

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 03/31/2015
--	---	--	---

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
--------------------	--	---------------	---	----------------------

W 000 Bldg. 00	<p>This visit was for the investigation of complaints #IN00160595 and #IN00164040.</p> <p>Complaint #IN00160595: Substantiated, federal and state deficiencies related to the allegations are cited at: W102, W104, W122, W149, W154, W156 and W157.</p> <p>Complaint #IN00164040: Substantiated, no deficiencies related to the allegations are cited.</p> <p>Dates of Survey: 3/24/15, 3/25/15, 3/26/15 and 3/31/15.</p> <p>Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/6/15 by Ruth Shackelford, QIDP.</p>	W 000		
-----------------------	---	-------	--	--

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: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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
W 102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 2 of 3 sampled clients (A and B). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to complete investigations regarding an incident of client to client abuse for client A and DC (Discharged Client) F, client A's allegation of abuse by DC G, client B's allegation of abuse by client C, to develop and implement effective corrective measures to prevent further incidents of client to client abuse regarding DC F and client A, to develop and implement corrective measures to assess client A's sexual awareness and to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating</p>	W 102	<p>CORRECTION:</p> <p><i>The facility must ensure that specific governing body and management requirements are met. Specifically, the governing body has assured that:</i></p> <p>The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching</p>	04/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>direction over the facility to ensure the facility implemented its policy and procedures to complete investigations regarding an incident of client to client abuse for client A and DC (Discharged Client) F, client A's allegation of abuse by DC G, client B's allegation of abuse by client C, to develop and implement effective corrective measures to prevent further incidents of client to client abuse regarding DC F and client A, to develop and implement corrective measures to assess client A's sexual awareness and to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A. Please see W104.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 2 of 3 sampled clients (A and B). The governing body failed to implement its policy and procedures to complete investigations regarding an incident of client to client abuse for client A and DC (Discharged Client) F, client A's allegation of abuse by DC G, client B's allegation of abuse by client C, to develop and implement effective corrective measures to prevent further</p>		<p>of the QIDP throughout the investigation process for the next 90 days.</p> <p>The agency's Operations Team attended an investigation training session presented by Corporate Quality Assurance Manager on 4/6/15. The training included the need to report results on investigations in accordance with state law.</p> <p>The QIDP, will direct the team in completing an updated Human Development Assessment to evaluate Client A's current level of sexual awareness.</p> <p>PREVENTION:</p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>incidents of client to client abuse regarding DC F and client A, to develop and implement corrective measures to assess client A's sexual awareness and to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A. Please see W122.</p> <p>This federal tag relates to complaint #IN00160595.</p> <p>9-3-1(a)</p>		<p>their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations and report the results of investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>After completing investigations in which the allegations are verified, the QIDP, with the guidance of the Clinical Supervisor and Program Manager, will bring all relevant elements of the interdisciplinary team together to develop corrective measures to ensure the health and safety of clients. Revised Behavior Support Plans and other modifications will</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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>be reviewed and approved by the Clinical Supervisor prior to implementation.</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt residential manager) will be present, supervising and participating in active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to assure supports are implemented as written. Additionally supervisory staff will monitor client behavior to coach staff into developing a proactive approach that leads to early recognition, intervention and redirection when horseplay and other activities that could precipitate aggressive and/or other potentially harmful behavior.</p> <p>Members of the Operations</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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>Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions and documentation reviews no less than three times weekly for the next 30 days, no less than twice weekly for an additional 30 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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>the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/General Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will focus on:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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
