

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0000 Bldg. 00	<p>This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00197035.</p> <p>Complaint #IN00197035: Substantiated. Federal and State deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154 and W249.</p> <p>Dates of Survey: 5/12, 5/13, 5/19, and 5/20/2016.</p> <p>Facility number: 000738 Provider number: 15G212 AIM number: 100243260</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/31/16.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and</p>	W 0102	W102: The governing body must ensure that specific governing	06/19/2016

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>record review the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (clients A, B, C, and D) and 3 additional clients (clients E, F, and G). The governing body failed to ensure the following:</p> <ul style="list-style-type: none"> -To ensure maintenance and repairs were completed at the group home. -To ensure allegations of neglect and/or abuse were immediately reported and thoroughly investigated. -To ensure oversight of the outside contracted day service for clients B, C, and G. <p>Findings include:</p> <p>1. Please refer to W122. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C, and D) and 3 additional clients (clients E, F, and G) as evidenced by:</p> <ul style="list-style-type: none"> -The facility failed to ensure clients were not neglected and/or abused; to implement their abuse/neglect policy and procedure for immediately reporting of allegations and thoroughly investigating unwitnessed falls with injuries. -The facility failed to ensure client G's rights were protected to ensure access to 		<p>body and management requirements are met. The Executive Director will review all investigations that are completed due to serious injury (requiring more than first aid) from a fall. She will be reviewing for thoroughness and assuring that corrective action to prevent further occurrence is included. All maintenance issues will be corrected by June 19th. All staff will be trained to complete a work order whenever an environmental issue arises. Additionally, the Residential Manager/designee will complete the Home Environment form on a monthly basis and complete work orders for any maintenance issues that arise. The work orders will be forwarded to the Program Manager who will log them in and forward them to the Maintenance person. The Program Manager will follow up with Maintenance on a weekly basis to assure that work is completed in a timely manner. The Program Manager will do a bimonthly audit of the home which will include identifying any environmental issues. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly that will include checking for maintenance issues.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>her personal identification.</p> <ul style="list-style-type: none"> -The facility failed to ensure and protect client C from her personal nudity. -The facility failed to ensure clients A, B, C, and D's rights to access their community for outings. -The facility failed to ensure client B's plans included developed strategies to teach her to earn back the access to her locked personal cigarettes and to ensure client F's unimpeded access to her locked personal hearing aids without an identified need. <p>2. Please refer to W104. The governing body failed to provide oversight of the facility to ensure the facility completed maintenance and repairs of the group home for clients A, B, C, D, E, F, and G. The governing body failed to provide oversight to ensure the agency's policies and procedures to protect clients A, B, C, and G from abuse, neglect, and/or mistreatment were implemented. The governing body failed:</p> <ul style="list-style-type: none"> -To ensure allegations of neglect and/or abuse and unwitnessed injuries were immediately reported and thoroughly investigated. -To ensure the facility met the needs of client A's fall with injuries. -To ensure the facility's outside contracted services met the needs of 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0104 Bldg. 00	<p>clients B, C, and G.</p> <p>This federal tag relates to complaint #IN00197035.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and 3 additional clients (clients E, F, and G), the governing body failed to provide oversight of the facility to ensure the facility completed maintenance and repairs of the group home for clients A, B, C, D, E, F, and G. The governing body failed to provide oversight to ensure the agency's policies and procedures to protect clients A, B, C, and G from abuse, neglect, and/or mistreatment were implemented. The governing body failed:</p> <p>-To ensure allegations of neglect and/or abuse and unwitnessed injuries were immediately reported and thoroughly investigated.</p> <p>-To ensure the facility met the needs of</p>	W 0104	<p>W104: The governing body must ensure that specific governing body and management requirements are met. All staff will be trained to complete a work order whenever an environmental issue arises. Additionally, the Residential Manager/designee will complete the Home Environment form on a monthly basis and complete work orders for any maintenance issues that arise. The work orders will be forwarded to the Program Manager who will log them in and forward them to the Maintenance person. The Program Manager will follow up with the maintenance staff on a weekly basis to assure that work is completed in a timely manner. The Program Manager will do a bimonthly audit of the home which will include identifying any environmental issues and addressing those with the Maintenance staff. The</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>client A's fall with injuries.</p> <p>-To ensure the facility's outside contracted services met the needs of clients B, C, and G.</p> <p>Findings include:</p> <p>1. On 5/12/16 from 5:25am until 7:45am, and on 5/12/16 from 3:20pm until 5:35pm, clients A, B, C, D, E, F, and G were observed at the group home and accessed each area independently. From 3:20pm until 5:30pm, the following was observed with the RM (Residential Manager):</p> <p>-At 3:20pm, the RM indicated the hallway connecting the medication room to the living room and clients B and F's bedroom had 2 areas of unfinished dry wall patches; each measured fifteen inches by five inches (15" x 5"). The RM indicated the two hallway areas occurred as the result of client C's behavior of banging her head into the wall.</p> <p>-At 5:00pm, the RM stated there were five (5) areas of drywall damage in the living room: each damaged area was the "size of a softball" from client C banging her head into the wall.</p> <p>-At 5:00pm, the RM stated the hallway to the medication room had three (3) "new</p>		<p>Executive Director will review all investigations that are completed due to serious injury (requiring more than first aid) from a fall. She will be reviewing for thoroughness and assuring that corrective action to prevent further occurrence is included. In the future, when an allegation is made at the day program involving facility consumers, the facility will ask to be a part of the investigation to assure that it is thorough.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>areas" of drywall damage each "the size of a softball" from client C banging her head and fists into the drywall.</p> <p>-At 5:00pm, the RM stated the hallway connecting clients A, D, and C's bedroom had one (1) "new" area of drywall damage the "size of a softball" from client C banging her head and fists into the wall.</p> <p>-At 5:00pm, the RM stated the dining room had one new area of drywall damage "the size of a softball" from client C banging her fists and head into the drywall.</p> <p>On 5/13/16 at 2:00pm, an interview was conducted with the PM (Program Manager) and the RM. The PM indicated the drywall damage was from client C banging her head and fists into the drywall. The PM stated the maintenance man had repaired the damages to the drywall within the past month and client C had behaviors which "damaged the drywall again."