

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 9/16/14, 9/17/14, 9/18/14, 9/22/14, 9/23/14 and 9/24/14</p> <p>Facility Number: 000685 Provider Number: 15G666 AIMS Number: 100474600</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/3/14 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 record review and interview for 1 of 4 sampled clients (#1) plus 1 additional client (#8), the facility failed to implement its policy and procedures to ensure an incident of client to client aggression was reported to BDDS (Bureau of Developmental Disabilities Services) regarding client #1, to ensure 3 separate injuries of unknown origin were</p>	W000149	<p>CORRECTION:</p> <p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i></p>	10/24/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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>thoroughly investigated for clients #1 and #8 and 1 incident of client to client aggression regarding client #1 and to develop and implement actions to prevent further injuries of unknown origin for clients #1 and #8.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/18/14 at 2:14 PM. Client #1's Record of Visit form dated 7/29/14 indicated, "1. Reason for visit: Fall/Altercation. 2. Results/findings of examination: Right thigh/hip contusion."</p> <p>Interview with RM (Resident Manager) #1 on 9/24/14 at 1:30 PM indicated client #1's 7/29/14 Record of visit form was completed at a clinic following an altercation client #1 had with a peer.</p> <p>The facility's BDDS reports and investigations were reviewed on 9/17/14 at 9:23 AM. The review did not indicate documentation of client #1's 7/29/14 altercation being reported to the BDDS or of an investigation.</p> <p>The review indicated the following:</p> <p>2. BDDS report dated 4/21/14 indicated, "[Client #8] returned from an outing with her sister, who reported that [client #8]</p>		<p>The Residential Manager has been retrained on reporting regulations and will receive ongoing training to improve time management skills.</p> <p>The Residential Manager has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed, as well as the need to reproduce copies of investigation reports to medical surveyors upon request.</p> <p>Specifically for Client #8, the interdisciplinary team will develop support strategies to reduce the incidence of injuries of unknown origin.</p> <p>PERVENTION:</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and Program Manager who will in turn coordinate and follow-up with the facility Residential Manager to assure incidents are reported to state</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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>had been complaining of pain in her left shoulder. [Staff #1] transported [client #8] to the [hospital] ER (Emergency Room) for evaluation and treatment. ER personnel took x-rays which revealed a closed proximal fracture of the left humerus. [Client #8] said she doesn't know how she sustained the injury. Plan to resolve. The agency's management team is investigating to determine the cause of the injury. [Client #8] has a history of fractures secondary to Osteopenia (low bone density). A high risk plan for falls is in place. [Client #8] has an appointment with an orthopedic specialist on 2/22/14 (sic) and ResCare nursing is developing specific care guidelines to support prompt recovery from the injury. The IDT (Interdisciplinary Team) will meet to develop additional safety measures based on the recommendations of the orthopedic specialist and the results of the investigation."</p> <p>Investigation dated 4/21/14 regarding client #8's 4/21/14 injury of unknown origin did not indicate documentation of a summary of information and findings, analysis of interviews conducted, findings of fact and determination as to the source of the injuries of unknown origin, concerns and recommendations or methods to prevent future incidents. The</p>		<p>agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment.</p> <p>The Residential Manager will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly.</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to injuries of unknown origin and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
(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>sections of the investigation entitled, "Outcome", "Summary of Evidence", and "Conclusions" were blank/unanswered.</p> <p>3. BDDS report dated 7/12/14 indicated on 7/11/14 "Staff was assisting [client #8] with her shower when staff noticed that [client #8's] right ankle was swollen. Staff immediately notified the facility on-call nurse who instructed staff to take [client #8] to [clinic] for assessment. On called (sic) QIDP (Qualified Intellectual Disabilities Professional) called [client #8's] HCR (Health Care Representative). No new medication was prescribed. [Client #8] was diagnosed with a right foot sprain and released to staff with the recommendation to apply ice to (sic) area, rest, elevate and to wear acne (sic) bandage as needed for comfort. Plan to resolve. An injury flow chart was initiated and team will investigate the injury of the (sic) unknown origin."