			<ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff 2. Evaluation of the effectiveness of current behavior support plans. 3. Competent staff implementation of behavior supports and training programs. 4. Administrative documentation reviews will include but not be limited to assuring assessments are present, reflect current needs, with corresponding formal supports in place and that staff have received training on implementation of the plans. 5. Assuring continuous active treatment occurs, including but not limited to engineering a safe training environment. <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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
W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 3 sampled clients (A and B), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to complete investigations regarding an incident of client to client abuse for client A and DC (Discharged Client) F, client A's allegation of abuse by DC G, client B's allegation of abuse by client C, to develop and implement effective corrective measures to prevent further incidents of client to client abuse regarding DC F and client A, to develop and implement corrective measures to assess client A's sexual awareness and to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to complete investigations</p>	W 104	<p>CORRECTION:</p> <p><i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the governing body has facilitated the following:</i></p> <p>The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the</p>	04/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>regarding an incident of client to client abuse for client A and DC F, client A's allegation of abuse by DC G, client B's allegation of abuse by client C, to develop and implement effective corrective measures to prevent further incidents of client to client abuse regarding DC F and client A, to develop and implement corrective measures to assess client A's sexual awareness and to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A. Please see W149.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to complete investigations regarding an incident of client to client abuse for client A and DC F, client A's allegation of abuse by DC G and client B's allegation of abuse by client C. Please see W154.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A. Please see W156.</p>		<p>investigation process for the next 90 days.</p> <p>The agency's Operations Team attended an investigation training session presented by Corporate Quality Assurance Manager on 4/6/15. The training included the need to report results on investigations in accordance with state law.</p> <p>The QIDP, will direct the team in completing an updated Human Development Assessment to evaluate Client A's current level of sexual awareness.</p> <p>PREVENTION:</p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>4. The governing body failed to exercise general policy, budget and operating direction over the facility to develop and implement effective corrective measures to prevent further incidents of client to client abuse regarding DC F and client A and to develop and implement corrective measures to assess client A's sexual awareness. Please see W157.</p> <p>This federal tag relates to complaint #IN00160595.</p> <p>9-3-1(a)</p>		<p>Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations and report the results of investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>After completing investigations in which the allegations are verified, the QIDP, with the guidance of the Clinical Supervisor and Program Manager, will bring all relevant elements of the interdisciplinary team together to develop corrective measures to ensure the health and safety of clients. Revised Behavior Support Plans and other modifications will be reviewed and approved by the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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>Clinical Supervisor prior to implementation.</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt residential manager) will be present, supervising and participating in active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to assure supports are implemented as written. Additionally supervisory staff will monitor client behavior to coach staff into developing a proactive approach that leads to early recognition, intervention and redirection when horseplay and other activities that could precipitate aggressive and/or other potentially harmful behavior.</p> <p>Members of the Operations Team, comprised of Clinical</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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>Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions and documentation reviews no less than three times weekly for the next 30 days, no less than twice weekly for an additional 30 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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>hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/General Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will focus on:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/31/2015
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	
W 122	483.420		<ol style="list-style-type: none"> Mentorship and training of supervisory staff, monitoring and coaching of direct support staff Evaluation of the effectiveness of current behavior support plans. Competent staff implementation of behavior supports and training programs. Administrative documentation reviews will include but not be limited to assuring assessments are present, reflect current needs, with corresponding formal supports in place and that staff have received training on implementation of the plans. Assuring continuous active treatment occurs, including but not limited to engineering a safe training environment. <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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
--------------------	--	---------------	---	----------------------

