

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00179891.</p> <p>Complaint #IN00179891: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Dates of Survey: 11/2/15, 11/4/15, 11/5/15 and 11/9/15.</p> <p>Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/18/15.</p>	W 0000		
W 0149 Bldg. 00	<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 2 of 4 sampled clients (A and C), plus 2 additional clients (E and G), the facility failed to implement its policy and</p>	W 0149	<p>CORRECTION:</p> <p><i>The facility must develop and implement written policies and</i></p>	12/09/2015

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

TITLE

(X6) DATE

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

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	<p>procedures to prevent program intervention neglect regarding separate incidents of clients A and E's evasion of supervision while in the community, to ensure an allegation of staff to client abuse/mistreatment regarding client G and an allegation of client to client abuse/mistreatment were reported to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of the facility's knowledge of the allegations, to complete thorough investigations regarding two separate incidents of client A eloping from the group home and an incident of client E eloping from the group home, to report the results of investigations regarding an alleged incident of client to client abuse/mistreatment for clients C and G, an alleged incident of client to staff abuse/mistreatment regarding client G and an incident of elopement for client E within 5 business days of the alleged incidents and the facility failed to develop and implement effective corrective measures to prevent/address client A's elopement behaviors.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/2/15 at 12:49 PM. The review</p>		<p><i>procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i></p> <p>Staff responsible for failing to report the allegations on 4/7/15 and 9/3/15 no longer work for the facility.</p> <p>Facility staff will be retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.</p> <p>The governing body has established a Quality Assurance Department to assist with and coordinate the investigation process including but not limited to assuring thorough investigations occur as required and assuring results of investigations are reported to the administrator within five working days as required. The Operations Team, comprised of Clinical</p>	

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	<p>indicated the following:</p> <p>1. BDDS report dated 4/30/15 indicated, "[Client A] took 5:00 PM medications. Staff continued to pass medications to other consumers. Staff realized within 15 minutes that [client A] had walked off. Staff got in (sic) car and located [client A] off [intersection] around 6:30 PM. [Client A] stated to staff he was looking for his mom."</p> <p>The review indicated the facility completed an investigation of the 4/29/15 incident of elopement regarding client A. The Elopement/Missing Person Investigation Summary (EMPIS) dated 4/29/15 indicated the following:</p> <p>-"Introduction: [Client A]... has a history of elopement which is addressed in his BSP (Behavior Support Plan). He received enhanced supervision (15 minute checks) and was observed by staff at 5:45 PM after medication pass. At 5:30 PM, [client A] was not in the home and it was determined he had exited the building through its locked door. Staff initiated a search of the neighborhood and places that [client A] frequents and could not locate him. Date and time report electronically faxed to the administrator, 4/29/15, 6:30 PM."</p>		<p>Supervisor, the Program Manager, the Quality Assurance Manager, Quality Assurance Coordinator, Nurse Manager and Executive Director, and the QIDP will directly oversee all investigations. When, during the course of an investigation, additional allegations arise, the governing body will assure that a separate investigation is initiated and completed thoroughly, within required time lines. Oversight will include but not be limited to reconciling conflicting testimony and determining of staff negligence or neglect contributed to the alleged incidents.</p> <p>Additionally, the interdisciplinary team will modify Client A's current proactive and reactive behavior support strategies to prevent future elopements.</p> <p>PREVENTION:</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations</p>	

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	<p>The 4/29/15 EMPIS form did not indicate documentation of analysis regarding the inconsistencies between the 4/29/15 BDDS timeline of events and the 4/29/15 EMPIS timeline of events. The 4/29/15 EMPIS did not indicate documentation of a clear chronological description of when client A was last observed by staff, when staff first became aware of client A missing and staff's response to client A's elopement.</p> <p>- "How did the client elope/become missing without someone noticing? [Client A] took 5:00 PM medications and exited the medication room and sat on the sofa. One staff continued to pass medications while another prepared dinner in the kitchen."</p> <p>- "How was the client able to leave the premises? (I.E. (sic) was the door unlocked? Were there alarms on the doors? Etc.) [Client A] exited the home through a door that was locked from the inside. Alarms are in place."</p> <p>- "Was the client at risk to himself/herself or others? [Client A] receives 24 hour staff supervision and was considered to be at risk while out of staff's line of sight."</p> <p>The 4/29/15 EMPIS form did not indicate</p>		<p>Team, as appropriate. Internal and day service incident reports will be sent directly to the Program Managers and quality Assurance Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state 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. Members of the Operations Team (including the Program Manager, Quality Assurance Manager, Nurse Manager, Quality Assurance Coordinator and Executive Director) and the QIDP will conduct documentation reviews no less than twice weekly for the next 21 days, no less than 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. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely</p>	

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	<p>documentation of analysis of how client A eloped from the home without staff being aware of the entry/exit door alarms sounding.</p> <p>The 4/29/15 EMPIS form did not indicate documentation of a finding of fact and determination as to whether or not staff working in the home with client A on 4/29/15 implemented client A's BSP/enhanced supervision appropriately to prevent and respond to client A's elopement from the home.</p> <p>The 4/29/15 EMPIS form indicated the following recommendations to address client A's elopement behavior:</p> <p>- "The team consensually agreed that [client A's] current support cannot assure that future elopement attempts will not occur. (1) [Client A] told his team that he is running from his home and from staff because he is upset that he cannot move to [city] as he has requested. His guardian has said that [client A's] required level of support is not currently available in [city.]; (2.) [Client A] would benefit from counseling to assiting (sic) him with processing his feelings about his current living arrangements and future plans. Service intake is set with [counselor]; (3.) The team discussed [client A] trying out other programs like music and art</p>		<p>manner.</p> <p>The investigation team, comprised of the Program Manager, Quality Assurance Manager, Quality Assurance Coordinator and QIDPs will communicate daily through the course of all investigations –reviewing gathered evidence to determine if the scope of the current investigation needs to be expanded and whether new allegations must be reported and investigated.</p> <p>Additionally at the conclusion of investigation, members of the Operations Team including the Executive Director, Human Resources Specialist, Program Manager, Quality Assurance Manager and Nurse Manager, will conduct a peer review meeting to review the investigation summary and gathered evidence to assure all allegations have been duly reported and investigated. When deficiencies are noted, additional investigations will be initiated as needed.</p> <p>A tracking spreadsheet for incidents requiring investigation,</p>	

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	<p>therapy; (4.) [Client A's] medication was increased on 5/1/15 to address hallucinations; (5.) The BDDS generalist will discuss options with [client A's] guardian."</p> <p>-BDDS report dated 6/9/15 indicated, "[Client A] eloped on the evening shift on 6/8/15. The police arrived to (sic) home around 8:00 PM and informed staff [client A] was found at a local park and taken to [ER (Emergency Room)] for seizure like activity. [Client A] was diagnosed with low blood sugar and admitted due to (a) sugar level reading at 30."</p> <p>The review indicated the facility completed an investigation regarding client A's 6/8/15 elopement from the group home. The 6/11/15 EMPIS indicated the following:</p> <p>-"[Client A]... has a history of elopement which is addressed in his BSP. He receives enhanced supervision (15 minute checks) and was observed by staff at 7:45 PM. At 7:55 PM, [client A] was not in the home and it was determined he had exited the building through its unlocked door. Staff initiated a search of the neighborhood and places that [client A] frequents and could not locate him."</p>		<p>follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Program Manager (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 Program Manager 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 Quality Assurance Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The program Managers will provide weekly updates to the Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations</p>	

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	<p>-"[Client A] exited the home through a door that is not locked from the inside. Alarms are in place. [Client A] is believed to have turned the alarm off."</p> <p>-"Where were the staff and what were they doing at the time of the elopement/when the person became missing? Two staff was (sic) out with two consumers each on (a) separate outing. One staff was at (the) site with [client A] (3 clients total with one staff). This staff was in the kitchen checking consumer's lunches for the next day."</p> <p>-"How was the client found? (What were they doing and what condition was (sic) they in?) [Client A] was confused and staggering and thought to have had a seizure. [Client A] was taking (sic) to [ER] where he was treated for low blood sugar. [Client A's] blood sugar level was 38."</p> <p>-"[Client A] receives 24 hour staff supervision and was considered to be at risk while out of staff's line of sight."</p> <p>The review indicated the facility failed to develop and implement effective corrective measures to prevent client A's elopement behaviors since the 4/29/15 elopement incident.</p>		<p>within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>When deficiencies in current support strategies are identified during the course of investigations, the QIDP will bring all relevant elements of the interdisciplinary team together to reassess, develop and implement modifications to individuals' support plans. Members of the Operations Team comprised of the Executive Director, Program Managers, Quality Assurance Manager, Nurse Manager and Quality Assurance Coordinator will review investigation conclusions and facility support documents no less than monthly to assure corrective measures have been implemented.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team</p>	