</p> <p>-Investigation dated 7/11/14 regarding client #8's 7/11/14 injury of unknown origin indicated, "Outcome: The outcome was there was a conclusion that there was a possibility that during transfer of [client #8] that she could have sprain (sic)." The 7/11/14 investigation did not indicate documentation of a summary of information and findings, analysis of interviews conducted, findings of fact</p>		<p>review incidents which require interdisciplinary team action. When patterns of discovered injuries or other safety concerns emerge, the QIDP will work with the team to develop additional supports as needed</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: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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 determination as to the source of the injuries of unknown origin, concerns and recommendations or methods to prevent future incidents. The sections of the investigation entitled, "Summary of Evidence", and "Conclusions" were blank/unanswered.</p> <p>4. BDDS report dated 7/18/14 indicated, "On 7/17/14 staff was giving [client #8] a shower and noticed she had a total of 6 bruises on her legs (sic) 3 on the right and 3 on the left. The bruises were about the size of a dime. When staff asked [client #8] how she go (sic) the bruises she stated she did not know. [Client #8] did not complain of any pain as a result of the bruising. This is not a normal situation for [client #8]. [Client #8] has not had any other incidents since 7/17/14. Plan to resolve. [QIDP (Qualified Intellectual Disabilities Professional) #1] has meet (sic) with the team and has determined that [client #8] does not usually have incidents like this one. [QIDP #1] and team will continue to offer emotional support to [client #8]."</p> <p>Investigation dated 7/18/14 regarding client #8's 7/17/14 injury of unknown origin did not indicate documentation of a summary of information and findings, analysis of interviews conducted, findings of fact and determination as to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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 source of the injuries of unknown origin, concerns and recommendations or methods to prevent future incidents. The sections of the investigation entitled, "Outcome", "Summary of Evidence", and "Conclusions" were blank/unanswered.</p> <p>CS (Clinical Supervisor) #2 was interviewed on 9/18/14 at 11:30 AM. CS #2 indicated the facility's abuse and neglect policy should be implemented. CS #2 indicated allegations of abuse, neglect and mistreatment should be investigated. CS #2 indicated the IDT or administrative team should develop and implement corrective actions to prevent abuse, neglect, mistreatment and prevent further injuries of unknown origin.</p> <p>The facility's policy and procedures were reviewed on 9/22/14 at 1:17 PM. The facility's Abuse, Neglect, Exploitation and Mistreatment policy dated 2/26/11 indicated, "Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation or mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated and the policies of Adept, ResCare and local state and federal guidelines."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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
9-3-2(a)	<p>The facility's Investigations policy dated 9/14/07 indicated, "In order to ensure the health, safety and welfare of the people we support, events or collections of circumstances that are outside of what is normally expected, cannot by (sic) explained and understood by the existence of the even and result in or have the potential to result in injury or abuse, neglect or exploitation to the consumer must be investigated. Investigations will be conducted per the protocols listing in the incident management best practices manual."</p> <p>The 9/14/07 policy indicated, "A thorough investigation final report will be written at the completion of the investigation. The report shall include, but it not limited to the following: ... summary of information and findings (evidence collected, witnesses interviewed, date of the investigation, name(s) of the investigator(s))... description and chronology of what happened, analysis of the evidence, finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive, concerns and recommendations... methods to prevent future incidents."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 5 allegations of abuse, mistreatment and injuries of unknown origin reviewed, the facility failed to ensure an incident of client to client aggression was reported to BDDS (Bureau of Developmental Disabilities Services) within 24 hours regarding client #1 in accordance with state law.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 9/18/14 at 2:14 PM. Client #1's Record of Visit form dated 7/29/14 indicated, "1. Reason for visit: Fall/Altercation. 2. Results/findings of examination: Right thigh/hip contusion."</p> <p>Interview with RM (Resident Manager) #1 on 9/24/14 at 1:30 PM indicated client #1's 7/29/14 Record of visit form was completed at a clinic following an altercation client #1 had with a peer.</p> <p>The facility's BDDS reports and</p>	W000153	<p>CORRECTION:</p> <p><i>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, the Residential Manager has been retrained on reporting regulations and will receive ongoing training to improve time management skills.