mammogram done. The form indicated "Attempted to do exam pt (patient) refused after multiple attempts."</p> <p>A fax dated 11/12/13 indicated client H would not attend "...any appts (appointments) or is very combative once @ (at) appt. Can we get an order for a pre med (medication) for all appts? Valium 10 mg (milligrams po (by mouth) 1 hour prior to scheduled appointments."</p> <p>Client H's record indicated the facility's nursing services did not obtain the recommended Hemocult lab and/or mammogram examination.</p> <p>Interview with Clinical Supervisor (CS) #1 and LPN #1 on 5/19/15 at 1:53 PM indicated they were not sure if client H's ordered Hemocult lab and/or mammogram had been completed. LPN #1 indicated she would check. No additional information was provided.</p> <p>This federal tag relates to complaint #IN00172392.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0342 Bldg. 00	<p>483.460(c)(5)(iii) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on record review and interview for 1 of 4 sampled clients (A), the facility's nursing services failed to ensure group home staff were properly trained in regard to a client's health condition for Tubular Sclerosis (a rare genetic disorder of tumors on vital organs), and in regard to complications of the client's secondary diagnosis of anemia.</p> <p>Findings include:</p> <p>Review of the facility's reportables, internal incident reports and/or investigations were completed on 5/13/15 at 12:10 pm. A facility's Incident/Accident report dated 5/5/2015 at 8:20 am indicated "This morning while bathing [client A] she had brown dark brown blood (sic) on her. It was so dark I thought it was a bowel movement. I wiped her and it became lighter like</p>	W 0342	<p>CORRECTION:</p> <p><i>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Through staff interview and active treatment observation, the governing body has assessed that this deficient practice may have affected 7 additional clients: B – H. Therefore the facility nurse will facilitate training of all staff regarding proper implementation of all Comprehensive High Risk Plans.</i></p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>reddish. This continued throughout [client A's] day. It smelled bad - it had an odor to it." The facility Incident/Accident report did not indicate the facility's nurse was contacted in regard to the client's health status change.</p> <p>Client A's hospital records were reviewed on 5/13/15 at 2:30 pm. The 5/5/15 progress note signed by the Emergency Room physician indicated "the patient (client A) will be admitted to the hospital for GI bleeding, vaginal bleeding, dehydration and hypokalemia (low potassium)."</p> <p>Record review for client A was completed on 5/13/15 at 9:15 am. The Physician's Orders dated 4/1/15 - 4/30/15 indicated client A's diagnoses included but were not limited to Tubular Sclerosis and Normocytic Normochromic Anemia (decrease in number of red blood cells/chronic disease).</p> <p>A Record of Visit dated 4/3/15 from client A's primary care physician indicated "patient with bilateral angiomyolipoma (tumor in the kidney), probably renal cell carcinoma - hospitalized 2 times over past month. Last hospitalization was to ER and Lasix (diuretic) 40 mg (milligrams) bid (twice daily) was ordered. ER evaluation was</p>		<p>PREVENTION:</p> <p>The nurse, QIDP and Residential Manager will each conduct record reviews and face to face assessments to assure that staff display an appropriate level of competency with the implementation of Comprehensive High Risk Plans. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. 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. 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>for hemorrhoids. Legs are 3 - 4 pitting edema. Diagnosis: 1) Bilateral Angiomyolipoma, 2) Probable Renal Cell Cancer, 3) Hemorrhoids and 4) Edema of legs - keep Lasix and TED/support hose. BMP (Basic Metabolic Panel) to be done every two weeks."</p> <p>A Record of Visit form dated 4/9/14 indicated client A's physician wrote an order for client A to be evaluated for appropriateness of a wheelchair. A recommendation dated 8/13/14 was faxed to the facility from the Physical Therapist on 8/13/14 and again on 8/18/14. It indicated "based on the Physical Therapy/Mobility evaluation performed on 4/9/14, [client A] is in need of a standard wheelchair with leg rests for elevation of the legs."</p> <p>A Record of Visit dated 4/23/15 from client A's Neurologist indicated "Sz (seizure), 1st in years. Diagnosis - Seizure, Tubular Sclerosis. Recommendations for treatment EEG (Electroencephalogram), CT (Computed Tomography) of the head. D/C (discontinue) Dilantin, start Vimpat 200 mg x 1 dose, then 50 mg bid (twice daily) for one week, then 100 mg twice daily." A Record of visit dated 4/23/15 at client A's Oncologist indicated "referral for liposarcoma, recommended surgery</p>		<p>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> <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. As stated above, the Executive</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>biopsy to confirm diagnosis. Depending on biopsy will determine chemotherapy or palliative care. Family must make decision."