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	<p>The 6/11/15 EMPIS form did not indicate documentation of description of client A's behavior and/or health status prior to the elopement. The 6/11/15 EMPIS did not indicate documentation of a determination as to whether or not client A demonstrated any signs/symptoms of low blood sugar prior to his elopement. The 6/11/15 EMPIS did not indicate documentation of a finding of fact and determination as to whether staff working with client A appropriately implemented client A's 10/13/14 Comprehensive High Risk Health Plan (CHRHP) for Diabetes management and/or client A's 3/11/15 BSP.</p> <p>Client A's record was reviewed on 11/4/15 at 12:44 PM. Client A's CHRHP dated 10/13/14 indicated, "Triggers to notify nurse: (1.) High Blood Sugar: frequent urination, unusual thirst, extreme hunger, unusual weight loss, extreme fatigue and irritability, blurred vision, cuts/bruises that are slow to heal, tingling/numbness in the hands/feet, recurring skin, gum or bladder infections; (2.) Low Blood Sugar: shakiness, dizziness, sweating, hunger, headache, pale skin color, sudden moodiness or behavior changes such as crying for no apparent reason, clumsy or jerky movements, difficulty paying attention or confusion, tingling sensations around the</p>			

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	<p>mouth."</p> <p>Client A's CHRHP dated 10/13/14 regarding diabetes indicated, "Staff will monitor for, note, record and report to (the) nurse immediately any of the aforementioned symptoms noted (triggers to notify nurse)."</p> <p>Client A's 3/11/15 BSP indicated the following:</p> <p>- "Preventative Procedures. Recognize symptoms of escalation, i.e., access to escape from non-preferred tasks and change. Encourage him to cope by use of his walking with staff and removing himself from situation."</p> <p>- "Leaving Assigned Area: (1.) Currently [client A] is on 15 minute checks when he's at home. Once [client A] walks away from the designated area, a staff will follow [client A] and initially keep a bit of distance between him and themselves (no more than 10 feet). If possible, the second staff will use the van to follow. When [client A] is in the community he's a one to one (supervision) precaution, there's to be a staff with him at all times. The second and third shift staff (sic) will immediately notify the RM (Resident Manager) and follow their instructions."</p>			

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	<p>-"If [client A] is threatening/attempting to run into the road from the ground or from the van: attempt to block him from exiting the home...."</p> <p>Nurse #2 was interviewed on 11/4/15 at 1:33 PM. Nurse #2 indicated client A should be monitored for signs/symptoms of diabetes, high or low blood sugar.</p> <p>RM (Resident Manager) #1 was interviewed on 11/4/15 at 3:37 PM. RM #1 indicated client A's BSP should be implemented by staff. RM #1 indicated the group home had audible door alarms on the entry/exit doors of the home. RM #1 indicated client A knew how to turn the door alarms off. RM #1 indicated the police had located client A on 6/9/15 and taken him to the ER for low blood sugar.</p> <p>2. BDDS report dated 6/12/15, 6:55 AM indicated, "[Client E] called 911 and reported the house was on fire. While staff was on the phone with 911, [client E] turned the alarm off on the door and exited the home. [Client E] left the premises. Staff looked for him and was unable to locate him. [Client E] returned home around 9:00 AM. Staff will continue to provide services as outlined in BSP and ISP (Individual Support Plan). Staff will continue to complete 15 minute checks while in (the) home.</p>			

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	<p>[Client E] was provided emotional support from [RM #1]."</p> <p>The review indicated the facility completed an investigation regarding client E's 6/12/15 elopement. The 6/26/15 EMPIS form indicated the following:</p> <p>-"[Client E]... has a history of elopement which is addressed in his BSP. He receives 24/7 supervision. At 6:55 AM on 6/11/15, [client E], was not in the home and it was determined he had exited the building through its locked door. the door alarm had been turned off. Staff initiated a search of the neighborhood and places that [client E] frequents and could not locate him."</p> <p>-"How long was the client gone? Around 2 hours."</p> <p>-"What is the staffing level for the client? (How many people were on duty at the time of the elopement?) How many hours of daily/weekly services does the client receive? [Client E] requires 24 hour supervision. One staff was on duty at the time of the incident. There were five individuals home at the time."</p> <p>-"How did the client elope/become missing without someone noticing? [Client E] exited the home while staff</p>			

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	<p>was administering medications to a housemate."</p> <p>-"[Client E] receives 24 hour staff supervision and was considered to be at risk while out of staff line of site (sic)."</p> <p>The 6/26/15 EMPIS form did not indicate documentation of analysis regarding whether staff was on the phone with 911 as indicated in the 6/12/15 BDDS report or in the medication room administering medications as indicated in the EMPIS. The 6/26/15 EMPIS did not indicate documentation regarding how the one staff on duty at the time of the elopement was able to facilitate a search of the neighborhood as indicated in the EMPIS. The 6/26/15 EMPIS did not indicate documentation of a chronological description of events including when additional staff arrived and how and when staff responded and communicated client E's elopement and if the police were called for assistance. The 6/26/15 EMPIS did not indicate documentation of a finding of fact and determination as to whether staff working with client appropriately implemented client E's BSP.</p> <p>The review indicated the 6/26/15 EMPIS indicated the facility reported the results of the investigation of client E's 6/12/15</p>			

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	<p>elopement on 6/26/15.</p> <p>Client E's record was reviewed on 11/4/15 at 12:00 PM. Client E's BSP dated 9/11/14 indicated the following:</p> <p>-"[Client E] will be placed in line of site (sic) at all times due to his history and successful attempts of leaving the assigned area. When [client E] is upset he would call 911 and tell the dispatcher false stories of his mental health status. His behaviors will be implemented as follows (sic) and will be readjusted throughout and at the end of his initial 30 day assessment."</p> <p>-"Leaves assigned area: One staff will follow [client E] and initially keep a bit of distance between him and themselves (no more than 10 feet). If possible, the second staff will use the van to follow."</p> <p>-"If [client E] is threatening/attempting to run into the road from the ground or from the van: attempt to block him from exiting the home."</p> <p>-"If [client E] is no longer in staff's line of sight, 911 is to be called by [RM #1]."</p> <p>RM #1 was interviewed on 11/4/15 at 3:37 PM. RM #1 indicated client E's BSP should be implemented by staff. RM #1</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>indicated client E's BSP had been updated/revised since 9/11/14 and had changed client E's supervision from line of sight to 15 minute checks. RM #1 indicated she would provide documentation of client E's updated/revised plan. RM #1 did not provide additional documentation of an updated/revised BSP for client E. RM #1 indicated client E had eloped from the group home on 6/12/15 at 6:55 AM. RM #1 indicated one staff was on duty at the time of client E's elopement. RM #1 indicated a second staff came on duty at 7:00 AM on 6/12/15 after client E's elopement and initiated a search of the neighborhood. RM #1 indicated she had been notified of the incident. RM #1 indicated the police had not been called.</p> <p>3. BDDS report dated 4/9/15 indicated, "[Client G] informed staff on duty on 4/7/15 that [staff #1] had scratched him on his arm on 4/6/15." The review indicated the date of the facility's knowledge of client G's allegation was 4/7/15 and the date the facility reported the allegation to BDDS was 4/9/15. The review indicated client G's 4/7/15 allegation of staff to client abuse/mistreatment was not reported to BDDS within 24 hours of the facility's knowledge of the allegation.</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>4. BDDS report dated 9/5/15 indicated on 9/3/15 the facility had knowledge of a 9/3/15 incident regarding client C physically striking client G on the back of his head and attempting to damage client G's television remote. Client G was not injured as a result of being hit by client C. The review indicated the incident of client to client aggression was not reported to BDDS within 24 hours of the facility's knowledge.</p> <p>The review indicated the facility completed an investigation of the 9/3/15 incident of client to client aggression between clients C and G. The final investigation report form dated 11/1/15 substantiated client C had physically hit client G. The final investigation report indicated the results of the investigation were reported to the facility administrator on 11/1/15. The review indicated the facility did not report the findings of the 9/3/15 incident within 5 business days.</p> <p>5. BDDS report dated 8/7/15 indicated, "While investigating allegations of an argument between staff it was alleged that [TL (Team Leader) #1], [staff #2] and [staff #3] engaged in a pattern of yelling at [client A] and threatening to restrict his access to cigarettes."</p> <p>The review indicated the facility</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>completed an investigation of the 8/7/15 allegations of staff to client mistreatment/abuse. The investigation form dated 8/18/15 indicated the facility administrator was notified of the results of the investigation of the 8/7/15 allegation on 8/18/15. The review indicated the facility did not report the findings of the 8/7/15 allegation within 5 business days.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 11/4/15 at 3:40 PM. CS #1 indicated the facility's abuse and neglect policy should be implemented, allegations of abuse, neglect and mistreatment should be reported to BDDS within 24 hours of the facility knowledge of the allegation, the investigations of allegations of abuse, neglect and mistreatment should be thorough, the results of the investigations of abuse, neglect or mistreatment should be reported to the facility administrator within 5 business days of the alleged incident and the facility should develop and implement corrective measures to prevent recurrence of abuse, neglect or mistreatment.</p> <p>The facility's policies and procedures were reviewed on 11/5/15 at 7:26 PM. The facility's Abuse, Neglect, Exploitation and Mistreatment policy</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>dated 2/26/11 indicated the following:</p> <ul style="list-style-type: none"> - "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." - "Following Adept protocol to report incident, once the suspicion has been reported to the PC (Program Coordinator), the PC will report, within 24 hours, the suspected abuse, neglect, exploitation or mistreatment as follows... g. to the BDDS central office (via web-based form)." - "A full investigation will be conducted by Adept personnel for incident occurring residentially." <p>The facility's Investigations policy dated 9/14/07 indicated the following:</p> <ul style="list-style-type: none"> - "The primary purpose of an investigation is to describe and explain factors contributing to an incident and to prevent recurrence." - "10. A thorough investigation final report will be written at the completion of the investigation. The report shall 			