</i></p> <p>PREVENTION:</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and Program Manager who will in turn coordinate and follow-up with the facility Residential Manager to assure incidents are reported to state</p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000154	<p>investigations were reviewed on 9/17/14 at 9:23 AM. The review did not indicate documentation of client #1's 7/29/14 altercation being reported to the BDDS.</p> <p>CS (Clinical Supervisor) #2 was interviewed on 9/18/14 at 11:30 AM. CS #2 indicated allegations of abuse, neglect, mistreatment and injuries of unknown origin should be reported to the BDDS within 24 hours of knowledge of the allegation/incident.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 4 of 5 injuries of unknown origin reviewed, the facility failed to ensure 3 separate injuries of unknown origin for clients #1 and #8 and 1 incident of client to client aggression regarding client #1 were thoroughly investigated.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/18/14 at 2:14 PM. Client #1's Record of Visit form dated 7/29/14 indicated, "1. Reason for visit: Fall/Altercation. 2.</p>	W000154	<p>agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment.</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 have evidence that all alleged violations are thoroughly investigated. Specifically, the Residential Manager has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed, as well as the need to reproduce copies of investigation reports to medical surveyors upon request.</i></p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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>Results/findings of examination: Right thigh/hip contusion."</p> <p>Interview with RM (Resident Manager) #1 on 9/24/14 at 1:30 PM indicated client #1's 7/29/14 Record of visit form was completed at a clinic following an altercation client #1 had with a peer.</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/17/14 at 9:23 AM. The review did not indicate documentation of client #1's 7/29/14 altercation being investigated.</p> <p>The review indicated the following:</p> <p>2. BDDS report dated 4/21/14 indicated, "[Client #8] returned from an outing with her sister, who reported that [client #8] had been complaining of pain in her left shoulder. [Staff #1] transported [client #8] to the [hospital] ER (Emergency Room) for evaluation and treatment. ER personnel took x-rays which revealed a closed proximal fracture of the left humerus. [Client #8] said she doesn't know how she sustained the injury. Plan to resolve. The agency's management team is investigating to determine the cause of the injury. [Client #8] has a history of fractures secondary to Osteopenia (low bone density). A high</p>		<p>PREVENTION:</p> <p>The Residential Manager will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly.</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: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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>risk plan for falls is in place. [Client #8] has an appointment with an orthopedic specialist on 2/22/14 (sic) and ResCare nursing is developing specific care guidelines to support prompt recovery from the injury. The IDT (Interdisciplinary Team) will meet to develop additional safety measures based on the recommendations of the orthopedic specialist and the results of the investigation."</p> <p>Investigation dated 4/21/14 regarding client #8's 4/21/14 injury of unknown origin did not indicate documentation of a summary of information and findings, analysis of interviews conducted, findings of fact and determination as to the source of the injuries of unknown origin, concerns and recommendations or methods to prevent future incidents. The sections of the investigation entitled, "Outcome", "Summary of Evidence", and "Conclusions" were blank/unanswered.</p> <p>3. BDDS report dated 7/12/14 indicated on 7/11/14 "Staff was assisting [client #8] with her shower when staff noticed that [client #8's] right ankle was swollen. Staff immediately notified the facility on-call nurse who instructed staff to take [client #8] to [clinic] for assessment. On called (sic) QIDP (Qualified Intellectual Disabilities Professional) called [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
(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>#8's] HCR (Health Care Representative). No new medication was prescribed. [Client #8] was diagnosed with a right foot sprain and released to staff with the recommendation to apply ice to (sic) area, rest, elevate and to wear ace (sic) bandage as needed for comfort. Plan to resolve. An injury flow chart was initiated and team will investigate the injury of the (sic) unknown origin."</p> <p>-Investigation dated 7/11/14 regarding client #8's 7/11/14 injury of unknown origin indicated, "Outcome: The outcome was there was a conclusion that there was a possibility that during transfer of [client #8] that she could have sprain (sic)." The 7/11/14 investigation did not indicate documentation of a summary of information and findings, analysis of interviews conducted or findings of fact and determination as to the source of the injuries of unknown origin. The sections of the investigation entitled, "Summary of Evidence", and "Conclusions" were blank/unanswered.</p> <p>4. BDDS report dated 7/18/14 indicated, "On 7/17/14 staff was giving [client #8] a shower and noticed she had a total of 6 bruises on her legs (sic) 3 on the right and 3 on the left. The bruises were about the size of a dime. When staff asked [client #8] how she go (sic) the bruises</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226		
