

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 12/28/2012
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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W0000	<p>This visit was for the investigation of complaint #IN00121350.</p> <p>Complaint #IN00121350: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W149, W153 and W157.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 12/27/12 and 12/28/12</p> <p>Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/4/13 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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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W0149	<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 record review and interview for 3 of 9 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed for 3 of 4 sampled clients (A, C and D), the facility failed to implement its policy and procedures to ensure the facility immediately notified BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an incident of abuse for client A. The facility failed to implement its policy and procedures to ensure the facility reported the results of investigations of client to client abuse to the administrator within 5 days for clients A, C and D. The facility failed to implement its policy and procedures to ensure the facility implemented corrective action following the investigation of abuse regarding client A. The facility failed to implement its policy and procedures to ensure the facility implemented corrective action following the investigations of client to client abuse regarding clients A, C and D.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services)</p>	W0149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the facility:</i></p> <p>1. The employment of staff #1, Staff #2 and staff #3, who failed to report the allegation of abuse on 11/23/12, has been terminated.</p> <p>2. The results of the investigation into an incident of aggression between Client A and client D on 12/9/12 and between Client A and Client C on 12/16/12 will be reported to the administrator as required.</p> <p>3. Facility direct support staff have been retrained regarding abuse/neglect/mistreatment detection and prevention as recommended in the investigation concluded 12/14/12. In addition, the interdisciplinary team will meet to discuss measures to prevent further aggression between Client A and Clients C and D subsequent to investigations of client to client aggression that occurred on 12/9/12 and 12/16/12.</p> <p>PREVENTION:</p> <p>1. All direct support staff have been retrained regarding the need to report observed or suspected abuse, neglect,</p>	01/27/2013			

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	<p>reports and investigations were reviewed on 12/27/12 at 11:13 AM. The review indicated the following:</p> <p>-BDDS initial incident report dated 12/7/12 indicated, "It was brought to the attention of the ResCare supervisory personnel on 12/6/12 that a verbal argument between [client A] and staff occurred on the day of 11/23/12 at 1:30 PM. A neighbor near the [group home] witnessed 3 staff arguing with [client A] outside of the home."</p> <p>-BDDS follow up report dated 12/14/12 indicated, "The outcome of the investigation substantiated that staff were involved in arguing with [client A] outside the home. Additional evidence from the investigation indicated that [client A] was outside without a shirt on during this time and that staff kept him from entering the house for 20 minutes. The allegation of emotional abuse was substantiated. The three staff who were involved at the time of the incident [staff #1] , [staff #2] and [staff #3] have had their employment terminated. [Police] has also been contacted and a police report filed. [Client A] has been offered emotional support. Retraining to occur with [group home] staff on individual rights, respect and dignity as well as recognizing and reporting abuse, neglect,</p>		<p>mistreatment and exploitation immediately and refresher training for reporting expectations has been incorporated into monthly staff meeting agendas. Additionally, as part of its quarterly audit process, members of the Quality Assurance Team will interview staff to assure they have a clear understanding of reporting requirements.</p> <p>2. Professional staff will be retrained regarding proper completion of agency approved investigation report forms. The Quality Assurance Department will review completed investigation reports to assure reports are completed accurately and notification of investigation results occurs as required.</p> <p>3. The QDDP will bring all relevant elements of the interdisciplinary team together after incidents of client to client aggression to review current supports and to make adjustments and revisions as needed. The QDDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up.</p> <p>QDDPD, Team Lead, Direct Support Staff, Quality Assurance Team, Operations Team</p>				

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	<p>exploitation and mistreatment."</p> <p>-Investigation form dated 12/14/12 indicated, "The evidence substantiates that [staff #1], [staff #2] and [staff #3] locked [client A] (out of the house) on the afternoon of 11/23/12. The evidence substantiates the [client A] was not dressed appropriately for the weather while he was unable to re-enter his home. The evidence substantiates that [client A] experienced mental anguish as a result of the incident." The 12/14/12 investigation indicated staff #3 did not report the alleged abuse regarding staff #1, staff #2 and client A. The investigation indicated staff #3's participation in the incident was limited to watching the incident and not reporting.</p> <p>AS (administrative staff) #1 was interviewed on 12/27/12 at 12:45 PM. AS #1 indicated allegations of abuse, mistreatment, injuries of unknown origin and exploitation should be reported immediately to the QMRP (qualified mental retardation professional). AS #1 indicated the QMRP should then report the allegation to BDDS within 24 hours of being notified. AS #1 indicated staff #1, staff #2 and staff #3 did not report the allegation of abuse regarding 11/23/12 for client A to the QMRP or supervisory staff.</p>						

