

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2014
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W000000	<p>This visit was for the investigation of complaint #IN00150116.</p> <p>Complaint #IN00150116: SUBSTANTIATED, Federal and State deficiencies related to the allegations are cited at W149 and W249.</p> <p>Dates of Survey: 5/30, 5/31, 6/2, and 6/3/2014.</p> <p>Facility Number: 001008 Provider Number: 15G494 AIM Number: 100245080</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/10/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview for 6 incidents of AWOL (Absence Without Leave) (client A), the facility neglected to supervise client A</p>	W000149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of</i></p>	07/03/2014

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

TITLE

(X6) DATE

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

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	<p>based on client A's identified behavioral needs.</p> <p>Findings include:</p> <p>On 5/30/14 at 3:10pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 03/1/14 through 05/30/14 and indicated the following:</p> <p>-5/29/14 BDDS report for an incident on 5/29/14 at 12:30am indicated client A "who has a history of elopement, was upset because his Level of Care had been revoked and in 30 days he will no longer be eligible to receive [group home] or Waiver services." The report indicated client A "exited the house through the unlocked back door and began running," staff followed, and staff lost sight of client A. The report indicated the police were called and a missing persons report was filed. Client A was not returning multiple calls by the agency to his personal cell phone. The report indicated client A was "competent to spend 4 hours daily without supervision. He had used his supervision free time earlier in the evening and therefore staff implemented his elopement procedures when he left the house...[Client A's undated] assessment data indicates that [client A's]</p>		<p><i>the client.</i> Specifically, in response to planned changes to formal supports to enhance supervision and provide for safety, Client A voluntarily discontinued his participation in the ICF program, severed ties with the Bureau of Developmental Disability Services and no longer resides at the facility. The agency has offered to assist Client A and Client A's family with accessing alternative supports. A review of current supports and incident documentation indicates this deficient practice does not currently affect other clients living at the facility.</p> <p>PREVENTION: The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes and plan revisions to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations</p>		

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	<p>substantial functional limitation in the area of self Direction makes him a potential danger to himself when unsupervised for extended periods of time over four hours."</p> <p>-A 5/5/14 BDDS report for an incident on 5/5/14 at 1:25am indicated client A "had climbed out his unlocked bedroom window. Two staff were on duty at the time and were aware almost immediately that [client A] had exited the building. Staff searched the neighborhood and when they could not locate [client A], staff called 9-1-1 per the elopement protocol in [client A's] Behavior Support Plan. [Client A] who has a lengthy history of elopement, returned home on his own at 1:30pm and was not injured." The report indicated "The Clinical Supervisor has requested a meeting with the Bureau of Developmental Disability Services to discuss the fact that [client A] has stated repeatedly that he will not participate in the Supervised Group Home Living Program and that [client A] plans to continue to elope if he remains in his current residential setting."</p> <p>-A 4/18/14 BDDS report for an incident on 4/17/14 at 9:30pm, indicated client A "who has a history of leaving the assigned area was agitated throughout the evening due to an interdisciplinary team</p>		Team		

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	<p>decision to suspend his unsupervised community time due to safety concerns. While staff were providing first aid to a housemate, [client A] climbed out of his unlocked bedroom window and left the area. Two staff were on duty at the time and it was approximately 10 minutes before another housemate reported [client A] had left. Staff and supervisors initiated a search but were not able to locate [client A]. After 90 minutes a missing person's report was filed with the police per the elopement protocol in [client A's] behavior support plan. [Client A] remained away from ResCare supervision for 17 hours and returned to the service site on his own and unharmed."</p> <p>-A 4/17/14 BDDS report for an incident on 4/17/14 at 4:00pm, indicated "It was brought to the attention of the Residential Manager (RM) that a housemate observed [client A] hiding a plastic bag with a green leafy substance in the bathroom of his home. The RM immediately reported to the QIDP (Qualified Intellectual Disabilities Professional) who informed the Administration team. [Client A] stated that he obtained the green leafy substance from his cousin while out on alone time in the community. Team met and has suspended [client A's] alone time</p>			