</p> <p>2. Please refer to W149. The governing body neglected to implement its Abuse, Neglect, and/or Mistreatment policy and procedure to thoroughly investigate client A's injuries in her bedroom and clients B, C, and G's allegation of staff abuse at the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>workshop on 5/9/16 for 3 of 4 sampled clients (clients A, B, and C) and for 1 additional client (client G) for 2 of 13 BDDS (Bureau of Developmental Disabilities Services) reports reviewed from 3/1/16 through 5/12/16.</p> <p>3. Please refer to W153. The governing body failed to immediately report an allegation of verbal abuse of clients B, C, and G to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services -APS) for 1 of 2 investigations reviewed (clients B, C, and G).</p> <p>4. Please refer to W154. The governing body failed to thoroughly investigate client A's injuries in her bedroom and clients B, C, and G's allegation of staff abuse at the workshop on 5/9/16 for 2 of 13 BDDS (Bureau of Developmental Disabilities Services) reports and 2 of 2 investigations reviewed (for clients A, B, C, and G).</p> <p>5. Please refer to W120. The governing body failed to ensure clients B, C, and G's contract day services met the dining needs for each client and protect client's rights for 2 of 2 sampled clients (clients B and C) and for 1 additional client (client G) who attended contract day services site #1.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0120 Bldg. 00	<p>This federal tag relates to complaint #IN00197035.</p> <p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review, and interview, for 2 of 2 sampled clients (clients B and C) and for 1 additional client (client G) who attended contract day services site #1, the facility failed to ensure clients B, C, and G's contract day services met the dining needs for each client and protect client's rights.</p> <p>Findings include:</p> <p>1. On 5/12/16 from 11:10am until 12:20pm, clients B, C, and G were observed at the contracted day services site #1. From 11:10am until 11:30am, clients B and C sat at a dining room table without activity. From 11:10am until 11:17am, client B laid her head down on the table. At 11:17am, Workshop Staff (WKS) #1 walked into the dining room, unwrapped client C's lunch items from plastic ware and client C was not asked to help. WKS #1 placed the food containers</p>	W 0120	<p>W120: The facility must assure that outside services meet the needs of each client. Staff retraining will be provided to the staff at the day program regarding client's B, C and G program plans including dining plans. Re-training will include encouraging individual's to participate in their daily routine including preparing their own lunches prior to eating. The Program Manager of the day program will monitor staff adherence to individual clients' program plans. Upon knowledge of an allegation at the day program, the QIDP and/or Program Manager will insure that the allegation is reported in a timely manner by the day program or by the facility. The day program has initiated a system where there is a person available to report all BDDS reportable incidents in the event that their Program Manager is unavailable to do so. In the future, when an allegation is</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>on her side of the table away from client C. Client C had an empty scoop plate in front of her. From 11:17am until 11:45am, WKS #1 gave a single bite of food at a time to client C, waited for client C to chew the item, and gave client C another bite. Client C was not asked or encouraged to drink between bites and was not asked to lay down her silverware between bites of food. At 11:17am, WKS #1 asked an unidentified workshop staff to place client B's pureed food on a paper plate in front of her. Client B was not asked to assist to prepare her lunch meal. At 11:30am, the Workshop Supervisor indicated client C was plate to plate staff supervision (a dining procedure when staff give client C one bite of food at a time) for dining at the workshop and the workshop staff custodially prepared clients B and C's lunches on their plates. At 11:45am, WKS #1 stated client C was "plate to plate" a dining procedure when staff give client C one bite of food at a time.</p> <p>On 5/12/16 from 5:25am until 7:45am, and on 5/12/16 from 3:20pm until 5:35pm, clients B, C, and G were observed at the group home. During the observation period clients B, C, and G helped to prepare and served themselves their morning breakfast and evening meals at the group home. During the</p>		made at the day program involving facility consumers, the facility will ask to be a part of the investigation to assure that it is thorough. The QIDP will observe the day program 1 time per week and the Program Manager will observe 2 times per month. Observations will include mealtime to assure that day program staff is following the dining plans of all clients.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>observation periods clients B, C, and G served themselves and consumed pieces of sausage patties, a cinnamon roll, toast with butter, meatloaf, and corn. Client B served herself a pureed blend of food she prepared. Client C served herself menu items and was not on plate to plate staff supervision.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated clients B, C, and G should have prepared their own lunches at the contracted day services. The PM indicated clients B and C had the skill to prepare their lunches, heat their lunches, and consume their lunches with eye sight staff supervision. The PM indicated client C's plans did not include a plate to plate dining restriction.</p> <p>Client B's record was reviewed on 5/13/16 at 2:10pm. Client B's 12/8/15 ISP (Individual Support Plan) indicated she had the skill to operate a microwave oven, a goal to take small bites of food during meals, and a 4/1/16 "Physician's Order" for a pureed diet due to client B's "rapid spooning" of food.</p> <p>Client C's record was reviewed on 5/13/16 at 1:45pm. Client C's 6/1/15 ISP, 6/1/15 BSP (Behavior Support Plan), and 7/14/15 Registered Dietician's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>(RD) review did not indicate client C had a plan and/or an approved resident rights restriction for plate to plate dining. Client C's 7/14/15 RD review indicated "No noted chewing or swallowing deficits, but does tend to eat quickly. All meals are monitored by staff. She is occasionally offered foods plate to plate to slow eating pace...."</p> <p>2. On 5/12/16 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 3/1/16 through 5/12/16 were reviewed and indicated client B, C, and G's allegation of neglect:</p> <p>For clients B, C, and G: -A 5/9/16 BDDS report for an incident on 5/6/16 at 2:45pm indicated a BDDS report reported by the contract workshop. The BDDS report indicated "A call was received after the [name of contract workshop] was closed from [Group Home Staff (GHS) #4]. [GHS #4] reported that when she and [GHS #2] picked up [clients B, C, and G who attended this contract workshop] a [Workshop Staff (WKS) #1] came out to their van and allegedly was yelling at the clients in the van. The clients included [Clients B, C, and G]. [GHS #4] added that when they arrived at the [Workshop]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>at approximately 2:45pm, the clients seen (sic) the van pull up and they immediately came out to the van before [GHS #2 and GHS #4] could come in to pick them up and before a [workshop] staff member noticed they had arrived...A description of the staff member was given and [Workshop Staff #1] was identified. [Workshop Staff (WKS) #1] was contacted about the allegation. Per agency policy, [WKS #1] was suspended from duty pending the outcome of an investigation. When [WKS #1] was interviewed and per her written statement, she was working in the medication room checking medications. The medication room was open and she overheard another staff say [the name of the group home] ladies are walking out, their van is outside. [WKS #1] stated she went outside and all of the ladies were already in the van with their seatbelts on, and both staff were in their seats as if ready to leave. [WKS #1] stated she opened the van door and told the clients they knew they were not supposed to go out to their van without a [name of workshop] staff being with them or without their own staff coming in. She added that she told them they knew better. [WKS #1] admitted that she did talk loud (sic) and was stern with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>ladies. When interviewed she stated she always talks loud (sic), but she was stern with the ladies on this occasion due to the safety risks...