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	<p>The facility's policy and procedures were reviewed on 12/28/12 at 11:25 AM. The facility's 9/14/07 policy and procedure entitled Abuse, Neglect, Exploitation operating standard 1.26 indicated, "Following ResCare protocol for the exact process to report incidents, once the suspicion has been reported to the supervisor and/or PD (Program Director), the PD will report, within 24 hours, the suspected abuse, neglect or exploitation as follows:</p> <p>G. "To the BDDS central office...."</p> <p>2. The facility's 9/14/07 policy and procedure entitled, "Investigations" indicated, "Practices: 3. (b) Ensure alleged incident of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date the allegations were made and investigation was initiated."</p> <p>The facility failed to implement its policy and procedures to ensure the facility reported the results of investigations of client to client abuse to the administrator within 5 days for clients A, C and D. Please see W156.</p> <p>3. The facility's 9/14/07 policy and</p>				

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	<p>procedure entitled, "Investigations" indicated, "10. A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to the following: concerns and recommendations; methods to prevent future incidents."</p> <p>The facility failed to implement its policy and procedures to ensure the facility implemented corrective action following the investigations of client to client abuse regarding clients A, C and D. The facility failed to implement its policy and procedures to ensure the facility implemented corrective action following the investigation of staff to client abuse regarding client A. Please see W157.</p> <p>This federal tag relates to complaint #IN00121350.</p> <p>9-3-2(a)</p>				

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 9 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed for 1 of 4 sampled clients (A), the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an incident of staff abuse for client A.</p> <p>Findings include:</p> <p>The facility's BDDS reports and investigations were reviewed on 12/27/12 at 11:13 AM. The review indicated the following:</p> <p>-BDDS initial incident report dated 12/7/12 indicated, "It was brought to the attention of ResCare supervisory personnel on 12/6/12 that a verbal argument between [client A] and staff occurred on the day of 11/23/12 at 1:30 PM. A neighbor near the [group home] witnessed 3 staff arguing with [client A] outside of the home."</p>	W0153	<p>CORRECTION: The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, the employment of staff #1, Staff #2 and staff #3, who failed to report the allegation of abuse on 11/23/12, has been terminated. PREVENTION: All direct support staff have been retrained regarding the need to report observed or suspected abuse, neglect, mistreatment and exploitation immediately and refresher training for reporting expectations has been incorporated into monthly staff meeting agendas. Additionally, as part of its quarterly audit process, members of the Quality Assurance Team will interview staff to assure they have a clear understanding of reporting requirements. RESPONSIBLE PARTIES: QDDPD, Team Lead, Direct Support Staff, Quality Assurance Team, Operations Team</p>	01/27/2013	

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	<p>-BDDS follow up report dated 12/14/12 indicated, "The outcome of the investigation substantiated that staff were involved in arguing with [client A] outside the home. Additional evidence from the investigation indicated that [client A] was outside without a shirt on during this time and that staff kept him from entering the house for 20 minutes. The allegation of emotional abuse was substantiated."</p> <p>-Investigation form dated 12/14/12 indicated, "The evidence substantiates that [staff #1], [staff #2] and [staff #3] locked [client A] (out of the house) on the afternoon of 11/23/12. The evidence substantiates [client A] was not dressed appropriately for the weather while he was unable to re-enter his home. The evidence substantiates that [client A] experienced mental anguish as a result of the incident." The 12/14/12 investigation indicated staff #3 did not report the alleged abuse regarding staff #1 and staff #2 toward client A to the her supervisor or administrative staff. The investigation indicated staff #3's participation in the incident was limited to watching the incident and not reporting.</p> <p>AS (administrative staff) #1 was interviewed on 12/27/12 at 12:45 PM indicated allegations of abuse,</p>				

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	<p>mistreatment, injuries of unknown origin and exploitation should be reported immediately to the QMRP (qualified mental retardation professional). AS #1 indicated the QMRP should then report the allegation to BDDS within 24 hours of being notified. AS #1 indicated staff #1, staff #2 and staff #3 did not report the allegation of abuse regarding 11/23/12 for client A to the QMRP or supervisory staff.</p> <p>This federal tag relates to complaint #IN00121350.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>				