Bldg. 00	<p>CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (A and B). The facility failed to implement its policy and procedures to complete investigations regarding an incident of client to client abuse for client A and DC (Discharged Client) F, client A's allegation of abuse by DC G, client B's allegation of abuse by client C, to develop and implement effective corrective measures to prevent further incidents of client to client abuse regarding DC F and client A, to develop and implement corrective measures to assess client A's sexual awareness and to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to complete investigations regarding an incident of client to client abuse for client A and DC F, client A's allegation of abuse by DC G, client B's allegation of abuse by client C, to develop and implement effective</p>	W 122	<p>CORRECTION:</p> <p><i>The facility must ensure that specific governing body and management requirements are met. Specifically, the governing body has facilitated the following:</i></p> <p>The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next</p>	04/30/2015
----------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>corrective measures to prevent further incidents of client to client abuse regarding DC F and client A, to develop and implement corrective measures to assess client A's sexual awareness and to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A. Please see W149.</p> <p>2. The facility failed to complete investigations regarding an incident of client to client abuse for client A and DC F, client A's allegation of abuse by DC G and client B's allegation of abuse by client C. Please see W154.</p> <p>3. The facility failed to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A. Please see W156.</p> <p>4. The facility failed to develop and implement effective corrective measures to prevent further incidents of client to client abuse regarding DC F and client A and to develop and implement corrective measures to assess client A's sexual awareness. Please see W157.</p> <p>This federal tag relates to complaint</p>		<p>90 days.</p> <p>The agency's Operations Team attended an investigation training session presented by Corporate Quality Assurance Manager on 4/6/15. The training included the need to report results on investigations in accordance with state law.</p> <p>The QIDP, will direct the team in completing an updated Human Development Assessment to evaluate Client A's current level of sexual awareness.</p> <p>PREVENTION:</p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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
	#IN00160595. 9-3-2(a)		attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations and report the results of investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. After completing investigations in which the allegations are verified, the QIDP, with the guidance of the Clinical Supervisor and Program Manager, will bring all relevant elements of the interdisciplinary team together to develop corrective measures to ensure the health and safety of clients. Revised Behavior Support Plans and other modifications will be reviewed and approved by the Clinical Supervisor prior to	