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0153 Bldg. 00	<p>include, but is not limited to the following: (1.) Description of the allegation or incident; (2.) Purpose of the investigation; (3.) Parties providing information; (4.) Summary of information and findings (evidence collected, witnesses interviewed, date of the investigating, name(s) of investigator(s)); (5.) Description and chronology of what happened; (6.) Analysis of the evidence; (7.) Finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive; (8.) Concerns and recommendations...."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 11 allegations of abuse, neglect or mistreatment reviewed, the facility failed to ensure an allegation of staff to client abuse/mistreatment regarding client G and an allegation of client to client abuse/mistreatment for clients C and G</p>	W 0153	<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</i></p>	11/09/2015

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>were reported to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of the facility's knowledge of the allegations in accordance with state law.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/2/15 at 12:49 PM. The review indicated the following:</p> <p>1. BDDS report dated 4/9/15 indicated, "[Client G] informed staff on duty on 4/7/15 that [staff #1] had scratched him on his arm on 4/6/15." The review indicated the date of the facility's knowledge of the client G's allegation was 4/7/15 and the date the facility reported the allegation to BDDS was 4/9/15. The review indicated client G's 4/7/15 allegation of staff to client abuse/mistreatment was not reported to BDDS within 24 hours of the facility's knowledge of the allegation.</p> <p>2. BDDS report dated 9/5/15 indicated on 9/3/15 the facility had knowledge of a 9/3/15 incident regarding client C physically striking client G on the back of his head and attempting to damage client G's television remote. Client G was not</p>		<p><i>in accordance with State law through established procedures.</i> Specifically, the staff responsible for failing to report the allegations on 4/7/15 and 9/3/15 no longer work for the facility.</p> <p>Facility staff will be retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.</p> <p>PREVENTION:</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>injured as a result of being hit by client C. The review indicated the incident of client to client aggression was not reported to BDDS within 24 hours of the facility's knowledge.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 11/4/15 at 3:40 PM. CS #1 indicated allegations of abuse, neglect and mistreatment should be reported to BDDS within 24 hours of the facility knowledge of the allegation.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>		<p>coordinate and follow-up with the facility QIDP to assure incidents are reported to state 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. Members of the Operations Team (including the Program Manager, Quality Assurance Manager, Nurse Manager, Quality Assurance Coordinator and Executive Director) and the QIDP will conduct documentation reviews no less than twice weekly for the next 21 days, no less than 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. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner.</p> <p>RESPONSIBLE PARTIES:</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0154 Bldg. 00	<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 3 of 11 allegations of abuse, neglect or mistreatment reviewed, the facility failed to complete thorough investigations regarding two separate incidents of client A eloping from the group home and an incident of client E eloping from the group home.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/2/15 at 12:49 PM. The review indicated the following:</p> <p>1. BDDS report dated 4/30/15 indicated, "[Client A] took 5:00 PM medications. Staff continued to pass medications to other consumers. Staff realized within 15 minutes that [client A] had walked off. Staff got in (sic) car and located [client A] off [intersection] around 6:30 PM. [Client A] stated to staff he was looking for his mom."</p>	W 0154	<p>QIDP, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the governing body has established a Quality Assurance Department to assist with and coordinate the investigation process. The Operations Team, comprised of Clinical Supervisor, the Program Manager, the Quality Assurance Manager, Quality Assurance Coordinator, Nurse Manager and Executive Director, and the QIDP will directly oversee all investigations. When, during the course of an investigation, additional allegations arise, the governing body will assure that a separate investigation is initiated and completed thoroughly, within required time lines. Oversight will include but not be limited to reconciling conflicting testimony and determining of staff negligence or neglect contributed to the alleged incidents.</p>	12/09/2015

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>The review indicated the facility completed an investigation of the 4/29/15 incident of elopement regarding client A. The Elopement/Missing Person Investigation Summary (EMPIS) dated 4/29/15 indicated the following:</p> <p>-"Introduction: [Client A]... has a history of elopement which is addressed in his BSP (Behavior Support Plan). He received enhanced supervision (15 minute checks) and was observed by staff at 5:45 PM after medication pass. At 5:30 PM, [client A] was not in the home and it was determined he had exited the building through its locked door. Staff initiated a search of the neighborhood and places that [client A] frequents and could not locate him. Date and time report electronically faxed to the administrator, 4/29/15, 6:30 PM."</p> <p>The 4/29/15 EMPIS form did not indicate documentation of analysis regarding the inconsistencies between the 4/29/15 BDDS timeline of events and the 4/29/15 EMPIS timeline of events. The 4/29/15 EMPIS did not indicate documentation of a clear chronological description of when client A was last observed by staff, when staff first became aware of client A missing and staff's response to client A's elopement.</p>		<p>PREVENTION:</p> <p>The investigation team, comprised of the Program Manager, Quality Assurance Manager, Quality Assurance Coordinator and QIDPs will communicate daily through the course of all investigations –reviewing gathered evidence to determine if the scope of the current investigation needs to be expanded and whether new allegations must be reported and investigated.</p> <p>Additionally at the conclusion of investigation, members of the Operations Team including the Executive Director, Human Resources Specialist, Program Manager, Quality Assurance Manager and Nurse Manager, will conduct a peer review meeting to review the investigation summary and gathered evidence to assure all allegations have been duly reported and investigated. When deficiencies are noted, additional investigations will be initiated as needed.</p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>- "How did the client elope/become missing without someone noticing? [Client A] took 5:00 PM medications and exited the medication room and sat on the sofa. One staff continued to pass medications while another prepared dinner in the kitchen."</p> <p>- "How was the client able to leave the premises? (I.E. (sic) was the door unlocked? Were there alarms on the doors? Etc.) [Client A] exited the home through a door that was locked from the inside. Alarms are in place."</p> <p>- "Was the client at risk to himself/herself or others? [Client A] receives 24 hour staff supervision and was considered to be at risk while out of staff's line of sight."</p> <p>The 4/29/15 EMPIS form did not indicate documentation of analysis of how client A eloped from the home without staff being aware of the entry/exit door alarms sounding.</p> <p>The 4/29/15 EMPIS form did not indicate documentation of a finding of fact and determination as to whether or not staff working in the home with client A on 4/29/15 implemented client A's BSP/enhanced supervision appropriately to prevent and respond to client A's</p>		<p>corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Program Manager (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 Program Manager 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 Quality Assurance Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The program Managers will provide weekly updates to the Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>elopement from the home.</p> <p>2. BDDS report dated 6/9/15 indicated, "[Client A] eloped on the evening shift on 6/8/15. The police arrived to (sic) home around 8:00 PM and informed staff [client A] was found at a local park and taken to [ER (Emergency Room)] for seizure like activity. [Client A] was diagnosed with low blood sugar and admitted due to (a) sugar level reading at 30."</p> <p>The review indicated the facility completed an investigation regarding client A's 6/8/15 elopement from the group home. The 6/11/15 EMPIS indicated the following:</p> <p>-"[Client A]... has a history of elopement which is addressed in his BSP. He receives enhanced supervision (15 minute checks) and was observed by staff at 7:45 PM. At 7:55 PM, [client A] was not in the home and it was determined he had exited the building through its unlocked door. Staff initiated a search of the neighborhood and places that [client A] frequents and could not locate him."</p> <p>-"[Client A] exited the home through a door that is not locked from the inside. Alarms are in place. [Client A] is believed to have turned the alarm off."</p>		<p>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>	