(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	
W000157	<p>she stated she did not know. [Client #8] did not complain of any pain as a result of the bruising. This is not a normal situation for [client #8]. [Client #8] has not had any other incidents since 7/17/14. Plan to resolve. [QIDP (Qualified Intellectual Disabilities Professional) #1] has meet (sic) with the team and has determined that [client #8] does not usually have incidents like this one. [QIDP #1] and team will continue to offer emotional support to [client #8]."</p> <p>Investigation dated 7/18/14 regarding client #8's 7/17/14 injury of unknown origin did not indicate documentation of a summary of information and findings, analysis of interviews conducted or findings of fact and determination as to the source of the injuries of unknown origin. The sections of the investigation entitled, "Outcome", "Summary of Evidence", and "Conclusions" were blank/unanswered.</p> <p>CS (Clinical Supervisor) #2 was interviewed on 9/18/14 at 11:30 AM. CS #2 indicated allegations of abuse, neglect and mistreatment should be investigated.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 3 of 5 injuries of unknown origin reviewed, the facility failed to develop and implement actions to prevent further injuries of unknown origin for client #8.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/17/14 at 9:23 AM. The review indicated the following:</p> <p>1. BDDS report dated 4/21/14 indicated, "[Client #8] returned from an outing with her sister, who reported that [client #8] had been complaining of pain in her left shoulder. [Staff #1] transported [client #8] to the [hospital] ER (Emergency Room) for evaluation and treatment. ER personnel took x-rays which revealed a closed proximal fracture of the left humerus. [Client #8] said she doesn't know how she sustained the injury. Plan to resolve. The agency's management team is investigating to determine the cause of the injury. [Client #8] has a history of fractures secondary to Osteopenia (low bone density). A high risk plan for falls is in place. [Client #8] has an appointment with an orthopedic</p>	W000157	<p>CORRECTION:</p> <p><i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically for Client #8, the interdisciplinary team will develop support strategies to reduce the incidence of injuries of unknown origin. A review of incident documentation indicated that this deficient practice did not affect other clients.</i></p> <p>PREVENTION:</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to injuries of unknown origin and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes 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. When patterns of discovered injuries or other safety concerns emerge, the QIDP will work with the team to develop additional supports as needed</p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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>specialist on 2/22/14 (sic) and ResCare nursing is developing specific care guidelines to support prompt recovery from the injury. The IDT (Interdisciplinary Team) will meet to develop additional safety measures based on the recommendations of the orthopedic specialist and the results of the investigation."</p> <p>Investigation dated 4/21/14 regarding client #8's 4/21/14 injury of unknown origin did not indicate documentation of concerns and recommendations or methods to prevent future incidents.</p> <p>2. BDDS report dated 7/12/14 indicated on 7/11/14 "Staff was assisting [client #8] with her shower when staff noticed that [client #8's] right ankle was swollen. Staff immediately notified the facility on-call nurse who instructed staff to take [client #8] to [clinic] for assessment. On called (sic) QIDP (Qualified Intellectual Disabilities Professional) called [client #8's] HCR (Health Care Representative). No new medication was prescribed. [Client #8] was diagnosed with a right foot sprain and released to staff with the recommendation to apply ice to (sic) area, rest, elevate and to wear acne (sic) bandage as needed for comfort. Plan to resolve. An injury flow chart was initiated and team will investigate the</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: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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>injury of the (sic) unknown origin."</p> <p>-Investigation dated 7/11/14 regarding client #8's 7/11/14 injury of unknown origin did not indicate documentation of concerns and recommendations or methods to prevent future incidents.</p> <p>3. BDDS report dated 7/18/14 indicated, "On 7/17/14 staff was giving [client #8] a shower and noticed she had a total of 6 bruises on her legs (sic) 3 on the right and 3 on the left. The bruises were about the size of a dime. When staff asked [client #8] how she go (sic) the bruises she stated she did not know. [Client #8] did not complain of any pain as a result of the bruising. This is not a normal situation for [client #8]. [Client #8] has not had any other incidents since 7/17/14. Plan to resolve. [QIDP (Qualified Intellectual Disabilities Professional) #1] has meet (sic) with the team and has determined that [client #8] does not usually have incidents like this one. [QIDP #1] and team will continue to offer emotional support to [client #8]."