</p> <p>Client A's 2/13/15 and 4/13/15 Comprehensive High Risk Health Plans indicated the following health problems for the Direct Care Staff to be aware of: constipation, chronic lower extremity edema, choking, skin breakdown secondary to urinary incontinence, and anemia. The anemia 4/13/15 care plan indicated "Triggers to notify the nurse - fatigue, increased sleeping, increased need for rest during normal task or activities of daily living, changes in balance, muscle weakness, shortness of breath." It also indicated staff should notify the nurse when changes in the client's condition are noted and to record the observation in a progress note. The facility's 4/13/15 High Risk Plan for anemia did not instruct staff to notify the nurse of any evidence of bleeding or to take the client's vital signs, such as blood pressure, to check for change in cognition, the presence of dizziness, chest pain, shortness of breath, and/or pale skin. Included in client A's Comprehensive High Risk Plan was one for Edema (swelling in the lower legs). The risk plan for edema indicated "have [client A] utilize the leg rests on</p>		<p>Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include assuring staff demonstrate competency in the implementation of all Comprehensive High Risk Plans.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>wheelchair when wheelchair is used for extended periods."</p> <p>Review of the Group Home Staff training was reviewed on 5/21/15 at 8:47 am. The facility's 1/3/14, 5/7/14, 5/19/14, 1/28/15, 2/16/15, 3/27/15, 4/20/15 and 5/1/15 Consumer Specific Training records did not specifically indicate the facility trained staff on when to call the nurse nor did it include specialized training in regard to the client's diagnosis of Tubular Sclerosis.</p> <p>Interview with LPN #1 on 5/19/15 and Clinical Supervisor (CS) #1 at 1:53 pm stated on 5/5/15 LPN #1 had gone to the group home to do "a nursing audit" of the Group Home clients' medical charts. LPN #1 stated staff at the group home advised her client A had been "experiencing significant bleeding either from the vagina or rectum all day." The LPN stated "staff thought [client A] was having her monthly period even though the client was 68 years old." The LPN indicated Group Home staff had been trained on client A's High Risk Plan for anemia and should have notified her during the morning of 5/5/15 of the abnormal bleeding so the client could be assessed by the nurse at that time. CS #1 and LPN #1 indicated facility staff had not been trained on what complications</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0382 Bldg. 00	<p>and signs and symptoms to monitor client A for.</p> <p>This federal tag relates to complaint #IN00172392.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on and observation and interview for 3 of 4 sampled clients (B, C, and D) and 4 additional clients (E, F, G, H) the facility failed to keep the door to the medication room locked as well as keeping the lock box containing Narcotics secured when staff was not administering medications.</p> <p>Findings include:</p> <p>During morning observation at the Group Home on 5/13/15 at 7:35 am, staff #2 left the medication room and went to the kitchen to check on toast in the oven. The door to the medication room was left open and the narcotics lock box was not secured. Client G was observed entering the medication room. She then turned around and exited shortly thereafter.</p>	W 0382	<p>CORRECTION:</p> <p><i>The facility must keep all drugs and biologicals locked except when being prepared for administration. Specifically, the nurse will facilitate retraining of all staff regarding the operation's medication administration procedures which are consistent with Core A and Core B (Living in the Community), including but not limited to keeping the medication room locked and/or the medications secured in a locked cabinet when the medications are not being prepared or administered.</i></p> <p>PREVENTION:</p> <p>The Residential Manager will be</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 B, C, D, E F and G's medications were kept in the unlocked office area.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional - Designee) was completed on 5/14/15 at 5:20 pm. She stated "the med room (medication room) should always be locked when staff is not administering medications and the Narcotics lock box should always be locked when staff is not in the med room."</p> <p>9-3-6(a)</p>		<p>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 assuring the provision of continuous active treatment. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure staff secure medication per Living in the Community standards. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. 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. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>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> <p>The Executive Director and Director of Operations/Regional</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0436 Bldg. 00	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on record review and interview for 1 of 8 clients (client A), the facility failed to provide an appropriate wheelchair with leg rests.</p> <p>Findings include:</p>	W 0436	<p>Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the <i>facility</i>. Administrative support at the home will include assuring staff secure medication per Living in the Community standards.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing</i></p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205			