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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(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>- "Where were the staff and what were they doing at the time of the elopement/when the person became missing? Two staff was (sic) out with two consumers each on separate outing. One staff was at (the) site with [client A] (3 clients total with one staff). This staff was in the kitchen checking consumer's lunches for the next day."</p> <p>- "How was the client found? (What were they doing and what condition was (sic) they in?) [Client A] was confused and staggering and thought to have had a seizure. [Client A] was taking (sic) to [ER] where he was treated for low blood sugar. [Client A's] blood sugar level was 38."</p> <p>- "[Client A] receives 24 hour staff supervision and was considered to be at risk while out of staff's line of sight."</p> <p>The 6/11/15 EMPIS form did not indicate documentation of description of client A's behavior and/or health status prior to the elopement. The 6/11/15 EMPIS did not indicate documentation of a determination as to whether or not client A demonstrated any signs/symptoms of low blood sugar prior to his elopement. The 6/11/15 EMPIS did not indicate documentation of a finding of fact and</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>determination as to whether staff working with client A appropriately implemented client A's 10/13/14 Comprehensive High Risk Health Plan (CHRHP) for Diabetes management and/or client A's 3/11/15 BSP.</p> <p>Client A's record was reviewed on 11/4/15 at 12:44 PM. Client A's CHRHP dated 10/13/14 indicated, "Triggers to notify nurse: (1.) High Blood Sugar: frequent urination, unusual thirst, extreme hunger, unusual weight loss, extreme fatigue and irritability, blurred vision, cuts/bruises that are slow to heal, tingling/numbness in the hands/feet, recurring skin, gum or bladder infections; (2.) Low Blood Sugar: shakiness, dizziness, sweating, hunger, headache, pale skin color, sudden moodiness or behavior changes such as crying for no apparent reason, clumsy or jerky movements, difficulty paying attention or confusion, tingling sensations around the mouth."</p> <p>Client A's CHRHP dated 10/13/14 regarding diabetes indicated, "Staff will monitor for, note, record and report to (the) nurse immediately any of the aforementioned symptoms noted (triggers to notify nurse)."</p> <p>Client A's 3/11/15 BSP indicated 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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>following:</p> <p>- "Preventative Procedures. Recognize symptoms of escalation, i.e., access to escape from non-preferred tasks and change. Encourage him to cope by use of his walking with staff and removing himself from situation."</p> <p>- "Leaving Assigned Area: (1.) Currently [client A] is on 15 minute checks when he's at home. Once [client A] walks away from the designated area, a staff will follow [client A] and initially keep a bit of distance between him and themselves (no more than 10 feet). If possible, the second staff will use the van to follow. When [client A] is in the community he's a one to one (supervision) precaution, there's to be a staff with him at all times. The second and third shift staff (sic) will immediately notify the RM (Resident Manager) and follow their instructions."</p> <p>- "If [client A] is threatening/attempting to run into the road from the ground or from the van: attempt to block him from exiting the home...."</p> <p>3. BDDS report dated 6/12/15, 6:55 AM indicated, "[Client E] called 911 and reported the house was on fire. While staff was on the phone with 911, [client E] turned the alarm off on the door and</p>			
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>exited the home. [Client E] left the premises. Staff looked for him and was unable to locate him. [Client E] returned home around 9:00 AM. Staff will continue to provide services as outlined in BSP and ISP (Individual Support Plan). Staff will continue to complete 15 minute checks while in (the) home. [Client E] was provided emotional support from [RM #1]."</p> <p>The review indicated the facility completed an investigation regarding client E's 6/12/15 elopement. The 6/26/15 EMPIS form indicated the following:</p> <p>-"[Client E]... has a history of elopement which is addressed in his BSP. He receives 24/7 supervision. At 6:55 AM on 6/11/15, [client E], was not in the home and it was determined he had exited the building through its locked door. the door alarm had been turned off. Staff initiated a search of the neighborhood and places that [client E] frequents and could not locate him."</p> <p>-"How long was the client gone? Around 2 hours."</p> <p>-"What is the staffing level for the client? (How many people were on duty at the time of the elopement?) How many hours of daily/weekly services does the client</p>			

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>receive? [Client E] requires 24 hour supervision. One staff was on duty at the time of the incident. There were five individuals home at the time."</p> <p>-"How did the client elope/become missing without someone noticing? [Client E] exited the home while staff was administering medications to a housemates."</p> <p>-"[Client E] receives 24 hour staff supervision and was considered to be at risk while out of staff line of site (sic)."</p> <p>The 6/26/15 EMPIS form did not indicate documentation of analysis regarding whether staff was on the phone with 911 as indicated the in the 6/12/15 BDDS report or in the medication room administering medications as indicated in the EMPIS. The 6/26/15 EMPIS did not indicate documentation regarding how the one staff on duty at the time of the elopement was able to facilitate a search of the neighborhood as indicated in the EMPIS. The 6/26/15 EMPIS did not indicate documentation of a chronological description of events including when additional staff arrived and how and when staff responded and communicated client E's elopement and if the police were called for assistance. The 6/26/15 EMPIS did not indicate</p>			

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>documentation of a finding of fact and determination as to whether staff working with client appropriately implemented client E's BSP.</p> <p>Client E's record was reviewed on 11/4/15 at 12:00 PM. Client E's BSP dated 9/11/14 indicated the following:</p> <p>-"[Client E] will be placed in line of site (sic) at all times due to his history and successful attempts of leaving the assigned area. When [client E] is upset he would call 911 and tell the dispatcher false stories of his mental health status. His behaviors will be implemented as follows (sic) and will be readjusted throughout and at the end of his initial 30 day assessment."</p> <p>-"Leaves assigned area: One staff will follow [client E] and initially keep a bit of distance between him and themselves (no more than 10 feet). If possible, the second staff will use the van to follow."</p> <p>-"If [client E] is threatening/attempting to run into the road from the ground or from the van: attempt to block him from exiting the home."</p> <p>-"If [client E] is no longer in staff's line of sight, 911 is to be called by [RM #1]."</p>			

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
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W 0156	<p>RM #1 was interviewed on 11/4/15 at 3:37 PM. RM #1 indicated client E's BSP should be implemented by staff. RM #1 indicated client E's BSP had been updated/revised since 9/11/14 and had changed client E's supervision from line of sight to 15 minute checks. RM #1 indicated she would provide documentation of client E's updated/revised plan. RM #1 did not provide additional documentation of an updated/revised BSP for client E. RM #1 indicated client E had eloped from the group home on 6/12/15 at 6:55 AM. RM #1 indicated one staff was on duty at the time of client E's elopement. RM #1 indicated a second staff came on duty at 7:00 AM on 6/12/15 after client E's elopement and initiated a search of the neighborhood. RM #1 indicated she had been notified of the incident. RM #1 indicated the police had not been called.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 11/4/15 at 3:40 PM. CS #1 indicated the investigations of allegations of abuse, neglect and mistreatment should be thorough.</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: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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Bldg. 00	<p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 3 of 11 allegations of abuse, neglect and mistreatment reviewed, the facility failed to report the results of investigations regarding an alleged incident of client to client abuse/mistreatment for clients C and G, an alleged incident of client to staff abuse/mistreatment regarding client G and an incident of elopement for client E within 5 business days of the alleged incidents.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/2/15 at 12:49 PM. The review indicated the following:</p> <p>1. BDDS report dated 6/12/15, 6:55 AM indicated, "[Client E] called 911 and reported the house was on fire. While staff was on the phone with 911, [client E] turned the alarm off on the door and exited the home. [Client E] left the premises. Staff looked for him and was unable to locate him. [Client E] returned home around 9:00 AM. Staff will continue to provide services as outlined</p>	W 0156	<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 governing body has established a Quality Assurance Department to assist with and coordinate the investigation process, including but not limited to assuring results of investigations are reported to the administrator within five working days as required.</i></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 Program Manager (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>	12/09/2015