</p> <p>Investigation dated 7/18/14 regarding client #8's 7/17/14 injury of unknown origin did not indicate documentation of concerns and recommendations or methods to prevent future incidents.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000209	<p>CS (Clinical Supervisor) #2 was interviewed on 9/18/14 at 11:30 AM. CS #2 indicated the IDT or administrative team should develop and implement corrective actions to prevent abuse, neglect, mistreatment and prevent further injuries of unknown origin.</p> <p>9-3-2(a)</p> <p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4, the facility failed to ensure clients #1, #2, #3 and #4 or clients #1, #2, #3 and #4's guardians participated in the clients' IDT (Interdisciplinary Team) meetings regarding the development of their ISPs (Individual Support Plan).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/18/14 at 2:14 PM. Client #1's ISP dated 6/5/14 indicated client #1 was a self advocating adult with a HCR (Health Care Representative) for support. Client #1's ISP indicated, "I have been involved in the development of my ISP and I agree</p>	W000209	<p>CORRECTION:</p> <p><i>Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Specifically for Clients #1 – #4, as well as three additional clients, #6 - #8, the QIDP and Residential Manager will be retrained regarding the need to bring all elements of the interdisciplinary team including guardian and family members, to assist with the development of individual support plans.</i></p> <p>PERVENTION:</p>	10/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226		
(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>with this plan. I know I can appeal to the DDAR (Division of Disability, Aging and Rehabilitative Services) if I disagree with how this plan is put into action. Signed: (blank) Date: (blank)." Client #1's record did not indicate documentation of client #1 or client #1's HCR/advocate participation in an IDT meeting to develop client #1's ISP.</p> <p>2. Client #2's record was reviewed on 9/18/14 at 1:47 PM. Client #2's ISP dated 6/8/14 indicated client #2 was a self advocating adult with a HCR for support. Client #2's ISP indicated, "I have been involved in the development of my ISP and I agree with this plan. I know I can appeal to the DDAR if I disagree with how this plan is put into action. Signed: (blank) Date: (blank)." Client #2's record did not indicate documentation of client #2's participation in an IDT meeting to develop client #2's ISP.</p> <p>3. Client #3's record was reviewed on 9/18/14 at 12:31 PM. Client #3's ISP dated 8/10/14 indicated client #3 was an emancipated adult. Client #3's ISP indicated, "I have been involved in the development of my ISP and I agree with this plan. I know I can appeal to the DDAR if I disagree with how this plan is put into action. Signed: (blank) Date: (blank)." Client #3's record did not</p>		<p>The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring. The QIDP will turn in documentation of family/guardian communication to the Program Manager monthly. The Program Manager will in turn follow-up to assure that family members and guardians are invited and encouraged to participate in the ISP development process.</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: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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
W000259	<p>indicate documentation of client #3's participation in an IDT meeting to develop client #3's ISP.</p> <p>4. Client #4's record was reviewed on 9/18/14 at 2:48 PM. Client #4's ISP dated 9/26/13 indicated client #4 was an emancipated adult. Client #4's ISP indicated, "I have been involved in the development of my ISP and I agree with this plan. I know I can appeal to the DDAR if I disagree with how this plan is put into action. Signed: (blank) Date: (blank)." Client #4's record did not indicate documentation of client #4's participation in an IDT meeting to develop client #4's ISP.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 9/18/14 at 11:04 AM. CS #1 indicated clients #1, #2, #3 and #4 and/or their guardians should participate in IDTs and be given the opportunity to participate in the development of their ISPs. CS #1 indicated there was not additional documentation of IDTs regarding clients #1, #2, #3 or #4.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
(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>be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure client #2's CFA (Comprehensive Functional Assessment) was reviewed annually.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 9/18/14 at 1:47 PM. Client #2's CFA dated 6/7/13 indicated client #2's CFA was reviewed on 6/7/13. The review did not indicate documentation of annual review of client #2's CFA.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 9/18/14 at 3:43 PM. CS #1 indicated client #2's CFA should be reviewed annually. CS #1 indicated there was not additional documentation of annual review of client #2's CFA.</p> <p>9-3-4(a)</p>	W000259	<p>CORRECTION:</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Specifically, Client #2's Comprehensive Functional Assessment will be updated.</p> <p>PREVENTION:</p> <p>The QIDP will be retrained regarding the need to assure that all relevant assessments are reviewed and updated as needed but no less than annually. Members of the Operations Team will follow up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support</p>	10/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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