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	<p>indefinitely. [Client A] stated that he would like to sign his self out of ResCare and that he would be calling BDDS." The report indicated the team had requested a meeting with BDDS and client A.</p> <p>-A 3/30/14 BDDS report for an incident on 3/29/14 at 1:00pm indicated client A "is assessed as competent to have four hours of unsupervised time per day. On 3/29/14, [client A] reported to staff that he had been hit by a car while walking during the previous day and said that his left leg hurt." The report indicated client A had no visible injuries and was transported to the hospital Emergency Room. The report indicated client A was diagnosed with a "Tibial Plateau Fracture" and was referred to an Orthopedic physician. A police report was filed.</p> <p>-A 4/11/14 Follow up BDDS report indicated client A was seen on 3/31/14 by the Orthopedic physician and "After multiple tests, the Orthopedic doctor could not find any indication of any injury...No signs of a Tibial Plateau Fracture." The report indicated client A no longer had discomfort and/or pain in his leg.</p> <p>-The 4/2014 investigation into the incident indicated client A was not struck by a car and misrepresented the incident.</p>			

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	<p>During observations on 5/30/14 from 5:45pm until 6:10pm, at the group home client A was not present.</p> <p>Client A's record was reviewed on 5/30/14 at 3:40pm. Client A was admitted on 8/26/13 from the Foster Care System. Client A's 11/22/13 ISP (Individual Support Plan) and 10/22/13 BSP (Behavior Support Plan) indicated client A should be supervised by the facility staff. Client A's BSP indicated targeted behaviors of Physical Aggression, Verbal Aggression, Elopement, and Non Compliance with programming. Client A's BSP indicated "Leaves Assigned Area: One staff will follow [client A] and initially keep a bit of distance between him and themselves no more than 10 feet. If possible the second staff will use the van to follow...Let [client A] know that once he returns back to the home you and he will talk about what is upsetting him and help him come up with a solution...If [client A] is no longer in staffs line of sight, 9-1-1 is to be called...9-1-1 Emergency System may only be used when individual behaviors jeopardize the safety and well being of peers, community members and staff and only when all ResCare-Indianapolis ICF and Human Rights Committee approved de escalation</p>			
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	<p>and redirection techniques have been utilized and exhausted...."</p> <p>On 5/30/14 from 3:10pm until 5:10pm, an interview with the Clinical Supervisor (CS) #1 and CS #2 was conducted. Both the CS #1 and CS #2 indicated client A had left the home repeatedly without permission. CS #1 and CS #2 indicated the facility followed the BDDS reporting policy for abuse/neglect/mistreatment and both stated client A "was not" being supervised by facility staff when he was AWOL from the facility. CS #1 and CS #2 both stated client A "was quick" to leave and had left the facility even though client A continued to have four hours of alone time daily.</p> <p>On 5/30/14 at 5:00pm, CS #1 and CS #2 both indicated client A continued to be a client living in the group home and client A was not being supervised when client A continued to leave the facility AWOL.</p> <p>On 5/30/14 at 6:20pm, an interview was conducted with CS #2. CS #2 indicated he located client A walking south on [name of street, city] and client A returned to the group home.</p> <p>On 5/31/14 at 9:23am, CS #1 sent an E-mail which stated "I believe [CS #2] spoke to you yesterday evening, but I</p>			

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	<p>wanted to sent a note to confirm that on 5/30/14 at approximately 6:45pm, [CS #2] located [client A] walking with a friend on [name of street, city]. [Client A] returned to his SGL (Group Home) residence willingly and remains there at this time. A meeting has been scheduled for 6/2/14 with BDDS to discuss options for [client A's] transition."</p> <p>On 5/30/14 at 3:30pm, a record review was conducted of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 5/30/14 at 3:30pm, a record review was conducted of the facility's 9/14/2007 policy and procedures for Abuse, Neglect, Exploitation indicated allegations of neglect, exploitation and/or abuse indicated "Abuse, Neglect, Exploitation" neglect was defined as "failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment...." The 9/14/107 policy indicated failure to implement clients'</p>			