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>in BSP and ISP (Individual Support Plan). Staff will continue to complete 15 minute checks while in (the) home. [Client E] was provided emotional support from [RM #1]."</p> <p>The review indicated the facility completed an investigation regarding client E's 6/12/15 elopement. The review indicated the 6/26/15 EMPIS indicated the facility reported the results of the investigation of client E's 6/12/15 elopement on 6/26/15.</p> <p>2. BDDS report dated 9/5/15 indicated on 9/3/15 the facility had knowledge of a 9/3/15 incident regarding client C physically striking client G on the back of his head and attempting to damage client G's television remote. Client G was not injured as a result of being hit by client C.</p> <p>The review indicated the facility completed an investigation of the 9/3/15 incident of client to client aggression between clients C and G. The final investigation report form dated 11/1/15 substantiated client C had physically hit client G. The final investigation report indicated the results of the investigation were reported to the facility administrator on 11/1/15. The review indicated the facility did not report the findings of the</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 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>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Operations Team</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>9/3/15 incident within 5 business days.</p> <p>3. BDDS report dated 8/7/15 indicated, "While investigating allegations of an argument between staff it was alleged that [TL (Team Leader) #1], [staff #2] and [staff #3] engaged in a pattern of yelling at [client A] and threatening to restrict his access to cigarettes."</p> <p>The review indicated the facility completed an investigation of the 8/7/15 allegations of staff to client mistreatment/abuse. The investigation form dated 8/18/15 indicated the facility administrator was notified of the results of the investigation of the 8/7/15 allegation on 8/18/15. The review indicated the facility did not report the findings of the 8/7/15 allegation within 5 business days.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 11/4/15 at 3:40 PM. CS #1 indicated the results of the investigations of abuse, neglect or mistreatment should be reported to the facility administrator within 5 business days of the alleged incident.</p> <p>9-3-2(a)</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 11/09/2015
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
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W 0157 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 11 allegations of abuse, neglect or mistreatment reviewed, the facility failed to develop and implement effective corrective measures to address client A's elopement behaviors.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/2/15 at 12:49 PM. The review indicated the following:</p> <p>-BDDS report dated 4/30/15 indicated, "[Client A] took 5:00 PM medications. Staff continued to pass medications to other consumers. Staff realized within 15 minutes that [client A] had walked off. Staff got in (sic) car and located [client A] off [intersection] around 6:30 PM. [Client A] stated to staff he was looking for his mom."</p> <p>The review indicated the facility completed an investigation of the 4/29/15 incident of elopement regarding client A. The Elopement/Missing Person Investigation Summary (EMPIS) dated</p>	W 0157	<p>CORRECTION:</p> <p><i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, the interdisciplinary team will modify Client A's current proactive and reactive behavior support strategies to prevent future elopements.</i></p> <p>PREVENTION:</p> <p>When deficiencies in current support strategies are identified during the course of investigations, the QIDP will bring all relevant elements of the interdisciplinary team together to reassess, develop and implement modifications to individuals' support plans. Members of the Operations Team comprised of the Executive Director, Program Managers, Quality Assurance Manager, Nurse Manager and Quality Assurance Coordinator will review investigation conclusions and facility support documents no less than monthly to assure corrective measures have been implemented.</p>	12/09/2015	

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>4/29/15 indicated the following:</p> <p>- "The team consensually agreed that [client A's] current support cannot assure that future elopement attempts will not occur. (1) [Client A] told his team that he is running from his home and from staff because he is upset that he cannot move to [city] as he has requested. His guardian has said that [client A's] required level of support is not currently available in [city.]; (2.) [Client A] would benefit from counseling to assiting (sic) him with processing his feelings about his current living arrangements and future plans. Service intake is set with [counselor]; (3.) The team discussed [client A] trying out other programs like music and art therapy; (4.) [Client A's] medication was increased on 5/1/15 to address hallucinations; (5.) The BDDS generalist will discuss options with [client A's] guardian."</p> <p>-BDDS report dated 6/9/15 indicated, "[Client A] eloped on the evening shift on 6/8/15. The police arrived to (sic) home around 8:00 PM and informed staff [client A] was found at a local park and taken to [ER (Emergency Room)] for seizure like activity. [Client A] was diagnosed with low blood sugar and admitted due to (a) sugar level reading at 30."</p>		<p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	
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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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0159 Bldg. 00	<p>The review indicated the facility failed to develop and implement effective corrective measures to prevent client A's elopement behaviors since the 4/29/15 elopement incident.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 11/4/15 at 3:40 PM. CS #1 indicated the facility should develop and implement corrective measures to prevent recurrence of abuse, neglect or mistreatment.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 3 of 4 sampled clients (A, B and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients A, B and C's active treatment programs by failing to ensure clients A and B's formal ISP (Individual Support Plan) training objectives were monitored for progression/regression of skills, to ensure clients A, B and C or their guardians</p>	W 0159	<p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, the facility has a new QIDP in place.</i></p> <p>The QIDP has been trained regarding the need to</p>	12/09/2015
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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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>participated in the development of their ISPs, to ensure client C's CFA (Comprehensive Functional Assessment) was completed within 30 days of his admission to the facility, to ensure client C's vocational skills were assessed and his present and future employment options were reviewed, to ensure client C's active treatment schedule included an active treatment program during weekday hours, to ensure clients A and C or their individual guardians gave their written informed consent for the use of psychotropic medications for behavior management, to ensure the use of audible entry/exit door alarms was incorporated into clients A and E's BSPs (Behavior Support Plans) to manage their elopement behaviors and to ensure clients A and B had formal training to teach them to use their prescription eyeglasses.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 11/4/15 at 12:44 PM. Client A's ISP dated 3/11/15 indicated client A had the following formal training objectives:</p> <p>-"Given skills training and 3 VPs (Verbal Prompts), [client A] will stay in the designated area of the classroom, 20% of the time for TCMs (Three Consecutive Months)."</p>		<p>continuously review and modify prioritized learning objectives whenever a client has completed the objective(s) successfully, shown regression or failed to progress. All prioritized learning objectives will be modified based on current progress.</p> <p>Clients A, B and C, the QIDP and will be trained 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. A review of facility support documents indicated this deficient practice did not affect additional clients.</p> <p>The interdisciplinary team will complete a comprehensive functional assessment for Client C. A review of facility assessment data indicated this deficient practice did not affect any additional clients.</p> <p>The interdisciplinary team will complete a vocational assessment for Client C including a review of potential employment options. A review of facility assessment data indicated this deficient practice</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>-"Given skills training and 3 VPs, [client A] will complete his daily hygiene independently 50% of the time for TCMs."</p> <p>-"Given skills training and 3 VPs, [client A] will independently make purchases by handling his own money, 55% of the time for 3 TCMs."</p> <p>-"Given skills training and 3 VPs, [client A] will administer his medications independently, 40% of the time for TCMs."</p> <p>-"Given skills training and 3 VPs, [client A] will prepare a smile (sic) (simple) meal with independence (sic), 40% of the time for TCMs."</p> <p>-"Given skills training and 3 VPs, [client A] will follow the proper steps required to complete a task or an assignment independently, 20% of the time for TCMs."</p> <p>Client A's ISP dated 3/11/15 indicated client A's goals would be reviewed for progress/regression on 6/15 and 9/15 (quarterly). Client A's record did not indicate documentation of monthly tracking or quarterly review of client A's formal training objectives.</p>		<p>did not affect any additional clients.</p> <p>The interdisciplinary team will develop Active Treatment Schedules for Client C that reflects current support needs, including but not limited to structured activities on weekdays, during the day. A review of facility support documents indicated this deficient practice did not affect any additional clients.</p> <p>Written informed consent for restrictive programs will be obtained from Client A and Client C's guardians for all restrictive programs. A review of documentation indicated that no additional clients were affected by this deficient practice.</p> <p>The QIDP will modify Client #A and Client E's Behavior Support Plans (BSP) to incorporate the use of exit alarms to prevent elopement.</p> <p>The QIDP will develop prioritized learning objectives to train Client</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>2. Client B's record was reviewed on 11/4/15 at 11:56 AM. Client B's ISP dated 11/17/14 indicated client B had the following formal training objectives:</p> <p>-"Given skills training and 2 VPs, [client B] will speak in a (sic) appropriate tone of voice, 60% of the time for TCMs."</p> <p>-"Given skills training and 2 VPs, [client B] will brush his teeth independently, 65% of the time for TCMs."</p> <p>-"Given skills training and 2 VPs, [client B] will clean his room independently, 80% of the time for TCMs."</p> <p>-"Given skills training and 3 VPs, [client B] will count change from a \$10.00 bill, 50% of the time for TCMs."</p> <p>-"Given skills training and 3 VPs, [client B] will participate in a (sic) exercise of his choice, 60% of the time for TCMs."</p> <p>-"Given skills training and 2 VPs, [client B] will participate in meal preparation, 65% of the time for TCMs."</p> <p>-"Given skills training and 3 VPs, [client C] will identify the needs of his Depakote (Schizo-affective Disorder), 65% of the time for TCMs."</p>		<p>A and Client B to wear their eyeglasses and staff will be trained on implementation of these goals. A review of facility adaptive equipment needs indicated that this deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>The QIDP will turn in copies of monthly summaries to the Program Manager for review and follow-up to assure learning objectives are modified as required.</p> <p>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>The facility's new QIDP will be trained regarding the need to:</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>Client B's ISP dated 11/17/14 indicated client B's goals would be reviewed for progress/regression on 6/15 and 9/15 (quarterly). Client B's record did not indicate documentation of monthly tracking or quarterly review of client B's formal training objectives.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #2 was interviewed on 11/4/15 at 3:30 PM. QIDP #2 indicated clients A and B's formal training objectives should be monitored for progression/regression of skills on a monthly basis. QIDP #2 indicated there was not additional documentation available for review regarding clients A and B's formal goal tracking.</p> <p>3. The QIDP failed to integrate, coordinate and monitor clients A, B and C's active treatment programs by failing to ensure clients A, B and C or their guardians participated in the development of their ISPs. Please see W209.</p> <p>4. The QIDP failed to integrate, coordinate and monitor client C's active treatment program by failing to ensure client C's CFA was completed within 30 days of his admission to the facility. Please see W210.</p>		<p>-Assure all needed assessments are completed within 30 days of admission.</p> <p>-Provide Active Treatment Schedules for all clients that reflect current support needs including but not limited to appropriate training and leisure activities on days that the client(s) are not at work or participating in formal day programming.</p> <p>-Incorporate all proactive and reactive strategies into Behavior support Plans as needed based on interdisciplinary team consensus.</p> <p>-Develop prioritized training objectives when clients do not cooperate with using their prescribed adaptive equipment.</p> <p>Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator and Executive Director) and the QIDP will conduct active treatment observations and documentation reviews no less than twice weekly for the next 21 days, no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>5. The QIDP failed to integrate, coordinate and monitor client C's active treatment program by failing to ensure client C's vocational skills were assessed and his present and future employment options were reviewed. Please see W225.</p> <p>6. The QIDP failed to integrate, coordinate and monitor client C's active treatment program by failing to ensure client C's active treatment schedule included an active treatment program during weekday hours. Please see W250.</p> <p>7. The QIDP failed to integrate, coordinate and monitor clients A and C's active treatment programs by failing to ensure clients A and C or their individual guardians gave their written informed consent for the use of psychotropic medications for behavior management. Please see W263.</p> <p>8. The QIDP failed to integrate, coordinate and monitor clients A and E's active treatment programs by failing to ensure the use of audible entry/exit door alarms was incorporated into clients A and E's BSPs to manage their elopement behaviors. Please see W289.</p> <p>9. The QIDP failed to integrate, coordinate and monitor clients A and B's active treatment programs by failing to</p>		<p>monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>ensure clients A and B had formal training to teach them to use their prescription eyeglasses. Please see W436.</p> <p>9-3-3(a)</p>		<p>Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include: assuring the QIDP has modified learning objectives as required, assuring that initial and ongoing assessment occurs as required, assuring active treatment schedules are in place and reflect the training and support needs of all clients, assuring prior written informed consent has been obtained for all restrictive programs, assuring all current practices are incorporated into support documents and assuring all clients receive training toward making informed choices about</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0209 Bldg. 00	<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. Based on record review and interview for 3 of 4 sampled clients (A, B and C), the facility failed to ensure clients A, B and C or their guardians participated in the development of their ISPs (Individual Support Plans).</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 11/4/15 at 1:24 PM. Client A's ISP dated 3/11/15 indicated client A had a legal guardian. Client A's 3/11/15 ISP/record did not indicate documentation of client A or client A's guardian's participation in the development of client A's ISP.</p> <p>2. Client B's record was reviewed on 11/4/15 at 11:56 AM. Client B's ISP dated 11/17/14 indicated client B was an</p>	W 0209	<p>the use of adaptive equipment.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <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 A, B and C, the QIDP and will be trained 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. A review of facility support documents indicated this deficient practice did not affect additional clients.</i></p> <p>PERVENTION:</p>	12/09/2015