(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>Review of client A's medical records was completed on 5/14/2015 at 9:45 AM. A 4/9/14 Record of Visit form indicated client A's physician wrote an order for client A to be evaluated for appropriateness of a wheelchair. A recommendation dated 8/13/14 was faxed to the facility from the Physical Therapist on 8/18/14. It indicated "based on the Physical Therapy/Mobility evaluation performed on 4/9/14, [client A] is in need of a standard wheelchair with leg rests for elevation of the legs." Included in client A's 2/13/15 Comprehensive High Risk Plan was one for Edema (swelling in the lower legs). The risk plan for edema indicated "have [client A] utilize leg rests on wheelchair when wheelchair is used for extended periods."</p> <p>Interview with the facility nurse was completed on 5/13/15 at 9:15 am. She stated "I have been trying to get an appropriate wheelchair with the recommended leg rests for [client A] since I started here at the facility over a year ago. I keep sending requests to the purchasing department but it has never been ordered." She indicated client A did have a wheelchair but it did not have any leg rests.</p> <p>This federal tag relates to complaint</p>		<p><i>and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</i> Specifically, a review of facility adaptive equipment needs indicated that this deficient practice affected one client in addition to Former client A –Client E. The facility will assure that Client E's bedroom audio monitor and chair alarm function properly and that all staff are trained on their use and maintenance.</p> <p>PERVENTION:</p> <p>Facility Professional staff have been retrained regarding the need to furnish all necessary adaptive equipment to all clients. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will review assessment data and compare it to adaptive equipment available at the facility, making recommendations and expediting the acquisition of new and additional adaptive equipment as appropriate. These reviews will occur as needed but no less than quarterly. Additionally, the QIDP has revised each Client's adaptive equipment checklist to include</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205		
(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 0460 Bldg. 00	<p>#IN00172392.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation and interview for 3 of 4 sampled clients (B, C and D) and for 4 additional clients (E, F, G and H), the facility failed to post a menu to indicate what clients were to eat and to ensure a sufficient food supply was kept at the group home.</p> <p>Findings include:</p> <p>During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home for clients B, C, D and H, had staff #2 custodially prepared the oatmeal, toast in the oven for the clients' breakfast. Client B prepared juice for them to drink. Clients B and C only had oatmeal and juice and client D had cold cereal and juice for breakfast. At one</p>	W 0460	<p>more detail to assist with maintaining equipment in good repair.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Specifically, the Clinical Supervisor has provided a set of current menus to the facility. All staff have been retrained regarding the need to follow the facility's menu or to provide documentation to the dietician that appropriate, nourishing substitution occurs. Additionally, the Residential Manager and Team Lead will assure that menued food items are available in the home to prepare as scheduled.</i></p>	06/27/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>point while staff #2 was preparing the breakfast, staff #2 indicated there were no eggs to cook. No menu was posted in the kitchen. During the above mentioned observation period, there was a pile of green menus stacked on top of the microwave. The menus did not have a date on them and there was no order to the menus. At 7:55 AM, observation of the food supply indicated the facility was low on food for clients B, C, D, E, F, G and H to eat. The facility had 1 roll of hamburger, 1 pack of chicken, several packs of vegetables, a bag of greens, and french fries in the refrigerator's freezer.</p> <p>Interview with staff #2 on 5/13/15 at 7:32 AM in regards to what menu he was following, staff #2 looked through the stack of menus on the microwave and shrugged his shoulders. Staff #2 did not locate any menu. Staff #2 stated "I give them oatmeal" and walked away.