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W000249	<p>program plans could also be considered neglect.</p> <p>This federal tag relates to complaint #IN00150116.</p> <p>9-3-2(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.</p> <p>Based on observation, record review, and interview, for 6 incidents of AWOL (Absence Without Leave) (client A), the facility failed to supervise client A based on client A's identified behavioral needs/program.</p> <p>Findings include:</p> <p>On 5/30/14 at 3:10pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 03/1/14 through 05/30/14 and indicated the following:</p> <p>-5/29/14 BDDS report for an incident on</p>	W000249	<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.</i></p> <p>Specifically, in response to planned changes to formal supports to enhance supervision and provide for safety, Client A voluntarily discontinued his participation in the ICF program, severed ties with the Bureau of Developmental Disability Services and no longer resides at the</p>	07/03/2014

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	<p>5/29/14 at 12:30am indicated client A "who has a history of elopement, was upset because his Level of Care had been revoked and in 30 days he will no longer be eligible to receive [group home] or Waiver services." The report indicated client A "exited the house through the unlocked back door and began running," staff followed, and staff lost sight of client A. The report indicated the police were called and a missing persons report was filed. Client A was not returning multiple calls by the agency to his personal cell phone. The report indicated client A was "competent to spend 4 hours daily without supervision. He had used his supervision free time earlier in the evening and therefore staff implemented his elopement procedures when he left the house...[Client A's undated] assessment data indicates that [client A's] substantial functional limitation in the area of self Direction makes him a potential danger to himself when unsupervised for extended periods of time over four hours."</p> <p>-A 5/5/14 BDDS report for an incident on 5/5/14 at 1:25am indicated client A "had climbed out his unlocked bedroom window. Two staff were on duty at the time and were aware almost immediately that [client A] had exited the building. Staff searched the neighborhood and</p>		<p>facility. The agency has offered to assist Client A and Client A's family with accessing alternative supports. A review of current supports and incident documentation indicates this deficient practice does not currently affect other clients living at the facility.</p> <p>PREVENTION: The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes and plan revisions to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>	

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	<p>when they could not locate [client A], staff called 9-1-1 per the elopement protocol in [client A's] Behavior Support Plan. [Client A] who has a lengthy history of elopement, returned home on his own at 1:30pm and was not injured." The report indicated "The Clinical Supervisor has requested a meeting with the Bureau of Developmental Disability Services to discuss the fact that [client A] has stated repeatedly that he will not participate in the Supervised Group Home Living Program and that [client A] plans to continue to elope if he remains in his current residential setting."</p> <p>-A 4/18/14 BDDS report for an incident on 4/17/14 at 9:30pm, indicated client A "who has a history of leaving the assigned area was agitated throughout the evening due to an interdisciplinary team decision to suspend his unsupervised community time due to safety concerns. While staff were providing first aid to a housemate, [client A] climbed out of his unlocked bedroom window and left the area. Two staff were on duty at the time and it was approximately 10 minutes before another housemate reported [client A] had left. Staff and supervisors initiated a search but were not able to locate [client A]. After 90 minutes a missing person's report was filed with the police per the elopement protocol in</p>			