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 03/31/2015
--	---	--	---

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>implementation.</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt residential manager) will be present, supervising and participating in active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to assure supports are implemented as written. Additionally supervisory staff will monitor client behavior to coach staff into developing a proactive approach that leads to early recognition, intervention and redirection when horseplay and other activities that could precipitate aggressive and/or other potentially harmful behavior.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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>Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions and documentation reviews no less than three times weekly for the next 30 days, no less than twice weekly for an additional 30 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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>skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/General Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will focus on:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/31/2015
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	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS		<ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff 2. Evaluation of the effectiveness of current behavior support plans. 3. Competent staff implementation of behavior supports and training programs. 4. Administrative documentation reviews will include but not be limited to assuring assessments are present, reflect current needs, with corresponding formal supports in place and that staff have received training on implementation of the plans. 5. Assuring continuous active treatment occurs, including but not limited to engineering a safe training environment. <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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
Bldg. 00	<p>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 2 of 3 sampled clients (A and B), the facility failed to implement its policy and procedures to complete investigations regarding an incident of client to client abuse for client A and DC (Discharged Client) F, client A's allegation of abuse by DC G, client B's allegation of abuse by client C, to develop and implement effective corrective measures to prevent further incidents of client to client abuse regarding DC F and client A, to develop and implement corrective measures to assess client A's sexual awareness and to report the findings of an investigation to the facility administrator within 5 business days regarding an allegation of client to client abuse for DC F and client A.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 3/24/15 at 2:49 PM. The review indicated the following:</p> <p>1. BDDS report dated 12/2/14 indicated, "[Client A] reported that housemate [DC (Discharged Client) F] drugged (sic) him</p>	W 149	<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> <p>The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next</p>	04/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>out of the bed and down the hall leaving a carpet burn on his back. The supervisor asked [DC F] why did he do this. [DC F] stated that staff had asked [client A] to take a shower, so when [client A] didn't comply he then took matters into his own hands and pulled [client A] out of bed and drugged (sic) him down the hall towards the bathroom. Staff asked [client A] was he hurt as a result to (sic) this incident he said (sic) that he was not in any pain. Statements have been collected from both individuals. The staff that was on duty at the time of the incident has been suspended."</p> <p>-IS (Investigative Summary) dated 12/14/14 indicated DC F did pull client A from his bed and cause carpet burns on his back. The 12/14/14 IS peer review recommendations indicated, "Corrective Action (for) failure to report; Retrain [staff #1] on reporting procedure; DC F will move to new site."</p> <p>The review indicated the IS regarding client A's 12/2/14 allegation of abuse was completed on 12/14/14. The investigation was not completed within 5 business days.</p> <p>-BDDS report dated 12/15/14 indicated, "[DC F] and [client A] got into an altercation. [DC F] went into the</p>		<p>90 days.</p> <p>The agency's Operations Team attended an investigation training session presented by Corporate Quality Assurance Manager on 4/6/15. The training included the need to report results on investigations in accordance with state law.</p> <p>The QIDP, will direct the team in completing an updated Human Development Assessment to evaluate Client A's current level of sexual awareness.</p> <p>PREVENTION:</p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>medication room while [client A] was trying to take medication and hit [client A] in the face. Staff stopped both consumers before it went any further."</p> <p>The review indicated the facility failed to implement effective corrective measures to prevent further incidents of client to client aggression regarding DC F and client A.</p> <p>The review did not indicate documentation of an investigation regarding the 12/15/14 incident of client to client aggression between DC F and client A.</p> <p>2. BDDS report dated 1/30/15 indicated, "[Client A] approached staff and said that he was in pain and that [DC G] had hurt him. Staff performed a physical assessment and observed two 6 inch abrasions on [client A's] chest and abdomen. Housemates reported that [client A] had entered [DC G's] bedroom and refused to leave and that [DC G] had dragged [client A] out of the room."</p> <p>The review did not indicate documentation of an investigation regarding client A's 1/30/15 allegation.</p> <p>3. BDDS report dated 2/13/15 indicated, "[DC G] reported to staff that he had</p>		<p>attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations and report the results of investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>After completing investigations in which the allegations are verified, the QIDP, with the guidance of the Clinical Supervisor and Program Manager, will bring all relevant elements of the interdisciplinary team together to develop corrective measures to ensure the health and safety of clients. Revised Behavior Support Plans and other modifications will be reviewed and approved by the Clinical Supervisor prior to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>engaged in sexual intercourse with [client A] in the home's bathroom on the previous evening. [Client A] was taken to the [hospital] emergency department where a forensic exam was performed and a police report was filed."</p> <p>-Follow up BDDS report dated 3/9/15 indicated, "[DC G] was removed from the home and placed in hotel pending the transition into a waiver setting. Since the incident occurred the individuals has (sic) not made contact with one another."</p> <p>-IS dated 2/19/15 indicated the facility substantiated DC G did have sexual intercourse with client A.</p> <p>-IS dated 2/19/15 included an interview with staff #2 which indicated, "I have seen [client A] and [client DC G] demonstrate some kind of sexual behavior in the living room (joking around and making gestures) after which I redirect them to their privacy (sic). But I have never seen them in any kind of sexual relationship. This happens after watching a pornographic video."