[GHS #4] was questioned about coming in to the building at least to pick up the communication book for this home. [GHS #4] reported the ladies came out before they could come in...Clients [B and G] were interviewed about the incident. Their recall of the incident was similar in that they recalled the staff member came out to the van to remind them that they did not follow the dismissal procedures. [Client G] stated the staff was screaming and [client B] stated she was talking to them. Both admitted they did not follow the dismissal procedures and neither was upset about the incident when interviewed. After reviewing the information presented it was determined that the alleged abuse is not substantiated. [WKS #1] was provided retraining about [name of workshop] abuse/neglect policy and was counseled about watching her tone of voice when working with clients."</p> <p>-An undated "Investigation Summary" for the 5/6/16 incident indicated the investigation did not address why staff were not present to supervise clients B,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>C, and G leaving the building unattended. Two of the three clients present were interviewed. Client C was not interviewed. One of the two group home staff present during the incident was interviewed. GHS #2 was not interviewed, and a list of questions asked was not available for review. The witness statements were paraphrased and typed by the workshop.</p> <p>-A 5/9/16 at 11:03am, email from the PM to the Workshop Supervisor indicated the PM questioned the workshop supervision of the clients waiting to be picked up from workshop regarding: "Where were [workshop] staff that 3 clients could leave the building unattended? Why was only one of the [Group Home Staff] interviewed? There were 2 in the vehicle. It appears the [Group Home Staff] who was interviewed was only asked about the communication book and no asked if [WKS #1] was yelling or using a tone of voice that was not appropriate. Was she asked how the [workshop staff] interacted with the consumers? Is so, what was her response. Why was the other consumer [client C] not interviewed?"</p> <p>-A 5/10/16 at 7:28am, email from the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>Workshop Supervisor indicated a the following response: "...there were 3 staff on duty" during the incident, two staff were assisting other clients in the bathroom and the "3rd staff stepped into the medication room prior to the other 2 returning to the multipurpose room." "When I was talking to [GHS #4] on the phone, [GHS #2] could be heard in the background giving same information...The reason I asked about the communication book was because I found it curious that [GHS #2 and #4] kept repeating that they were going to come in and let us know they were leaving...I didn't feel I needed to ask whether the [workshop] staff was yelling or how they were interacting, because [GHS #4] had already told me. This was the reason she called initially...[Client C] was not interviewed as she was not at the [workshop] today..." and the workshop supervisor completed the investigation by telephone in another town. No further information was available for review.</p> <p>On 5/13/16 at 10:45am, an interview with the PM (Program Manager) and the Residential Manager (RM) was conducted. The PM and the RM both indicated the agency did not report and did not conduct an investigation into</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0122 Bldg. 00	<p>clients B, C, and G's verbal abuse allegation at the workshop on 5/6/16. The PM indicated the workshop reported the incident to BDDS on 5/9/16. The PM indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The PM indicated allegations should be immediately reported and thoroughly investigated. The PM indicated clients B, C, and D's allegation of verbal abuse was not immediately reported and was not thoroughly investigated by the workshop.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated clients B, C, and G's allegation of staff to client verbal abuse was not immediately reported and was not thoroughly investigated. The PM indicated no further information was available for review.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Client</p>	W 0122	W122: The facility must ensure that specific client	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>Protections for 4 of 4 sampled clients (A, B, C, and D) and 3 additional clients (clients E, F, and G).</p> <p>-The facility failed to ensure clients were not neglected and/or abused; to implement their abuse/neglect policy and procedure for immediately reporting of allegations and thoroughly investigating unwitnessed falls with injuries.</p> <p>-The facility failed to ensure client G's rights were protected to ensure access to her personal identification.</p> <p>-The facility failed to ensure and protect client C from her personal nudity.</p> <p>-The facility failed to ensure clients A, B, C, and D's rights to access their community for outings.</p> <p>-The facility failed to ensure client B's plans included developed strategies to teach her to earn back the access to her locked personal cigarettes and to ensure client F's unimpeded access to her locked personal hearing aids without an identified need.</p> <p>Findings include:</p> <p>1. Please refer to W149. The facility neglected to implement its Abuse, Neglect, and/or Mistreatment policy and procedure to thoroughly investigate client A's injuries in her bedroom and clients B, C, and G's allegation of staff verbal abuse</p>		<p>protections requirements are met.</p> <p>The Executive Director will review all investigations that are completed due to serious injury (requiring more than first aid) from a fall. She will be reviewing for thoroughness and assuring that corrective action to prevent further occurrence is included. The IDT will meet to discuss the supervision level that Client A requires based on her needs. The Facility staff will be retrained on reporting abuse/neglect to their supervisors, even if the allegation occurred at the day program. Upon knowledge of an allegation at the day program, the QIDP and/or Program Manager will insure that the allegation is reported in a timely manner by the day program or by the facility. In the future, when an allegation is made at the day program involving facility consumers, the facility will ask to be a part of the investigation to assure that it is thorough. The day</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>at the workshop on 5/9/16 for 3 of 4 sampled clients (clients A, B, and C) and for 1 additional client (client G) for 2 of 13 BDDS (Bureau of Developmental Disabilities Services) reports reviewed from 3/1/16 through 5/12/16.</p> <p>2. Please refer to W153. The facility failed to immediately report an allegation of verbal abuse of clients B, C, and G to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services -APS) for 1 of 2 investigations reviewed (clients B, C, and G).</p> <p>3. Please refer to W154. The facility failed to thoroughly investigate client A's injuries in her bedroom and clients B, C, and G's allegation of staff verbal abuse at the workshop on 5/9/16 for 2 of 13 BDDS (Bureau of Developmental Disabilities Services) reports and 2 of 2 investigations reviewed (for clients A, B, C, and G).