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 2 of 9 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed for 3 of 4 sampled clients (A, C and D), the facility failed to report the results of investigations of client to client abuse to the administrator within 5 days for clients A, C and D.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/27/12 at 11:13 AM. The review indicated the following:</p> <p>-BDDS report dated 12/16/12 indicated, "[Client A] was agitated about calling his sister. [Client A] begin (sic) getting irate and charging the other individuals that were in the living room, so staff redirected those individuals to their bedroom. [Client C] heard the commotion and came out of his bedroom (sic) before staff could intervene [client A] grabbed [client C] by the arm and attempted to bite him. Staff was able to redirect [client</p>	W0156	<p>CORRECTION: <i>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Specifically, the results of the investigation into an incident of aggression between Client A and client D on 12/9/12 and between Client A and Client C on 12/16/12 will be reported to the administrator as required.</i></p> <p>PREVENTION: Professional staff will be retrained regarding proper completion of agency approved investigation report forms. The Quality Assurance Department will review completed investigation reports to assure reports are completed accurately and notification of investigation results occurs as required.</p> <p>RESPONSIBLE PARTIES: QDDPD, Team Lead, Direct Support Staff, Quality Assurance Team, Operations Team</p>	01/27/2013

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	<p>A] away from [client C] before he had a chance to (sic). During the altercation [client C] did receive a scratch on his arm. A housemate of [client A] called the police and [client A] was transported by ambulance to [hospital] to be evaluated by psychiarty doctor (sic)."</p> <p>-Investigation dated 12/16/12 regarding the 12/16/12 BDDS report for clients A and C did not indicate the date and time the administrator was notified of the conclusion of the investigation. The investigation form was blank in the section designated as the date and time the administrator was notified of the conclusion of the investigation.</p> <p>-BDDS report dated 12/9/12 indicated, "[Client A] was agitated about not seeing his sister. [Client A] grabbed [client D] around his neck with his hands for a brief period of time. [Client A] was redirected to his bedroom to calm down. [Client D] had no injuries or bruises to his neck. [Client A] continued to target staff and other individuals, so staff notified the police. The police placed handcuffs on [client A] but did not take him to jail." The 12/9/12 BDDS report indicated, "The QMRP (qualified mental retardation professional) will investigate the circumstances of the altercation."</p>						

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	<p>-Investigation dated 12/9/12 regarding the 12/9/12 BDDS report for clients A and D did not indicate the date and time the administrator was notified of the conclusion of the investigation. The investigation form was blank in the section designated as the date and time the administrator was notified of the conclusion of the investigation.</p> <p>QMRP #1 was interviewed on 12/27/12 at 12:32 PM. QMRP #1 indicated he had completed the 12/9/12 investigation for clients A and D and the 12/16/12 investigation for clients A and C. QMRP #1 indicated the investigation dated 12/9/12 had been completed and had substantiated client to client abuse regarding clients A and C. QMRP #1 indicated the investigation findings/conclusion had not been reported to the administrator. QMRP #1 indicated the investigation dated 12/16/12 had been completed and had substantiated client to client abuse regarding clients A and D. QMRP #1 indicated the investigation findings/conclusion had not been reported to the administrator. QMRP #1 indicated the conclusion of investigations should be reported to the administrator within five days.</p> <p>AS (administrative staff) #1 was interviewed on 12/27/12 at 12:45 PM. AS</p>			

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	#1 indicated the results of investigations should be reported to the administrator within five days. 9-3-2(a)			