</p> <p>-IS dated 2/19/15 included an interview with staff #3 which indicated, "I previously worked at [group home] on Thursdays, Fridays and Saturdays from 4:00 PM through 12:00 AM. During my</p>		<p>implementation.</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt residential manager) will be present, supervising and participating in active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to assure supports are implemented as written. Additionally supervisory staff will monitor client behavior to coach staff into developing a proactive approach that leads to early recognition, intervention and redirection when horseplay and other activities that could precipitate aggressive and/or other potentially harmful behavior.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>time there, I have encountered [DC G] making inappropriate comments to not only myself but also to the other staff. There was one time, I went to check on [client A] when he was in [DC G's] room along with [client E] where they were watching pornography. When I asked for [client A], [DC G] told me [client A] was in the dark closet. I found [client A] just standing in the closet smiling and staff pulled him out. He was fully clothed."</p> <p>IS dated 2/19/15 indicated, "The evidence substantiates that [client A] lacked the ability to give informed consent for intimate sexual activity."</p> <p>The IS dated 2/19/15 did not indicate documentation of corrective measures to specifically assess client A's awareness of sexual behavior or use of pornographic materials.</p> <p>4. BDDS report dated 3/3/15 indicated, "Staff was administering medication in the medication room when [client B] yelled. [Client B] reported that [client C] had hit him in the back of the neck and on the forehead with a plate. Staff observed a bruise on [client B's] forehead."</p> <p>The review did not indicate documentation of an investigation</p>		<p>Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions and documentation reviews no less than three times weekly for the next 30 days, no less than twice weekly for an additional 30 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>regarding client B's 3/3/15 allegation.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 3/24/15 at 1:10 PM. CS #1 indicated the abuse and neglect policy should be implemented. CS #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated, corrective measures should be developed and implemented to prevent recurrence and the results of investigations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to the facility administrator within 5 business days of the alleged incident. CS #1 indicated client A had not been assessed regarding his sexual awareness.</p> <p>The facility's policies and procedures were reviewed on 3/26/15 at 5:27 PM. The facility's policy entitled, "Abuse, Neglect, Exploitation, Mistreatment" dated 2/26/11 indicated the following:</p> <p>- "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 under the policies of Adept, ResCare and local and</p>		<p>skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/General Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will focus on:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/31/2015
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	
W 154	<p>state and federal guidelines."</p> <p>-"Program intervention neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan, inappropriate application of intervention without a qualified person notification/review."</p> <p>The facility's policy entitled, 'Investigations' dated 9/14/07 indicated the following:</p> <p>-"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:... 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> <p>This federal tag relates to complaint #IN00160595.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>		<ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff 2. Evaluation of the effectiveness of current behavior support plans. 3. Competent staff implementation of behavior supports and training programs. 4. Administrative documentation reviews will include but not be limited to assuring assessments are present, reflect current needs, with corresponding formal supports in place and that staff have received training on implementation of the plans. 5. Assuring continuous active treatment occurs, including but not limited to engineering a safe training environment. <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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
Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 3 of 27 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to complete investigations regarding an incident of client to client abuse for clients A and DC (Discharged Client) F, client A's allegation of abuse by DC G and client B's allegation of abuse by client C.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 3/24/15 at 2:49 PM. The review indicated the following:</p> <p>1. BDDS report dated 12/15/14 indicated, "[DC F] and [client A] got into an altercation. [DC F] went into the medication room while [client A] was trying to take medication and hit [client A] in the face. Staff stopped both consumers before it went any further."</p> <p>The review did not indicate documentation of an investigation regarding the 12/15/14 incident of client to client aggression between DC F and</p>	W 154	<p>CORRECTION:</p> <p><i>The facility must have evidence that all alleged violations are thoroughly investigated.</i></p> <p>Specifically: the Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days.</p>	04/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>client A.</p> <p>2. BDDS report dated 1/30/15 indicated, "[Client A] approached staff and said that he was in pain and that [DC G] had hurt him. Staff performed a physical assessment and observed two 6 inch abrasions on [client A's] chest and abdomen. Housemates reported that [client A] had entered [DC G's] bedroom and refused to leave and that [DC G] had dragged [client A] out of the room."</p> <p>The review did not indicate documentation of an investigation regarding client A's 1/30/15 allegation.</p> <p>3. BDDS report dated 3/3/15 indicated, "Staff was administering medication in the medication room when [client B] yelled. [Client B] reported that [client C] had hit him in the back of the neck and on the forehead with a plate. Staff observed a bruise on [client B's] forehead."</p> <p>The review did not indicate documentation of an investigation regarding client B's 3/3/15 allegation.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 3/24/15 at 1:10 PM. CS #1 indicated all allegations of abuse, neglect and mistreatment should be</p>		<p>PREVENTION:</p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/31/2015
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	
W 156 Bldg. 00	<p>thoroughly investigated.</p> <p>This federal tag relates to complaint #IN00160595.</p> <p>9-3-2(a)</p> <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. Based on record review and interview for 1 of 27 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to report the findings of an investigation to the facility administrator within 5 business days of the alleged incident regarding an allegation of client to client abuse for DC (Discharged Client) F and client A.</p> <p>Findings include:</p>	W 156	<p>weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><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 agency's Operations Team attended an investigation training session presented by Corporate Quality Assurance Manager on 4/6/15. The training included the need to report results on investigations in</i></p>	04/30/2015	