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	<p>[client A's] behavior support plan. [Client A] remained away from ResCare supervision for 17 hours and returned to the service site on his own and unharmed."</p> <p>-A 4/17/14 BDDS report for an incident on 4/17/14 at 4:00pm, indicated "It was brought to the attention of the Residential Manager (RM) that a housemate observed [client A] hiding a plastic bag with a green leafy substance in the bathroom of his home. The RM immediately reported to the QIDP (Qualified Intellectual Disabilities Professional) who informed the Administration team. [Client A] stated that he obtained the green leafy substance from his cousin while out on alone time in the community. Team met and has suspended [client A's] alone time indefinitely. [Client A] stated that he would like to sign his self out of ResCare and that he would be calling BDDS." The report indicated the team had requested a meeting with BDDS and client A.</p> <p>-A 3/30/14 BDDS report for an incident on 3/29/14 at 1:00pm indicated client A "is assessed as competent to have four hours of unsupervised time per day. On 3/29/14, [client A] reported to staff that he had been hit by a car while walking</p>			

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	<p>during the previous day and said that his left leg hurt." The report indicated client A had no visible injuries and was transported to the hospital Emergency Room. The report indicated client A was diagnosed with a "Tibial Plateau Fracture" and was referred to an Orthopedic physician. A police report was filed.</p> <p>-A 4/11/14 Follow up BDDS report indicated client A was seen on 3/31/14 by the Orthopedic physician and "After multiple tests, the Orthopedic doctor could not find any indication of any injury...No signs of a Tibial Plateau Fracture." The report indicated client A no longer had discomfort and/or pain in his leg.</p> <p>-The 4/2014 investigation into the incident indicated client A was not struck by a car and misrepresented the incident.</p> <p>During observations on 5/30/14 from 5:45pm until 6:10pm, at the group home client A was not present.</p> <p>Client A's record was reviewed on 5/30/14 at 3:40pm. Client A was admitted on 8/26/13 from the Foster Care System. Client A's 11/22/13 ISP (Individual Support Plan) and 10/22/13 BSP (Behavior Support Plan) indicated client A should be supervised by the facility staff. Client A's BSP indicated</p>			

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	<p>targeted behaviors of Physical Aggression, Verbal Aggression, Elopement, and Non Compliance with programming. Client A's BSP indicated "Leaves Assigned Area: One staff will follow [client A] and initially keep a bit of distance between him and themselves no more than 10 feet. If possible the second staff will use the van to follow...Let [client A] know that once he returns back to the home you and he will talk about what is upsetting him and help him come up with a solution...If [client A] is no longer in staffs line of sight, 9-1-1 is to be called...9-1-1 Emergency System may only be used when individual behaviors jeopardize the safety and well being of peers, community members and staff and only when all ResCare-Indianapolis ICF and Human Rights Committee approved de escalation and redirection techniques have been utilized and exhausted...."</p> <p>On 5/30/14 from 3:10pm until 5:10pm, an interview with the Clinical Supervisor (CS) #1 and CS #2 was conducted. Both the CS #1 and CS #2 indicated client A had left the home repeatedly without permission. CS #1 and CS #2 indicated the facility followed the BDDS reporting policy for abuse/neglect/mistreatment and both stated client A "was not" being supervised by facility staff when he was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2014
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	<p>AWOL from the facility. CS #1 and CS #2 both stated client A "was quick" to leave and had left the facility even though client A continued to have four hours of alone time daily.</p> <p>On 5/30/14 at 5:00pm, CS #1 and CS #2 both indicated client A continued to be a client living in the group home and client A was not being supervised when client A continued to leave the facility AWOL.</p> <p>On 5/30/14 at 6:20pm, an interview was conducted with CS #2. CS #2 indicated he located client A walking south on [name of street, city] and client A returned to the group home.</p> <p>On 5/31/14 at 9:23am, CS #1 sent an E-mail which stated "I believe [CS #2] spoke to you yesterday evening, but I wanted to sent a note to confirm that on 5/30/14 at approximately 6:45pm, [CS #2] located [client A] walking with a friend on [name of street, city]. [Client A] returned to his SGL (Group Home) residence willingly and remains there at this time. A meeting has been scheduled for 6/2/14 with BDDS to discuss options for [client A's] transition."</p> <p>This federal tag relates to complaint #IN00150116.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	9-3-4(a)				