</p> <p>4. Please refer to W125. The facility failed to encourage and teach client G to carry personal identification and a wallet when she worked in the community and rode the community transit for 1 additional client (client G).</p> <p>5. Please refer to W130. The facility</p>		<p>program provided retraining to the staff member involved with that allegation on 5/9/16. The day program is providing retraining for its staff regarding their agencies policy that prohibits abuse, neglect and mistreatment of clients. The QIDP will observe the day program 1 time per week and the Program Manager will observe 2 times per month. All clients who are able to carry their IDs will be given a form of ID to have on their person and encouraged to carry it when going in the community. QIDP will check weekly with clients to see that they have IDs with them as they choose to carry them. All staff have been trained on redirecting client C whenever she exits her bedroom or bathroom not completely dressed. A goal will be written to address her personal privacy. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>failed to protect client C's personal privacy when she walked through the group home nude for 1 of 4 sampled clients (client C).</p> <p>6. Please refer to W136. The facility failed to ensure and document clients A, B, C, and D's participation in outings/activities in the community for 4 of 4 sampled clients (clients A, B, C, and D).</p> <p>7. Please refer to W137. The facility failed to ensure client B's plans included how client B was to access her locked personal cigarettes and how client B was to learn the skill of managing her own cigarettes. The facility failed to ensure client F had unimpeded access to her locked personal hearing aids kept inside the locked medication cabinet for 1 of 4 sampled clients (client B) and 1 additional client (client F).</p> <p>This federal tag relates to complaint #IN00197035.</p> <p>9-3-2(a)</p>		<p>Program Manager) will observe in the home. Observations will include assuring that staff are redirecting Client C if she is not appropriately dressed. All clients will be asked what they would like to do for their leisure activities—in the home as well as the community. This will be documented on a form contained in their ISP book. Clients will be offered at least 1 activity of their choice (may be 1:1 or small group) on a weekly basis. Other activities will be offered as a group activity (bowling, festivals, going to the park, going on a picnic, etc) that the consumer may choose to participate in. QIDP will check activities weekly to assure that consumers are getting out into the community. Member of the Management team will check activities as they are doing their weekly observations. Client B's cigarettes are restricted due to health and financial reasons. A program will be developed for Client B that</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow		will include guidelines for how she will learn a skill to decrease the need for the restriction. Client F has indicated that she wanted to have her hearing aids in the med room for safekeeping. The facility will purchase a lock box for Client F (she will have a key) where she can put her hearing aids in nightly and keep them in her room. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. Observations will include monitoring Client B's cigarette program and assuring that there is a program to decrease the need for the restriction and that Client F does have a safe place to put her hearing aids.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, for 1 additional client (client G), the facility failed to encourage and teach client G to carry personal identification and a wallet when she worked in the community and rode the community transit.</p> <p>Findings include:</p> <p>During observations and interviews on 5/12/16 from 5:25am until 7:45am and on 5/12/16 from 3:20pm until 5:35pm, client G was at the group home and did not have her personal information. On 5/12/16 at 3:45pm, GHS (Group Home Staff) #8 and client G both indicated client G worked independently in the community at a restaurant on Wednesdays and Fridays. At 3:45pm, client G indicated the staff kept her identification at the group home and she did not carry her personal identification when she rode the community transit to work in the community. Client G indicated the group home staff take her to workshop in the mornings on Wednesdays and Fridays, then she rides the transit independently to work, and the group home staff pick her up from work</p>	W 0125	W125: The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. All clients who are able to carry their IDs will be given a form of ID to have on their person and encouraged to carry it when going in the community. QIDP will check weekly with clients to see that they have IDs with them as they choose to carry them.	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0130 Bldg. 00	<p>at the end of the day. Client G stated she would like to carry identification with her, "but the staff keep it."</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated there was no evidence client G had her personal identification. The PM indicated client G should have her identification available for her to carry while independent in the community.</p> <p>On 5/13/16 at 11:00am, client C's 2015 CFA (Comprehensive Functional Assessment), 10/12/15 Lifestyle Plan, and 10/12/15 ISP (Individual Support Plan) were reviewed and did not indicate whether client G had the skill to carry her identification and did not assess whether she could carry a wallet.</p> <p>9-3-2(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation, record review and interview for 1 of 4 sampled clients (client C), the facility failed to protect client C's personal privacy when she</p>	W 0130	W130: The facility must ensure the rights of all clients. Therefore, the facility	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>walked through the group home nude.</p> <p>Findings include:</p> <p>During observations on 5/12/16 from 5:25am until 7:45am, observation and interviews were conducted at the group home. At 6:15am, client C was verbally asked by GHS (Group Home Staff) #8 to go from her bedroom to the bathroom. Client C was nude from the waist down and wore a tee shirt as she walked from her bedroom to the bathroom. At 6:15am, client C walked back and forth between the two rooms nude from the waist down. At 6:45am, client C exited the bathroom and was nude. Client C walked to the doorway to the living room, asked the RM (Residential Manager) a question, and then walked nude to her bedroom. No redirection by the facility staff was observed to protect client C's personal privacy.</p> <p>Client C's record was reviewed on 5/13/16 at 1:45pm. Client C's 6/1/15 ISP (Individual Support Plan) did not indicate a goal/objective to teach her personal privacy. Client C's 6/1/15 BSP (Behavior Support Plan) indicated targeted behaviors of stripping. Client C's BSP indicated "Stripping occurs when [client C] wants to gain the attention of staff. She will strip in her home or in public, so</p>		<p>must ensure privacy during treatment and care of personal needs. All staff have been trained on redirecting client C whenever she exits her bedroom or bathroom not completely dressed. A goal will be written to address her personal privacy. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly to assure that staff are redirecting Client C if she is not completely dressed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0136 Bldg. 00	<p>it is important to intervene as quickly as possible no matter where the location...Redirect [client C] to her bedroom to get her to put her clothes on in a private place."</p> <p>An interview with PM (Program Manager) was conducted on 5/20/16 at 3:06pm. The PM indicated client C should be prompted to go to a private place to dress when she was nude. The PM indicated she was unsure if client C had a bathrobe to wear after bathing. The PM indicated client C should have been redirected back into her bedroom and assisted by the facility staff.