W000262	<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 record review and interview for 1 of 4 sampled clients (#1), the facility's HRC (Human Rights Committee) failed to review and approve client #1's use of psychotropic medication.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 9/18/14 at 2:14 PM. Client #1's BSP (Behavior Support Plan) dated 6/5/14 indicated client #1 received Lithium Carbonate (bipolar), Zyprexa (bipolar) and Risperdal (bipolar) daily for the management of client #1's behaviors. Client #1's record did not indicate documentation of the facility's HRC review or approval of client #1's use of psychotropic medications for behavior management.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 9/18/14 at 3:43 PM. CS #1 indicated the use of psychotropic medication for behavior management</p>	W000262	<p>Staff, Operations Team</p> <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. Specifically, the facility will obtain approval from the Human Rights Committee for Client #1's behavior controlling medications. A review of Human Rights Committee documentation indicated that this deficient practice did not affect any additional clients.</i></p> <p>PREVENTION:</p> <p>The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs for all clients. The agency has established a</p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226		
(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	
W000263	<p>should be reviewed and approved by the HRC.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 1 of 4 sampled clients (#4), the facility's HRC (Human Rights Committee) failed to obtain the written informed consent of client #4 before the use of psychotropic medications used for the management of client #4's behavior.</p>	W000263	<p>quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility on a bi-weekly basis for the next 60 days and after two months, no less than monthly The Program Manager will incorporate monitoring of annual HRC approvals of restrictive programs into the current tracking process.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically the team will obtain written consent from</i></p>	10/24/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
(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>Client #4's record was reviewed on 9/18/14 at 2:48 PM. Client #4's ISP (Individual Support Plan) dated 9/16/13 indicated client #4 was an emancipated adult. Client #4's BSP (Behavior Support Plan) dated 9/26/13 indicated client #4 received Depakote 500 milligrams (bipolar) and Seroquel 400 milligrams (bipolar). Client #4's record did not indicate documentation of client #4's written informed consent for the use of Depakote or Seroquel for the management of client #4's behavior.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 9/18/14 at 3:43 PM. CS #1 indicated client #4's written informed consent should be obtained before the use of psychotropic medication for behavior management.</p> <p>9-3-4(a)</p>				<p>Client #4 for the use of behavior controlling medication. A review of support documents indicated this deficient practice did not affect additional clients.</p> <p>PREVENTION:</p> <p>Professional staff will be retrained regarding the need to obtain prior written informed consent from guardians, advocates and healthcare representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human Rights Committee will obtain confirmation that the facility has received prior written informed consent from guardians or other legal representatives. 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. Administrative staff will conduct visits to the facility as needed but no less than monthly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
(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			
W000322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview for 3 of 4 sampled clients (#2, #3 and #4), the facility failed to ensure clients #2, #3 and #4 had annual physical examinations.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 9/18/14 at 1:47 PM. Client #2's annual physical examination form dated 7/16/13 indicated client #2's annual physical was completed on 7/16/13. Client #2's record did not indicate additional documentation of annual physical examination since 7/16/13.</p> <p>2. Client #3's record was reviewed on 9/18/14 at 12:31 PM. Client #3's annual physical examination form dated 7/9/13 indicated client #3's annual physical was completed on 7/9/13. Client #3's record did not indicate additional documentation of annual physical examination since</p>	W000322	<p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p>The facility must provide or obtain preventive and general medical care. Specifically, the facility has obtained an annual physical examination for Clients #2 – #4. A review of medical records indicated this deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that</p>	10/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