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0210 Bldg. 00	<p>emancipated adult. Client B's 11/17/14 ISP/record did not indicate documentation of client B's participation in the development of his 11/17/14 ISP.</p> <p>3. Client C's record was reviewed on 11/4/15 at 2:52 PM. Client C's ISP dated 8/24/15 indicated client C was an emancipated adult. Client C's 8/24/15 ISP/record did not indicate documentation of client C's participation in the development of his ISP.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 11/4/15 at 3:40 PM. QIDP #1 indicated clients or their guardians should participate in the development of their ISPs.</p> <p>9-3-4(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 4 sampled clients (C), the facility failed to ensure client C's CFA (Comprehensive Functional Assessment) was completed within 30 days of his</p>	W 0210	<p>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> <p>CORRECTION:</p> <p><i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to</i></p>	12/09/2015

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 11/09/2015
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
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	<p>admission to the facility.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 11/4/15 at 2:52 PM. Client C's Physician's Orders form dated 10/20/15 indicated client C's date of admission to the facility was 7/22/15. Client C's record did not indicate documentation of a CFA.</p> <p>RM (Resident Manager) #1 was interviewed on 11/4/15 at 3:30 PM. RM #1 indicated client C had been admitted to the facility on 7/22/15 and had been incarcerated/discharged on 9/12/15. RM #1 indicated client C had been incarcerated and discharged and then re-admitted to the facility. RM #1 indicated client C's CFA should have been completed between his 7/22/15 date of admission and his 9/12/15 date of discharge due to incarceration.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #2 was interviewed on 11/4/15 at 3:30 PM. QIDP #2 indicated client C's CFA should be completed within 30 days of admission to the facility.</p> <p>9-3-4(a)</p>		<p><i>supplement the preliminary evaluation conducted prior to admission.</i> Specifically, the interdisciplinary team will complete a comprehensive functional assessment for Client C. A review of facility assessment data indicated this deficient practice did not affect any additional clients.</p> <p>PERVENTION:</p> <p>A new QIDP is in place at the facility and will be trained regarding the need to assure all needed assessments are completed within 30 days of admission. Members of the Operations Team (including the Program Manager, Quality Assurance Manager, Nurse Manager, Quality Assurance Coordinator and Executive Director) will review support documents and medical records no less than monthly to assure that initial and ongoing assessment occurs as required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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(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 0225 Bldg. 00	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include, as applicable, vocational skills. Based on record review and interview for 1 of 4 sampled clients (C), the facility failed to ensure client C's vocational skills were assessed and his present and future employment options were reviewed.</p> <p>Findings include:</p> <p>Client C was interviewed on 11/4/15 at 5:25 PM. Client C indicated he did not currently attend day services, sheltered workshop or have a community based job. Client C stated, "I'm kind of new here. I'd like to work at [restaurant], like my roommate." Client C indicated he had been looking for community based jobs and would like to work and make money for himself.</p> <p>Client C's record was reviewed on 11/4/15 at 2:52 PM. Client C's Physician's Orders form dated 10/20/15 indicated client C's date of admission to the facility was 7/22/15. Client C's record did not indicate documentation of a vocational skills assessment.</p> <p>RM (Resident Manager) #1 was interviewed on 11/4/15 at 3:30 PM. RM #1 indicated client C had been admitted</p>	W 0225	<p>CORRECTION:</p> <p><i>The comprehensive functional assessment must include, as applicable, vocational skills. Specifically, the interdisciplinary team will complete a vocational assessment for Client C including a review of potential employment options. A review of facility assessment data indicated this deficient practice did not affect any additional clients.</i></p> <p>PERVENTION:</p> <p>A new QIDP is in place at the facility and will be trained regarding the need to assure all needed assessments are completed within 30 days of admission. Members of the Operations Team (including the Program Manager, Quality Assurance Manager, Nurse Manager, Quality Assurance Coordinator and Executive Director) will review support</p>	12/09/2015