</p> <p>9-3-2(a)</p> <p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on observation, interview, and record review, for 4 of 4 sampled clients (clients A, B, C, and D), the facility failed to ensure and document clients A, B, C, and D's participation in outings/activities in the community.</p> <p>Findings include:</p>	W 0136	W136: The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>On 5/12/16 at 3:45pm, clients A and B indicated they enjoyed going into the community for outings. At 3:45pm, client A stated she "would like to go more often, but cannot because staff schedule" their outings.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated clients A, B, C, and D participated in outings planned by the facility. The PM indicated clients should be taught and encouraged to make choices of activity. The PM indicated clients A, B, C, and D went on an outing each week to get a pop on Wednesdays and to watch a movie at the agency office every other Friday evening. The PM indicated no community outings were available for review to determine if the clients attended outings and/or were provided a choice of activities to participate in the community. The PM indicated clients A, B, C, and D's activity calendars did not indicate how each client participated and if the clients got out of the facility van.</p> <p>Client A's record was reviewed on 5/13/16 at 12:15pm. Client A's 7/31/15 ISP (Individual Support Plan) did not indicate an objective to participate in leisure activities of her choice. Client A's record indicated an activity calendar</p>		<p>All clients will be asked what they would like to do for their leisure activities—in the home as well as the community. This will be documented on a form contained in their ISP book. Clients will be offered at least 1 activity of their choice (may be 1:1 or small group) on a weekly basis. Other activities will be offered as a group activity (bowling, festivals, going to the park, going on a picnic, etc) that the consumer may choose to participate in. QIDP will check activities weekly to assure that consumers are getting out into the community. Member of the Management team will check activities as they are doing their weekly observations.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>listing and/or participation in community activities for the outside the group home: "[name of store]" on 3/21/16, and 3/13/16; "Grocery" on 5/12/16 and 1/2/16; "Pop Run" on 5/11/16, 5/4/16, 4/27/16, 4/20/16, 4/13/16, 4/6/16, 3/30/16, 3/23/16, 2/17/16, 2/13/16, 2/10/16, 2/3/16, 1/27/16, 1/20/16, 1/16/16, 1/13/16, 1/6/16, 12/30/15, 12/23/15, 12/16/15, 12/9/15, and 12/2/15; and "movie night" at the agency office on 5/13/16, 4/29/16, 4/21/16, 4/15/16, 3/17/16, 1/15/16, 1/1/16, 12/18/15, and 12/4/15; "Dinner with Boyfriend" on: 4/18/16 and 12/8/15.</p> <p>Client B's record was reviewed on 5/13/16 at 2:10pm. Client B's 12/8/15 ISP indicated she was able to choose her leisure activities. Client B's record indicated an activity calendar listing and/or participation in community activities for the outside the group home: "[name of store]" on 4/2/16 and 3/25/16; "Van Ride" on 4/9/16; "Grocery" on 5/12/16 and 1/23/16; "Tobacco Shop" on 2/16/16; "Pop Run" on 5/11/16, 5/4/16, 4/27/16, 4/20/16, 4/13/16, 4/6/16, 3/30/16, 3/23/16, 2/17/16, 2/13/16, 2/10/16, 2/6/16, 2/3/16, 1/27/16, 1/20/16, 1/13/16, 1/6/16, 12/30/15, 12/23/15, 12/16/15, 12/9/15, and 12/2/15; and "movie night" at the agency office on 5/13/16, 4/29/16, 4/21/16, 4/15/16,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>3/17/16, 1/29/16, 1/15/16, 1/1/16, 12/18/15, and 12/4/15; and "Dinner with Boyfriend" on: 4/28/16, 4/7/16, 12/10/15, and 12/25/15.</p> <p>Client C's record was reviewed on 5/13/16 at 1:45pm. Client C's 6/1/15 ISP indicated she was encouraged to choose her activities. Client C's record indicated an activity calendar listing and/or participation in community activities for the outside the group home: "[name of store]" on 4/2/16, and 3/13/16; "Grocery" on 5/12/16 and 1/16/16; "Pop Run" on 5/14/16, 5/11/16, 5/4/16, 4/27/16, 4/20/16, 4/13/16, 4/6/16, 3/30/16, 3/23/16, 2/24/16, 2/17/16, 2/10/16, 2/3/16, 1/27/16, 1/20/16, 1/13/16, 1/6/16, 12/30/15, 12/23/15, 12/16/15, 12/9/15, and 12/2/15; and "movie night" at the agency office on 5/13/16, 4/29/16, 4/21/16, 4/15/16, 3/17/16, 2/26/16, 1/9/16, 1/15/16, 1/1/16, 12/18/15, and 12/4/15.</p> <p>Client D's record was reviewed on 5/13/16 at 1:00pm. Client D's 1/6/16 ISP indicated a goal to choose her leisure activity. Client D's record indicated an activity calendar listing and/or participation in community activities for the outside the group home: "Van Ride" on 5/15/16; Out to eat on 3/17/16; "[name of store]" on 3/12/16 and 2/21/16;</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0137 Bldg. 00	<p>"Pop Run" on 5/11/16, 5/4/16, 4/27/16, 4/20/16, 4/13/16, 4/6/16, 3/30/16, 3/23/16, 2/24/16, 2/17/16, 2/13/16, 2/10/16, 2/3/16, 1/27/16, 1/20/16, 1/16/16, 1/13/16, 12/30/15, 12/23/15, 12/16/15, 12/9/15, and 12/2/15; and "movie night" at the agency office on 5/13/16, 4/29/16, 4/21/16, 4/15/16, 3/17/16, 1/29/16, 1/15/16, and 12/4/15.</p> <p>9-3-2(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, interview, and record review, for 1 of 4 sampled clients (client B) and 1 additional client (client F), the facility failed to ensure client B's plans included how client B was to access her locked personal cigarettes and how client B was to learn the skill of managing her own cigarettes. The facility failed to ensure client F had unimpeded access to her locked personal hearing aids kept inside the locked medication cabinet.</p> <p>Findings include:</p> <p>Observations and interviews were</p>	W 0137	<p>W137: The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Client B's cigarettes are restricted due to health and financial reasons. A program will be developed for Client B that will include guidelines for how she would learn a skill to decrease the need for the</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>conducted at the group home on 5/12/16 from 5:25am until 7:45am, and on 5/12/16 from 3:20pm until 5:32pm. During the observation periods client B asked staff for her locked cigarettes which were one after each meal. Client B lit and smoked independently outside on the patio. During both the observation periods client B requested her cigarettes from GHS (Group Home Staff) #1, #2, #3, #4, #6, #8, and the Residential Manager (RM) throughout the observation periods. During both observation periods client B requested her cigarette from staff and the RM, independently exited the facility outside the back door alone, sat down in a chair outside the back door, lit her cigarette, and smoked each cigarette without a staff being present or within view of client B smoking independently. After each cigarette client B extinguished her cigarette butt and entered the group home. On 5/12/16 at 7:00am, GHS #8 stated client B's cigarettes were kept "locked because her guardian wanted [client B's] smoking limited." On 5/12/16 at 7:00am, GHS #8 stated client F's right and left hearing aids were kept secured inside the medication cabinet to "keep them safe." GHS #8 indicated staff were responsible to ensure client F wore her prescribed hearing aids daily.</p>		<p>restriction. Client F has indicated that she wanted to have her hearing aids in the med room for safekeeping. The facility will purchase a lock box for Client F where she can put her hearing aids in nightly and keep them in her room. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. Observations will include monitoring Client B's cigarette program and assuring that there is a program to decrease the need for the restriction and that Client F does have a safe place to put her hearing aids.