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 03/31/2015
--	---	--	---

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>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 3/24/15 at 2:49 PM. The review indicated the following:</p> <p>BDDS report dated 12/2/14 indicated, "[Client A] reported that housemate [DC (Discharged Client) F] drugged (sic) him out of the bed and down the hall leaving a carpet burn on his back. The supervisor asked [DC F] why did he do this. [DC F] stated that staff had asked [client A] to take a shower, so when [client A] didn't comply he then took matters into his own hands and pulled [client A] out of bed and drugged (sic) him down the hall towards the bathroom. Staff asked [client A] was he hurt as a result to (sic) this incident he said (sic) that he was not in any pain. Statements have been collected from both individuals. The staff that was on duty at the time of the incident has been suspended."</p> <p>-IS (Investigative Summary) dated 12/14/14 indicated DC F did pull client A from his bed and cause carpet burns on his back.</p> <p>The review indicated the IS regarding client A's 12/2/14 allegation of abuse was completed on 12/14/14. The investigation was not completed within 5 business</p>		<p>accordance with state law.</p> <p>PREVENTION:</p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to report the results of investigations investigations</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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
W 157 Bldg. 00	<p>days.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 3/24/15 at 1:10 PM. CS #1 indicated the results of investigations of allegations of abuse, neglect and mistreatment should be reported to the facility administrator within 5 business days.</p> <p>This federal tag relates to complaint #IN00160595.</p> <p>9-3-2(a)</p> <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 2 of 27 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to develop and implement effective corrective measures to prevent further incidents of client to client abuse regarding DC F and client A and to develop and implement corrective measures to assess client A's sexual awareness.</p> <p>Findings include:</p>	W 157	<p>within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Operations Team</p> <p>CORRECTION: <i>If the alleged violation is verified, appropriate corrective action must be taken.</i> Specifically: the QIDP, will direct the team in completing an updated Human Development Assessment to evaluate Client A's current level of sexual awareness. PREVENTION: After completing investigations in which the allegations are verified, the QIDP, with the guidance of the Clinical Supervisor and Program Manager, will bring all relevant elements of the interdisciplinary team together to</p>	04/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 3/24/15 at 2:49 PM. The review indicated the following:</p> <p>1. BDDS report dated 12/2/14 indicated, "[Client A] reported that housemate [DC (Discharged Client) F] drugged (sic) him out of the bed and down the hall leaving a carpet burn on his back. The supervisor asked [DC F] why did he do this. [DC F] stated that staff had asked [client A] to take a shower, so when [client A] didn't comply he then took matters into his own hands and pulled [client A] out of bed and drugged (sic) him down the hall towards the bathroom. Staff asked [client A] was he hurt as a result to (sic) this incident he said (sic) that he was not in any pain. Statements have been collected from both individuals. The staff that was on duty at the time of the incident has been suspended."</p> <p>-IS (Investigative Summary) dated 12/14/14 indicated DC F did pull client A from his bed and cause carpet burns on his back. The 12/14/14 IS peer review recommendations indicated, "Corrective Action (for) failure to report; Retrain [staff #1] on reporting procedure; DC F will move to new site."</p>		<p>develop corrective measures to ensure the health and safety of clients. Revised Behavior Support Plans and other modifications will be reviewed and approved by the Clinical Supervisor prior to implementation. The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt residential manager) will be present, supervising and participating in active treatment during no less than 4 evening active treatment sessions and one morning active treatment session per week to assure supports are implemented as written. Additionally supervisory staff will monitor client behavior to coach staff into developing a proactive approach that leads to early recognition, intervention and redirection when horseplay and other activities that could precipitate aggressive and/or other potentially harmful behavior.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>-BDDS report dated 12/15/14 indicated, "[DC F] and [client A] got into an altercation. [DC F] went into the medication room while [client A] was trying to take medication and hit [client A] in the face. Staff stopped both consumers before it went any further."</p> <p>The review indicated the facility failed to implement effective corrective measures to prevent further incidents of client to client aggression regarding DC F and client A.</p> <p>2. BDDS report dated 2/13/15 indicated, "[DC G] reported to staff that he had engaged in sexual intercourse with [client A] in the home's bathroom on the previous evening. [Client A] was taken to the [hospital] emergency department where a forensic exam was performed and a police report was filed."</p> <p>-Follow up BDDS report dated 3/9/15 indicated, "[DC G] was removed from the home and placed in hotel pending the transition into a waiver setting. Since the incident occurred the individuals has (sic) not made contact with one another."</p> <p>-IS dated 2/19/15 indicated the facility substantiated DC G did have sexual intercourse with client A.</p>		<p>active treatment sessions and documentation reviews no less than three times weekly for the next 30 days, no less than twice weekly for an additional 30 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	---	---

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>-IS dated 2/19/15 included an interview with staff #2 which indicated, "I have seen [client A] and [client DC G] demonstrate some kind of sexual behavior in the living room (joking around and making gestures) after which I redirect them to their privacy (sic). But I have never seen them in any kind of sexual relationship. This happens after watching a pornographic video."</p> <p>-IS dated 2/19/15 included an interview with staff #3 which indicated, "I previously worked at [group home] on Thursdays, Fridays and Saturdays from 4:00 PM through 12:00 AM. During my time there, I have encountered [DC G] making inappropriate comments to not only myself but also to the other staff. There was one time, I went to check on [client A] when he was in [DC G's] room along with [client E] where they were watching pornography. When I asked for [client A], [DC G] told me [client A] was in the dark closet. I found [client A] just standing in the closet smiling and staff pulled him out. He was fully clothed."</p> <p>IS dated 2/19/15 indicated, "The evidence substantiates that [client A] lacked the ability to give informed consent for intimate sexual activity."</p>		<p>frequently if training issues or problems are discovered. The Executive Director and Director of Operations/General Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will focus on:</p> <ol style="list-style-type: none"> 1. Mentorship and training of supervisory staff, monitoring and coaching of direct support staff 2. Evaluation of the effectiveness of current behavior support plans. 3. Competent staff implementation of behavior supports and training programs. 4. Administrative documentation reviews will include but not be limited to assuring assessments are present, reflect current needs, with corresponding formal supports in place and that staff have received training on implementation of the plans. 5. Assuring continuous active treatment occurs, including but not limited to engineering a safe training environment. <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
--	---	--	---

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>The IS dated 2/19/15 did not indicate documentation of corrective measures to specifically assess client A's awareness of sexual behavior or use of pornographic materials.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 3/24/15 at 1:10 PM. CS #1 indicated corrective measures should be developed implemented to prevent recurrence of allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin. CS #1 indicated client A had not been assessed regarding his sexual awareness.</p> <p>This federal tag relates to complaint #IN00160595.</p> <p>9-3-2(a)</p>			