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 11/09/2015	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
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W 0250 Bldg. 00	<p>to the facility on 7/22/15 and had been incarcerated/discharged on 9/12/15. RM #1 indicated client C had been incarcerated and discharged and then re-admitted to the facility. RM #1 indicated client C did not currently attend day services or have a job. RM #1 indicated client C has expressed that he would like to have a community based job. RM #1 indicated client C looks for jobs in the community. RM #1 indicated client C has an appointment scheduled with vocational rehabilitation services to have an assessment completed and services initiated.</p> <p>9-3-4(a)</p> <p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 1 of 4 sampled clients (C), the facility failed to ensure client C's active treatment schedule included an active treatment program during weekday hours.</p> <p>Findings include:</p> <p>Client C was interviewed on 11/4/15 at 5:25 PM. Client C indicated he did not</p>	W 0250	<p>documents and medical records no less than monthly to assure that initial and ongoing assessment occurs as required.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Specifically, the interdisciplinary team will develop Active Treatment Schedules for Client C that reflects current</i></p>	12/09/2015			

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>currently attend day services, sheltered workshop or have a community based job.</p> <p>Client C's record was reviewed on 11/4/15 at 2:52 PM. Client C's active treatment schedule/outline (undated) did not indicate or specify client C's active treatment program during weekday (Monday through Friday) day time hours (9 AM through 4 PM).</p> <p>RM (Resident Manager) #1 was interviewed on 11/4/15 at 3:30 PM. RM #1 indicated client C did not currently attend day services or have a job. RM #1 indicated client C stayed at home at the group home during week and did not have a set routine/program in place.</p> <p>9-3-4(a)</p>		<p>support needs, including but not limited to structured activities on weekdays, during the day. A review of facility support documents indicated this deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>Professional staff will be trained regarding the need to provide Active Treatment Schedules for all clients that reflect current support needs including but not limited to appropriate training and leisure activities on days that the client(s) are not at work or participating in formal day programming. Members of the Operations Team (including the Program Manager, Quality Assurance Manager, Nurse Manager, Quality Assurance Coordinator and Executive Director) will review support documents no less than monthly to assure active treatment schedules are in place and reflect the training and support needs of all clients.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Direct Support Staff, Health</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0263 Bldg. 00	<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 2 of 4 sampled clients who utilized psychotropic medications for behavior management (A and C), the facility failed to ensure clients A and C or their individual guardians gave their written informed consent for the use of psychotropic medications for behavior management.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 11/4/15 at 12:44 PM. Client A's ISP (Individual Support Plan) dated 3/11/15 indicated client A had a legal guardian. Client A's BSP (Behavior Support Plan) dated 3/11/15 indicated client A received the following psychotropic medications to manage his behavior:</p> <p>-Klonopin 0.5 milligrams tablet (Impulse Control).</p> <p>-Clonidine 0.1 milligram tablet</p>	W 0263	<p>Services Team, Behavior Therapist, 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, written informed consent for restrictive programs will be obtained from Client A and Client C's guardians for all restrictive programs. A review of documentation indicated that no additional clients were affected by this deficient practice.</i></p> <p>PREVENTION:</p> <p>When guardians and healthcare representatives are unable to attend team meetings face to face, consent forms will be sent via postal mail for review and signature, along with a stamped envelope addressed to the facility. If consents are not</p>	12/09/2015

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>(Attention Deficit/Hyper Activity Disorder (ADHD)).</p> <p>-Invega 3.0 milligram tablet (Bi-Polar).</p> <p>-Divalproex 500 milligram tablet (Bi-Polar).</p> <p>-Topiramate 200 milligram tablet (Impulse Control).</p> <p>-Trazodone 100 milligram tablet (Impulse Control).</p> <p>Client A's record did not indicate documentation of client A's guardian's written informed consent for the use of Klonopin, Clonidine, Invega, Divalproex, Topiramate or Trazodone for the management of client A's behaviors.</p> <p>2. Client C's record was reviewed on 11/4/15 at 2:52 PM. Client C's ISP dated 8/24/15 indicated client C was an emancipated adult. Client C's BSP dated 8/24/15 indicated client C received Adderall 20 milligrams (Oppositional Defiant Disorder), Fluoxetine 20 milligrams (Oppositional Defiant Disorder) and Quetiapine 300 milligrams (Oppositional Defiant Disorder) for behavior management. Client C's 8/24/15 BSP did not indicate documentation of client C's written informed consent for</p>		<p>returned to the facility in a timely manner via standard postal mail, the QIDP will send the forms to the appropriate legal representative via registered mail to assure the documents have been delivered and received. Members of the Operations Team (including the Program Manager, Quality Assurance Manager, Nurse Manager, Quality Assurance Coordinator and Executive Director) will review support documents no less than monthly to assure prior written informed consent has been obtained.</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: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0289 Bldg. 00	<p>the use of the psychotropic medications for the management of his behavior. Client C's Consent for Medication form dated 8/2015 did not indicate documentation of client C's written informed consent.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 11/4/15 at 3:40 PM. CS #1 indicated the facility should obtain client A's guardian and client C's written informed consent prior to the use of psychotropic medications for used for behavior management.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review and interview for 1 of 4 sampled clients (A), plus 1 additional client (E), the facility failed to ensure the use of audible entry/exit door alarms was incorporated into clients A and E's BSPs (Behavior Support Plans) to manage their elopement behaviors.</p>	W 0289	<p>CORRECTION:</p> <p><i>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan. Specifically, the QIDP will modify Client #A and Client E's Behavior</i></p>	12/09/2015

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 11/09/2015
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	<p>Findings include:</p> <p>Observations were conducted at the group home on 11/2/15 from 4:45 PM through 5:45 PM and on 11/4/15 from 6:15 AM through 8:00 AM. Clients A and E were observed in the home throughout the observation periods. Each time the home's entry/exit doors were opened or shut, an audible door alarm/chime was heard.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 11/2/15 at 5:35 PM. CS #1 indicated all entry/exit doors in the home have audible alarms to assist staff to monitor clients A and E's elopement behaviors.</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/2/15 at 12:49 PM. The review indicated the following:</p> <p>1. BDDS report dated 4/30/15 indicated, "[Client A] took 5:00 PM medications. Staff continued to pass medications to other consumers. Staff realized within 15 minutes that [client A] had walked off. Staff got in (their) car and located [client A] off [intersection] around 6:30 PM. [Client A] stated to staff he was looking for his mom."</p>		<p>Support Plans (BSP) to incorporate the use of exit alarms to prevent elopement.</p> <p>PREVENTION:</p> <p>A new QIDP is in place at the facility and will be trained regarding the need to incorporate all proactive and reactive strategies into Behavior support Plans as needed based on interdisciplinary team consensus. Members of the Operations Team (including the Program Manager, Quality Assurance Manager, Nurse Manager, Quality Assurance Coordinator and Executive Director) will review support documents no less than monthly to assure all current practices are incorporated into support documents.</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: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2015
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	<p>The review indicated the facility completed an investigation of the 4/29/15 incident of elopement regarding client A. The Elopement/Missing Person Investigation Summary (EMPIS) dated 4/29/15 indicated the following:</p> <p>- "Introduction: [Client A]... has a history of elopement which is addressed in his BSP (Behavior Support Plan). He received enhanced supervision (15 minute checks) and was observed by staff at 5:45 PM after medication pass. At 5:30 PM, [client A] was not in the home and it was determined he had exited the building through it's locked door."</p> <p>- "How was the client able to leave the premises? (I.E. (sic) was the door unlocked? Were there alarms on the doors? Etc.) [Client A] exited the home through a door that was locked from the inside. Alarms are in place."</p> <p>- BDDS report dated 6/9/15 indicated, "[Client A] eloped on the evening shift on 6/8/15. The police arrived to (sic) home around 8:00 PM and informed staff [client A] was found at a local park and taken to [ER (Emergency Room)] for seizure like activity."</p> <p>The review indicated the facility</p>			

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	<p>completed an investigation regarding client A's 6/8/15 elopement from the group home. The 6/11/15 EMPIS indicated the following:</p> <p>-"[Client A] exited the home through a door that is not locked from the inside. Alarms are in place. [Client A] is believed to have turned the alarm off."</p> <p>Client A's record was reviewed on 11/4/15 at 12:44 PM. Client A's 3/11/15 BSP indicated client A's targeted behaviors included but were not limited to leaving his assigned area. Client A's 3/11/15 BSP did not indicate documentation of door alarms being incorporated into client A's BSP. Specifically, the 3/11/15 BSP did not address when and how the alarms would be utilized, how the alarms would be monitored for functionality or how client A would be monitored to prevent/address turning the alarms off prior to elopement behaviors.</p> <p>RM (Resident Manager) #1 was interviewed on 11/4/15 at 3:37 PM. RM #1 indicated client A's BSP should be implemented by staff. RM #1 indicated the group home had audible door alarms on the entry/exit doors of the home. RM #1 indicated client A knew how to turn the door alarms off.</p>			