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Client B's record was reviewed on 5/13/16 at 2:10pm. Client B's 12/8/15 ISP (Individual Support Plan and 12/8/15 BSP (Behavior Support Plan) did not indicate the identified need for locked cigarettes, a documented plan for the restriction, and did not include consent for his personal cigarettes to be kept locked/secured. Client B's 12/7/15 "Modification of Individual Rights" indicated "Services that will be provided in order that the right may be restored...Right to be modified: Freedom to fully access cigarettes. Manner in which the right will be modified. [Client B] will receive one cigarette after each meal and one cigarette before bed. [Client B's] cigarettes are kept in the locked medicine room due to [client B's] inability to control the amount of cigarettes she smokes." The facility failed to develop guidelines for how client B would learn a skill to decrease the need for the restriction.</p> <p>Client F's record was reviewed on 5/12/16 at 6:15pm. Client F's 10/12/15 ISP indicated client F wore prescribed right and left hearing aids to hear. Client F's ISP did not indicate the identified need for client F's hearing aids to be kept locked inside the medication room.</p> <p>On 5/13/16 at 2:00pm, an interview with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0149	<p>the PM (Program Manager) and the RM (Residential Manager) was conducted. The PM and RM both indicated client B's cigarettes were kept locked inside the group home medication room. The RM indicated if client B had access to her cigarettes she would smoke them until the cigarettes were gone. The PM indicated client B's guardian had approved the restriction of locking up client B's cigarettes and indicated client B's plans did not include a teaching strategy for client B to accomplish to gain free access to her locked cigarettes back. The PM indicated client F's locked hearing aids should not have been kept locked and no plan or approved restriction of client F's rights was available for review.</p> <p>On 5/20/16 at 3:06pm, the PM indicated no further information was available for review. The PM indicated client B's plan for locked cigarettes did not include a teaching objective for how she was to get her right back to access her own cigarettes. The PM indicated client F's hearing aids should not have been locked inside the medication cabinet.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 3 of 4 sampled clients (clients A, B, and C) and for 1 additional client (client G) for 2 of 13 BDDS (Bureau of Developmental Disabilities Services) reports reviewed from 3/1/16 through 5/12/16, the facility neglected to implement its Abuse, Neglect, and/or Mistreatment policy and procedure to thoroughly investigate client A's injuries in her bedroom and clients B, C, and G's allegation of staff verbal abuse at the workshop on 5/9/16.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 5/12/16 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 3/1/16 through 5/12/16 were reviewed and indicated client A's injuries in her bedroom: <p>For client A: -A 3/29/16 BDDS report for an incident on 3/28/16 at 9:30pm indicated client A had "was taken to [name of hospital] ER (Emergency Room) via (by way of) staff car. [Client A] was in her bedroom when staff heard a thud. Staff went into her bedroom and [client A] was lying (sic) on</p>	W 0149	W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The Executive Director will review all investigations that are completed due to serious injury (requiring more than first aid) from a fall. She will be reviewing for thoroughness and assuring that corrective action to prevent further occurrence is included. The IDT will meet to discuss the supervision level that Client A requires based on her needs. The Facility staff will be retrained on reporting abuse/neglect to their supervisors, even if the allegation occurred at the day program. Upon knowledge of an allegation at the day program, the facility QIDP and/or Program Manager will insure that the allegation is reported in a timely manner by the day program or by the	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the floor between her night stand and bed. She was bleeding from lacerations to her forehead...[Client A] was evaluated and received three stitches above left eye and two stitches above her right eye. CT Scan results came back normal...[Client A] has a fall risk plan and it was being followed. Review of risk plan and revisions will be completed as necessary."</p> <p>-A 3/31/16 "Investigative Summary" indicated "staff was in the med (medication) room at the time of the fall and did not witness the fall...[Client A] stated she fell out of her bed, while her mother said [client A] told her she lost her footing while going back to bed after using the restroom. There was nothing on the floor that could have caused the fall. Findings: Neglect was unsubstantiated. Staff was following fall risk plan in place. It is unsure how the fall occurred and it could be possible that [client A] could have hit her head on the nightstand. This seems to be an isolated incident. The night stand will be moved away from the bed to prevent future injuries. The nurse updated [client A's] fall risk plan." The investigation indicated one staff was on duty at 9:30pm with seven (7) clients. The investigation did not indicate what type or if shoes</p>		<p>facility. In the future, when an allegation is made at the day program involving facility consumers, the facility will ask to be a part of the investigation to assure that it is thorough. The day program provided retraining to the staff member involved with that allegation on 5/9/16. The day program is providing retraining for its staff regarding their agencies policy that prohibits abuse, neglect and mistreatment of clients. The QIDP will observe the day program 1 time per week and the Program Manager will observe 2 times per month.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>were worn by client A. The investigation did not address why the one staff on duty was not assisting client A to get up from her bed based on her identified need in her risk plan. The investigation did not address what type of staff supervision client A required.</p> <p>Client A was observed on 5/12/16 from 5:25am until 7:45am and on 5/12/16 from 3:20pm until 5:35pm. During both observation periods client A walked throughout the group home, her feet dragging on the tile making a scraping sound, and she was not prompted to pick up her feet to walk.</p> <p>Client A's record was reviewed on 5/13/16 at 12:15pm. Client A's 7/31/15 ISP (Individual Support Plan), 7/31/15 BSP (Behavior Support Plan), and 4/2016 Physician Orders indicated client A's diagnoses included, but were not limited to: Hydrocephalus, Seizures, and Scoliosis. Client A's record indicated she was at risk for falls related to her diagnoses. Client A's 3/29/16 and 6/29/15 "Fall Risk Plans" indicated client A was a "Fall Risk (because of) Seizures, Scoliosis...Interventions...PT (Physical Therapy) evaluation to be requested from PCP (Primary Care Physician). Staff will</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>assist [client A] when standing up to reach for things not within her reach and notify nurse with any changes. Staff will encourage [client A] to get up slowly when transferring from sitting to standing position. Staff will assist and encourage [client A] with daily movement to increase strength and mobility...Staff will assist [client A] with only using shoes that provide good support. Staff will ensure that they continuously remind [client A] of the importance of not walking across surfaces that could be potential safety hazards such as a wet surface...." Client A's record did not identify what type of staff supervision she required based on client A's identified need.</p> <p>On 5/13/16 at 10:45am, an interview with the PM (Program Manager) and the Residential Manager (RM) was conducted. The PM and the RM both indicated client A's injury on 3/28/16 was the result of a fall and client A's fall risk plan was updated after her fall. The PM and the RM both indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The PM indicated injuries should be immediately reported and investigated. The PM indicated client A's injuries were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>not witnessed.