</p> <p>Interview with Clinical Supervisor (CS) #1 on 5/19/15 at 11:40 AM indicated the group home should have a menu posted. CS #1 indicated he realized there was no menu when he arrived at the group home on 5/13/15. CS #1 stated the group home's menu was "not in a functional state." CS #1 stated the grocery shopping was to be done at the beginning of the week but the "team lead was out sick."</p>		<p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring the staff assists clients with preparing meals according to the established menu.</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 during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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
	CS #1 indicated he sent the staff to the store on 5/13/15 to get food for the group home. 9-3-8(a)		<p>Days. 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. 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>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. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring the staff assists clients with preparing meals according to the established menu.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 0488 Bldg. 00	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D) and for 4 additional clients (E, F, G and H), the facility failed to ensure the clients participated in meal preparation and/or ate at a level they were capable of.</p> <p>Findings include:</p> <p>During the 5/13/15 observation period between 5:40 AM and 8:00 AM, at the group home, staff #2 custodially prepared the oatmeal, placed bread on a cookie sheet and placed it in the oven without involving clients B, C, D, E, F, G and H. At one point, client B came into the kitchen while staff #2 was preparing the breakfast and independently prepared a container of juice. At 7:18 AM, staff #3 placed 1 scoop of oatmeal into 4 separate bowls and sat the bowls on the table. Client B started to eat her oatmeal but the oatmeal stuck to the spoon. Client B asked staff #3 if she could have honey to put in her oatmeal. Staff #3 suggested client B put milk in her oatmeal. Client</p>	W 0488	<p>Leader, Direct Support Staff, Operations Team, Dietician</p> <p>CORRECTION:</p> <p><i>The facility must assure that each client eats in a manner consistent with his or her developmental level. Specifically, staff will be retrained regarding the need to assure all clients participate in all aspects of meal preparation to the extent of their capabilities. Additionally, the facility will modify the staffing matrix to assure that there are no less than two staff on duty at meal times.</i></p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>B indicated she did not like milk in her oatmeal. Client H added sugar to her oatmeal to eat. Staff #3 sat the juice on the table for the clients to drink. Staff #3 did not offer the clients' toast to eat with their oatmeal as staff #3 was not aware the toast was in the oven. Client D told staff #3 she did not want the oatmeal for breakfast. Staff #3 fixed client D a bowl of cereal without allowing the client to make her own bowl of cereal. At 7:33 AM, client H was at the table to eat. Staff #2 then told staff #3 about the toast. Staff #3 took 2 slices of the toast, buttered them and cut them into small pieces for client H without involving the client.</p> <p>Client C's record was reviewed on 5/18/15 at 2:30 PM. Client C's 7/1/14 Individual Support Plan (ISP) indicated the client had an objective to prepare side dish on the menu for that day.</p> <p>Client D's record was reviewed on 5/18/15 at 3:30 PM. Client D's 9/11/14 ISP indicated client D had an objective to assist in meal preparation.</p> <p>Client B's record was reviewed on 5/18/15 at 3:49 PM. Client B's 6/2/14 ISP indicated client B had an objective to prepare a side dish on menu.</p>		<p>(non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation and other domestic activities.</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 during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. 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. 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,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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>Interview with Clinical Supervisor (CS) #1 on 5/19/15 at 11:40 AM indicated facility staff should be encouraging and assisting clients to cook their meals. CS #1 stated clients should prepare their own cereal and should "be cooking as a part of active treatment."</p> <p>9-3-8(a)</p>		<p>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> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G565	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 5011 ALLISONVILLE RD INDIANAPOLIS, IN 46205
---	---

(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 –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to meal preparation and family style dining.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	