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W0157	<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 3 of 9 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed for 3 of 4 sampled clients (A, C and D), the facility failed to implement corrective action following the investigation of abuse regarding client A. The facility failed to implement corrective action following the investigations of client to client abuse regarding clients A, C and D.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/27/12 at 11:13 AM. The review indicated the following:</p> <p>-BDDS initial incident report dated 12/7/12 indicated, "It was brought to the attention of the ResCare supervisory personnel on 12/6/12 that a verbal argument between [client A] and staff occurred on the day of 11/23/12 at 1:30 PM. A neighbor near the [group home] witnessed 3 staff arguing with [client A] outside of the home."</p> <p>-BDDS follow up report dated 12/14/12</p>	W0157	<p>CORRECTION: <i>If the alleged violation is verified, appropriate corrective action must be taken.</i> Specifically, Facility direct support staff have been retrained regarding abuse/neglect/mistreatment detection and prevention as recommended in the investigation concluded 12/14/12. In addition, the interdisciplinary team will meet to discuss measures to prevent further aggression between Client A and Clients C and D subsequent to investigations of client to client aggression that occurred on 12/9/12 and 12/16/12.</p> <p>PREVENTION: The QDDP will bring all relevant elements of the interdisciplinary team together after incidents of client to client aggression to review current supports and to make adjustments and revisions as needed. The QDDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up.</p> <p>RESPONSIBLE PARTIES: QDDPD, Team Lead, Direct Support Staff, Quality Assurance Team, Operations Team</p>	01/27/2013	

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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			
(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 outcome of the investigation substantiated that staff were involved in arguing with [client A] outside the home. Additional evidence from the investigation indicated that [client A] was outside without a shirt on during this time and that staff kept him from entering the house for 20 minutes. The allegation of emotional abuse was substantiated.</p> <p>The three staff who were involved at the time of the incident [staff #1] , [staff #2] and [staff #3] have had their employment terminated. [Police] has also been contacted and a police report filed. [Client A] has been offered emotional support. Retraining to occur with [group home] staff on individual rights, respect and dignity as well as recognizing and reporting abuse, neglect, exploitation and mistreatment."</p> <p>-Investigation form dated 12/14/12 indicated, "Recommendations: 4. Retrain and onsite coaching on abuse, neglect, mistreatment, exploitation and appropriate interactions and approach with individuals we support."</p> <p>The review did not indicate staff had been retrained regarding abuse, neglect, mistreatment, and exploitation. The review did not indicate staff had been retrained regarding appropriate</p>						

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	<p>interactions including treating clients with respect, dignity or recognizing and reporting abuse, neglect, exploitation and mistreatment.</p> <p>-BDDS report dated 12/16/12 indicated, "[Client A] was agitated about calling his sister. [Client A] begin (sic) getting irate and charging the other individuals that were in the living room, so staff redirected those individuals to their bedroom. [Client C] heard the commotion and came out of his bedroom (sic) before staff could intervene [client A] grabbed [client C] by the arm and attempted to bite him. Staff was able to redirect [client A] away from [client C] before he had a chance to (sic). During the altercation [client C] did receive a scratch on his arm. A housemate of [client A] called the police and [client A] was transported by ambulance to [hospital] to be evaluated by psychiarty doctor (sic)." The 12/16/12 BDDS report indicated an IDT (interdisciplinary team) meeting would be held after the completion of an investigation.</p> <p>-Investigation form dated 12/16/12 regarding the 12/16/12 BDDS report for clients A and C substantiated client to client abuse.</p> <p>The review did not indicate an IDT had</p>						

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	<p>been convened following the investigation to make recommendations to prevent reoccurrence.</p> <p>-BDDS report dated 12/9/12 indicated, "[Client A] was agitated about not seeing his sister. [Client A] grabbed [client D] around his neck with his hands for a brief period of time. [Client A] was redirected to his bedroom to calm down. [Client D] had no injuries or bruises to his neck. [Client A] continued to target staff and other individuals, so staff notified the police. The police placed handcuffs on [client A] but did not take him to jail." The 12/9/12 BDDS report indicated, "The QMRP (qualified mental retardation professional) will investigate the circumstances of the altercation." The 12/9/12 BDDS report indicated an IDT would be convened and staff would be retrained on client A's BSP (behavior support plan).</p> <p>-Investigation form dated 12/9/12 regarding the 12/9/12 BDDS report for clients A and D substantiated client to client abuse.</p> <p>The review did not indicate an IDT had been convened following the investigation to make recommendations to prevent reoccurrence.</p>						

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	<p>QMRP #1 was interviewed on 12/27/12 at 12:32 PM. QMRP #1 indicated staff had not been retrained regarding abuse, neglect, mistreatment, exploitation and appropriate interactions and approach with clients. QMRP #1 indicated the IDT had not met to discuss the 12/9/12 client to client abuse between clients A and D. QMRP #1 indicated the IDT had not met to discuss the 12/16/12 client to client abuse between clients A and C.</p> <p>This federal tag relates to complaint #IN00121350.</p> <p>9-3-2(a)</p>				