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated client A's injuries were thoroughly investigated. The PM indicated client A was able to be alone inside her bedroom at the group home. The PM indicated no further information was available for review.</p> <p>2. On 5/12/16 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 3/1/16 through 5/12/16 were reviewed and indicated client B, C, and G's allegation of verbal abuse:</p> <p>For clients B, C, and G: -A 5/9/16 BDDS report for an incident on 5/6/16 at 2:45pm indicated a BDDS report reported by the contract workshop. The BDDS report indicated "A call was received after the [name of contract workshop] was closed from [Group Home Staff (GHS) #4]. [GHS #4] reported that when she and [GHS #2] picked up [clients B, C, and G who attended this contract workshop] a [Workshop Staff (WKS) #1] came out to their van and allegedly was yelling at the clients in the van. The clients included</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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
	[Clients B, C, and G]. [GHS #4] added that when they arrived at the [Workshop] at approximately 2:45pm, the clients seen (sic) the van pull up and they immediately came out to the van before [GHS #2 and GHS #4] could come in to pick them up and before a [workshop] staff member noticed they had arrived...A description of the staff member was given and [Workshop Staff #1] was identified. [Workshop Staff (WKS) #1] was contacted about the allegation. Per agency policy, [WKS #1] was suspended from duty pending the outcome of an investigation. When [WKS #1] was interviewed and per her written statement, she was working in the medication room checking medications. The medication room was open and she overheard another staff say [the name of the group home] ladies are walking out, their van is outside. [WKS #1] stated she went outside and all of the ladies were already in the van with their seatbelts on, and both staff were in their seats as if ready to leave. [WKS #1] stated she opened the van door and told the clients they knew they were not supposed to go out to their van without a [name of workshop] staff being with them or without their own staff coming in. She added that she told them they knew			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>better. [WKS #1] admitted that she did talk loud (sic) and was stern with the ladies. When interviewed she stated she always talks loud (sic), but she was stern with the ladies on this occasion due to the safety risks...[GHS #4] was questioned about coming in to the building at least to pick up the communication book for this home. [GHS #4] reported the ladies came out before they could come in...Clients [B and G] were interviewed about the incident. Their recall of the incident was similar in that they recalled the staff member came out to the van to remind them that they did not follow the dismissal procedures. [Client G] stated the staff was screaming and [client B] stated she was talking to them. Both admitted they did not follow the dismissal procedures and neither was upset about the incident when interviewed. After reviewing the information presented it was determined that the alleged abuse is not substantiated. [WKS #1] was provided retraining about [name of workshop] abuse/neglect policy and was counseled about watching her tone of voice when working with clients."</p> <p>-An undated "Investigation Summary" for the 5/6/16 incident indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>investigation did not address why staff were not present to supervise clients B, C, and G leaving the building unattended, two of the three clients present were interviewed, and client C was not interviewed. One of the two group home staff present during the incident was interviewed. GHS #2 was not interviewed; and a list of questions asked was not available for review. The witness statements were paraphrased and typed by the workshop.</p> <p>-A 5/9/16 at 11:03am, email from the PM to the Workshop Supervisor indicated the PM questioned the workshop supervision of the clients waiting to be picked up from workshop regarding: "Where were [workshop] staff that 3 clients could leave the building unattended? Why was only one of the [Group Home Staff] interviewed? There were 2 in the vehicle. It appears the [Group Home Staff] who was interviewed was only asked about the communication book and no asked if [WKS #1] was yelling or using a tone of voice that was not appropriate. Was she asked how the [workshop staff] interacted with the consumers? Is so, what was her response. Why was the other consumer [client C] not interviewed?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>-A 5/10/16 at 7:28am, email from the Workshop Supervisor indicated the following response: "...there were 3 staff on duty" during the incident, two staff were assisting other clients in the bathroom and the "3rd staff stepped into the medication room prior to the other 2 returning to the multipurpose room." "When I was talking to [GHS #4] on the phone, [GHS #2] could be heard in the background giving same information...The reason I asked about the communication book was because I found it curious that [GHS #2 and #4] kept repeating that they were going to come in and let us know they were leaving...I didn't feel I needed to ask whether the [workshop] staff was yelling or how they were interacting, because [GHS #4] had already told me. This was the reason she called initially...[Client C] was not interviewed as she was not at the [workshop] today..." and the workshop supervisor completed the investigation by telephone in another town. No further information was available for review.</p> <p>On 5/13/16 at 10:45am, an interview with the PM (Program Manager) and the Residential Manager (RM) was conducted. The PM and the RM both</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated the agency did not report and did not conduct an investigation into clients B, C, and G's verbal abuse allegation at the workshop on 5/6/16. The PM indicated the workshop reported the incident to BDDS on 5/9/16. The PM indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The PM indicated allegations should be immediately reported and thoroughly investigated. The PM indicated clients B, C, and D's allegation of verbal abuse was not immediately reported and was not thoroughly investigated by the workshop.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated clients B, C, and G's allegation of staff to client verbal abuse was not immediately reported and was not thoroughly investigated. The PM indicated no further information was available for review.</p> <p>On 5/13/16 at 11:00am, a record review was conducted of the 10/2005 "Bureau of Developmental Disabilities Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or exploitation by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."</p> <p>On 5/13/16 at 11:00am, the facility's 10/13 "Preventing Abuse and Neglect" policy and procedure indicated "Abuse means the following: 1. Intentional or willful infliction of physical injury...3. Punishment with resulting physical harm or pain...7. Corporal Punishment which includes forced physical (sic), hitting, pinching, application of painful or noxious stimuli, use of electric shock, and the infliction of physical pain...9. Violation of individual rights....Neglect means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual."</p> <p>This federal tag relates to complaint #IN00197035.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0153 Bldg. 00	<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 1 of 2 investigations reviewed (clients B, C, and G), the facility failed to immediately report an allegation of verbal abuse of clients B, C, and G to state officials (Bureau of Developmental Disabilities Services-BDDS and/or Adult Protective Services -APS) in accordance with state law.