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>2. BDDS report dated 6/12/15, 6:55 AM indicated, "[Client E] called 911 and reported the house was on fire. While staff was on the phone with 911, [client E] turned the alarm off on the door and exited the home. [Client E] left the premises. Staff looked for him and was unable to locate him. [Client E] returned home around 9:00 AM."</p> <p>The review indicated the facility completed an investigation regarding client E's 6/12/15 elopement. The 6/26/15 EMPIS form indicated the following:</p> <p>-"[Client E]... has a history of elopement which is addressed in his BSP. He receives 24/7 supervision. At 6:55 AM on 6/11/15, [client E], was not in the home and it was determined he had exited the building through its locked door. The door alarm had been turned off."</p> <p>Client E's record was reviewed on 11/4/15 at 12:00 PM. Client E's BSP dated 9/11/14 indicated the following:</p> <p>Client E's 9/11/14 BSP indicated client E's targeted behaviors included but were not limited to leaving his assigned area. Client E's 9/11/14 BSP did not indicate documentation of door alarms being</p>			

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W 0323 Bldg. 00	<p>incorporated into client E's BSP. Specifically, the 9/11/14 BSP did not address when and how the alarms would be utilized, how the alarms would be monitored for functionality or how client E would be monitored to prevent/address turning the alarms off prior to elopement behaviors.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 11/4/15 at 3:40 PM. CS #1 indicated restrictive practices should be included/incorporated into clients A and E's BSPs.</p> <p>9-3-5(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 2 of 4 sampled clients (A and C), the facility failed to ensure clients A and C's visual care recommendations were followed.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 11/4/15 at 12:44 PM. Client A's Visual Care Progress Report dated 4/9/14</p>			W 0323	<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, the facility will obtain current visual assessments for client A and Client C. A review of medical records indicated this deficient practice did not affect any additional clients.</i></p>		11/09/2015

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>indicated client A's vision had been evaluated regarding Astigmatism and Diabetic vision care. Client A's Visual Care Progress Report dated 4/9/14 indicated client A should return for a follow up visit in one year (4/9/15). Client A's record did not indicate additional documentation of visual assessment since 4/9/14.</p> <p>2. Client C's record was reviewed on 11/4/15 at 2:52 PM. Client C's record did not indicate documentation of a vision examination/assessment.</p> <p>Nurse #1 was interviewed on 11/4/15 at 3:37 PM. Nurse #1 indicated client A's 4/9/14 Visual Care Progress Report recommendations for a return visit in one year should have been implemented. Nurse #1 indicated there was not additional documentation of a vision examination/assessment regarding client C.</p> <p>9-3-6(a)</p>		<p>PREVENTION:</p> <p>The Health Services Team will work with The Residential Manager, QIDP and facility Medical coach to assure that all relevant assessments, including but not limited to visual examinations, are completed for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator and Executive Director) 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. Prior to admitting new clients, the Program Manager will assist the QIDP with developing a schedule to assure that all necessary assessments occur. Additionally, members of the Operations Team will review medical records no less than monthly to assure all required assessments and follow-up occur as required.</p> <p>RESPONSIBLE PARTIES:</p>	

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0368 Bldg. 00	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 4 sampled clients (A and C), plus 1 additional client (F), the facility failed to ensure clients A, C and F's medications were administered as prescribed by their individual physician's orders.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/2/15 at 12:49 PM. The review indicated the following:</p> <p>1. BDDS report dated 8/26/15 indicated, "During a routine nursing audit, [nurse #1] became aware that [client A] had not received his 9:00 PM dose of Lipitor 20 milligrams (cholesterol management) on 8/24/15."</p> <p>Client A's record was reviewed on 11/4/15 at 12:44 PM. Client A's POs</p>	W 0368	<p>Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Specifically, all facility staff will be retrained on agency medication administration procedures and the facility nurse will receive retraining on transcription protocols from the Nurse Manager.</i></p> <p>PREVENTION:</p> <p>As a check and balance, supervisors will review new physician's orders to assure they have been transcribed properly into the medication administration record. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per</p>	12/09/2015

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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>(Physician's Orders) form dated 10/20/15 indicated, "Atorvastatin/Lipitor tablet 20 milligrams, give one tablet by mouth once daily for hyperlipidemia."</p> <p>2. BDDS report dated 7/29/15 indicated client C missed a dose of his Meloxicam 7.5 milligrams (inflammation).</p> <p>-BDDS report dated 8/7/15 indicated, "During a weekly audit, the [nurse] discovered that she had improperly transcribed a physician's order onto the MAR (Medication Administration Record) and that [client C] had been receiving Meloxicam 7.5 milligrams twice daily instead of once daily as prescribed. Specifically, he received 7 extra doses of the medication. [Client C] did not appear to experience any adverse effects from the additional medication."</p> <p>Client C's record was reviewed on 11/4/15 at 2:52 PM. Client C's Prescription order form dated 7/26/15 indicated, "Take 1 tablet (7.5 milligrams total) by mouth daily for 14 days."</p> <p>3. BDDS report dated 8/21/15 indicated, "During a routine nursing audit, [nurse #1], became aware [client F] was given double doses of Cogentin 0.5 milligrams (Extrapyramidal symptoms/side effects of psychotropic medications), Fanapt 0.8</p>		<p>week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed. The Team Lead will be present during no less than 5 active treatment sessions per week to monitor medication administration. Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator and Executive Director) and the QIDP will conduct active treatment observations and documentation reviews no less than twice weekly for the next 21 days, no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning</p>	

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>milligrams (anti-psychotic) and Propranolol 10 milligrams and 20 milligrams (tremors)."</p> <p>Client F's record was reviewed on 11/4/15 at 11:40 AM. Client F's POs dated 10/20/15 indicated, "Benztropine/Cogentin tablet 0.5 milligrams, give one tablet by mouth twice daily."</p> <p>Nurse #1 was interviewed on 11/4/15 at 3:37 PM. Nurse #1 indicated clients A, C and F's medications should be administered as prescribed by their physicians.</p> <p>9-3-6(a)</p>		<p>active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive</p>	

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W 0436 Bldg. 00	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 2 of 6 clients with adaptive equipment, the facility failed to ensure clients A and B had formal training to teach them to use their prescription eyeglasses.</p> <p>Findings include:</p>	W 0436	<p>Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring all prescribed medications are transcribed properly and administered as ordered.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Lead, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices</i></p>	12/09/2015

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 11/09/2015
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	<p>Observations were conducted at the group home on 11/2/15 from 4:45 PM through 5:45 PM and on 11/4/15 from 6:15 AM through 8:00 AM. Clients A and B were observed in the home throughout the observation periods. Clients A and B did not wear eyeglasses.</p> <p>1. Client A's record was reviewed on 11/4/15 at 12:44 PM. Client A's Visual Care Progress report dated 4/9/14 indicated client A should wear prescription eyeglasses. Client A's ISP (Individual Support Plan) dated 3/11/15 did not indicate documentation of a formal training objective to teach client A to use his eyeglasses.</p> <p>2. Client B's record was reviewed on 11/4/15 at 11:56 AM. Client B's Visual Care Progress report dated 5/6/14 indicated client B should wear prescription eyeglasses. Client B's ISP dated 11/17/14 did not indicate documentation of a formal training objective to teach client B to use his eyeglasses.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 11/4/15 at 3:40 PM. CS #1 indicated clients A and B should wear their prescribed eyeglasses. CS #1 indicated clients A and B refused to utilize their eyeglasses. CS #1 indicated</p>		<p><i>identified by the interdisciplinary team as needed by the client.</i> Specifically the interdisciplinary team will develop prioritized learning objectives to train Client A and Client B to wear their eyeglasses and staff will be trained on implementation of these goals. A review of facility adaptive equipment needs indicated that this deficient practice did not affect any additional clients.</p> <p>PERVENTION:</p> <p>A new QIDP is in place at the facility and will be trained regarding the need to develop prioritized training objectives when clients do not cooperate with using their prescribed adaptive equipment. Members of the Operations Team (including the Quality Assurance Manager, Program Managers, Nurse Manager, Quality Assurance Coordinator and Executive Director) and the QIDP will conduct active treatment observations and documentation reviews no less than twice weekly for the next 21 days, no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine</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 11/09/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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	<p>clients A and B should have formal training objectives to teach them to utilize their eyeglasses as prescribed.</p> <p>9-3-7(a)</p>		<p>the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight</p>	

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			<p>shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative support at the home will include assuring clients receive training toward making informed decisions regarding the use of adaptive equipment.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	