(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			
W000323	<p>7/9/13.</p> <p>3. Client #4's record was reviewed on 9/18/14 at 2:48 PM. Client #4's annual physical examination form dated 1/3/13 indicated client #4's annual physical was completed on 1/3/13. Client #4's record did not indicate additional documentation of annual physical examination since 1/3/13.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 9/18/14 at 3:03 PM. LPN #1 indicated clients #2, #3 and #4 should have annual physical examinations. LPN #1 indicated there was not additional documentation regarding clients #2, #3 and #4's annual physical examinations.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to ensure clients #1 and #4's vision recommendations were followed.</p> <p>Findings include:</p>	W000323	<p>examinations including but not limited to visual evaluations take place as required.</p> <p>RESPONSIBLE PARTIES:</p> <p>Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Specifically, clients</i></p>	10/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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. Client #1's record was reviewed on 9/18/14 at 2:14 PM. Client #1's Vision Exam form dated 4/25/12 indicated the recommendation for client #1 to return for assessment/evaluation in 2 years. Client #1's record did not indicate documentation of client #1's 4/25/12 vision recommendations being completed.</p> <p>2. Client #4's record was reviewed on 9/18/14 at 2:48 PM. Client #4's record of visit form dated 12/20/11 indicated the recommendation to return in 2 years for a vision examination. Client #4's record did not indicate documentation of additional vision evaluation since 12/20/11.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 9/18/14 at 3:03 PM. LPN #1 indicated vision recommendations should be implemented. LPN #1 indicated there was not additional documentation regarding clients #1 and #4's visual care examinations/assessments.</p> <p>9-3-6(a)</p>		<p>#1 and #4 will receive a visual examination. A review of medical records indicated this deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>The Health Services Team will work with the Medical Director to develop a plan to assure the visual examination component of the Annual Physical is documented in a clear, understandable and accurate manner. In situations where the primary care physician is unable or unwilling to perform an annual visual examination, the facility will enlist the services of an optometrist. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that examinations including but not limited to visual evaluations take place as required.</p> <p>RESPONSIBLE PARTIES:</p> <p>Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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
W000327	<p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure an annual/yearly TB (Tuberculosis) testing, x-ray or symptom screening checklist was completed for clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client #1's record was reviewed on 9/18/14 at 2:14 PM. Client #1's TB form dated 3/22/13 indicated client #1's TB testing was completed on 3/22/13. Client #1's record did not indicate documentation of annual TB testing, x-ray or symptom screening since 3/22/13. Client #2's record was reviewed on 9/18/14 at 1:47 PM. Client #2's TB form dated 3/22/13 indicated client #2's TB testing was completed on 3/22/13. Client #2's record did not indicate documentation of annual TB testing, x-ray or symptom screening since 	W000327	<p>CORRECTION:</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Specifically for Clients # 1 – #4 and four additional clients #5 - #8, the facility will obtain current tuberculosis screenings.</p> <p>PERVENTION:</p> <p>The nurse will be trained regarding current recommendations of the American College of Chest Physicians regarding annual tuberculosis screenings and will assure all clients a tested accordingly. The Nurse Manager will assist the facility nurse and</p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226			
(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			
W000331	<p>3/22/13.</p> <p>3. Client #3's record was reviewed on 9/18/14 at 12:31 PM. Client #3's TB form dated 3/22/13 indicated client #3's TB testing was completed on 3/22/13. Client #3's record did not indicate documentation of annual TB testing, x-ray or symptom screening since 3/22/13.</p> <p>4. Client #4's record was reviewed on 9/18/14 at 2:48 PM. Client #4's TB form dated 3/22/13 indicated client #4's TB testing was completed on 3/22/13. Client #4's record did not indicate documentation of annual TB testing, x-ray or symptom screening since 3/22/13.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 9/18/14 at 3:03 PM. LPN #1 indicated clients #1, #2, #3 and #4 should have annual TB testing, x-ray or symptom screening. LPN #1 indicated there was not additional documentation of annual TB testing, x-ray or symptom screening for clients #1, #2, #3 or #4.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p>		<p>direct support medical coach with tracking routine appointments and lab tests, including but not limited to tuberculosis screens, to assure they occur as recommended. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate.</p> <p>RESPONSIBLE PARTIES: Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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 must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility nursing services failed to meet the health needs of clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/18/14 at 2:14 PM. Client #1's POF (Physicians Order Form) dated 8/28/14 indicated client #1 should have her Lithium labs completed every two weeks and her CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) every 3 months. Client #1's record of visit form dated 8/20/14 indicated, "Labs completed." Client #1's record of visit form did not specify the labs that were completed and/or the results/findings of the labs. Client #1's record did not indicate documentation of additional labs being completed for client #1.</p> <p>2. Client #2's record was reviewed on 9/18/14 at 1:47 PM. Client #2's POF dated 8/28/14 indicated, "Laboratory Orders. CMP, (Complete Metabolic Panel), Lipid panel, Hepatic panel, UA (Urine Analysis), CBC with differential annually. Dilantin level every 3 months. Fax results to [number]. TSH (Thyroid</p>	W000331	<p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically, for Clients # 1 – #4 and four additional clients #5 - #8, the facility will obtain current ordered laboratory tests.</i></p> <p>PREVENTION:</p> <p>The facility nurse will conduct weekly audits of clients' medical records and alert the Residential Manager to deadlines for appointments including but not limited to routine blood work. Members of the Operations Team will follow-up with front line supervisors to assure follow-through. The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate.</p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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>Stimulating Hormone) every 3 months." Client #2's record of visit form dated 8/20/14 indicated, "Labs completed." Client #2's record of visit form did not specify the labs that were completed and/or the results/findings of the labs. Client #2's Laboratory form dated 12/20/13 indicated client #2's Dilantin level was checked. Client #2's record did not indicate additional documentation of laboratory assessments being completed from 12/20/13 through 8/20/14.</p> <p>3. Client #3's record was reviewed on 9/18/14 at 12:31 PM. Client #3's POF dated 8/28/14 indicated, "Laboratory Orders. Lipid panel every 6 months. Annual CMP, CBC, UA...." Client #3's record of visit form dated 9/9/14 indicated client #3's laboratory orders had been completed. Client #3's laboratory form dated 9/23/13 indicated client #3's laboratory orders had been completed. Client #3's record did not indicate documentation of client #3's lipid panel being completed from 9/23/13 and 9/20/14.</p> <p>4. Client #4's record was reviewed on 9/18/14 at 2:48 PM. Client #4's POF dated 8/28/14 indicated client #4 should have a CBC with differential completed annually. Client #4's record of visit form dated 12/3/13 indicated, "Labs</p>		<p>RESPONSIBLE PARTIES:</p> <p>Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226
---	--

(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
W000356	<p>completed." Client #4's record of visit form did not specify the labs that were completed and/or the results/findings of the labs. Client #4's record did not indicate documentation of additional labs being completed for client #4.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 9/18/14 at 3:03 PM. LPN #1 indicated clients #1, #2, #3 and #4 should receive laboratory assessments as indicated on their POF's. LPN #1 indicated there was not additional documentation of laboratory evaluations for clients #1, #2, #3 and #4.</p> <p>9-3-6(a)</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1 received recommended follow up dental treatment.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 9/18/14 at 2:14 PM. Client #1's Dental Summary form dated 9/17/13 indicated,</p>	W000356	<p>CORRECTION:</p> <p><i>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Specifically, the facility will obtain a dental examination for Client #1.</i></p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 N RICHARDT INDIANAPOLIS, IN 46226		
(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>"Refer to [dentist] for restorations." Client #1's record did not indicate documentation of client #1 receiving the recommended restorations.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 9/18/14 at 3:03 PM. LPN #1 indicated there was not additional documentation regarding client #1 receiving dental services since 9/17/13.</p> <p>9-3-6(a)</p>		<p>PREVENTION:</p> <p>The facility nurse will conduct weekly audits of clients' medical records and alert the Residential Manager to deadlines for appointments including but not limited to dental examinations. Members of the Operations Team will follow-up with front line supervisors to assure follow-through. The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as recommended. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate.</p> <p>RESPONSIBLE PARTIES:</p> <p>Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>		