</p> <p>Findings include:</p> <p>On 5/12/16 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 3/1/16 through 5/12/16 were reviewed and indicated client B, C, and G's allegation of verbal abuse:</p> <p>For clients B, C, and G: -A 5/9/16 BDDS report for an incident on 5/6/16 at 2:45pm indicated a BDDS report reported by the contract workshop. The BDDS report indicated "A call was</p>	W 0153	W153: The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of an unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. The Facility staff will be retrained on reporting abuse/neglect to their supervisors, even if the allegation occurred at the day program. Upon knowledge of an allegation at the day program, the facility QIDP and/or Program Manager will insure that the allegation is reported in a timely manner by the day program or by the facility. The day program has initiated a system where there	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>received after the [name of contract workshop] was closed from [Group Home Staff (GHS) #4]. [GHS #4] reported that when she and [GHS #2] picked up [clients B, C, and G who attended this contract workshop] a [Workshop Staff (WKS) #1] came out to their van and allegedly was yelling at the clients in the van. The clients included [Clients B, C, and G]. [GHS #4] added that when they arrived at the [Workshop] at approximately 2:45pm, the clients seen (sic) the van pull up and they immediately came out to the van before [GHS #2 and GHS #4] could come in to pick them up and before a [workshop] staff member noticed they had arrived...A description of the staff member was given and [Workshop Staff #1] was identified. [Workshop Staff (WKS) #1] was contacted about the allegation. Per agency policy, [WKS #1] was suspended from duty pending the outcome of an investigation. When [WKS #1] was interviewed and per her written statement, she was working in the medication room checking medications. The medication room was open and she overheard another staff say [the name of the group home] ladies are walking out, their van is outside. [WKS #1] stated she went outside and all of the ladies were</p>		<p>is a person available to report all BDDS reportable incidents in the event that their Program Manager is unavailable to do so. The QIDP will observe the day program 1 time per week and the Program Manager will observe 2 times per month.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>already in the van with their seatbelts on, and both staff were in their seats as if ready to leave. [WKS #1] stated she opened the van door and told the clients they knew they were not supposed to go out to their van without a [name of workshop] staff being with them or without their own staff coming in. She added that she told them they knew better. [WKS #1] admitted that she did talk loud (sic) and was stern with the ladies. When interviewed she stated she always talks loud (sic), but she was stern with the ladies on this occasion due to the safety risks...[GHS #4] was questioned about coming in to the building at least to pick up the communication book for this home. [GHS #4] reported the ladies came out before they could come in...Clients [B and G] were interviewed about the incident. Their recall of the incident was similar in that they recalled the staff member came out to the van to remind them that they did not follow the dismissal procedures. [Client G] stated the staff was screaming and [client B] stated she was talking to them. Both admitted they did not follow the dismissal procedures and neither was upset about the incident when interviewed. After reviewing the information presented it was determined</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>that the alleged abuse is not substantiated. [WKS #1] was provided retraining about [name of workshop] abuse/neglect policy and was counseled about watching her tone of voice when working with clients."</p> <p>On 5/13/16 at 10:45am, an interview with the PM (Program Manager) and the Residential Manager (RM) was conducted. The PM and the RM both indicated the agency did not report clients B, C, and G's verbal abuse allegation at the workshop on 5/6/16. The PM indicated the workshop reported the incident to BDDS on 5/9/16. The PM indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The PM indicated allegations should be immediately reported. The PM indicated clients B, C, and D's allegation of verbal abuse was not reported by the agency and was not immediately reported by the workshop.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated clients B, C, and G's allegation of staff to client verbal abuse was not immediately reported. The PM indicated no further information was available for review.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0154 Bldg. 00	<p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review, and interview, for 2 of 13 BDDS (Bureau of Developmental Disabilities Services) reports and 2 of 2 investigations reviewed (for clients A, B, C, and G), the facility failed to thoroughly investigate client A's injuries in her bedroom and clients B, C, and G's allegation of verbal abuse at the workshop on 5/9/16.</p> <p>Findings include:</p> <p>1. On 5/12/16 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 3/1/16 through 5/12/16 were reviewed and indicated:</p> <p>For client A: -A 3/29/16 BDDS report for an incident on 3/28/16 at 9:30pm indicated client A had "was taken to [name of hospital] ER (Emergency Room) via (by way of) staff car. [Client A] was in her bedroom when staff heard a thud. Staff went into her bedroom and [client A] was lying (sic) on</p>	W 0154	<p>W154: The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>The Executive Director will review all investigations that are completed due to serious injury (requiring more than first aid) from a fall. She will be reviewing for thoroughness and assuring that corrective action to prevent further occurrence is included. The Facility staff will be retrained on reporting abuse/neglect to their supervisors, even if the allegation occurred at the day program. Upon knowledge of an allegation at the day program, the Facility QIDP and/or Program Manager will insure that the allegation is reported in a timely manner by the day program or by the</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the floor between her night stand and bed. She was bleeding from lacerations to her forehead...[Client A] was evaluated and received three stitches above left eye and two stitches above her right eye. CT Scan results came back normal...[Client A] has a fall risk plan and it was being followed. Review of risk plan and revisions will be completed as necessary."</p> <p>-A 3/31/16 "Investigative Summary" indicated "staff was in the med (medication) room at the time of the fall and did not witness the fall...[Client A] stated she fell out of her bed, while her mother said [client A] told her she lost her footing while going back to bed after using the restroom. There was nothing on the floor that could have caused the fall. Findings: Neglect was unsubstantiated. Staff was following fall risk plan in place. It is unsure how the fall occurred and it could be possible that [client A] could have hit her head on the nightstand. This seems to be an isolated incident. The night stand will be moved away from the bed to prevent future injuries. The nurse updated [client A's] fall risk plan." The investigation indicated one staff was on duty at 9:30pm with seven (7) clients. The investigation did not indicate what type or if shoes</p>		<p>facility. The day program has initiated a system where there is a person available to report all BDDS reportable incidents in the event that their Program Manager is unavailable to do so. In the future, when an allegation is made at the day program involving facility consumers, the facility will ask to be a part of the investigation to assure that it is thorough. The QIDP will observe the day program 1 time per week and the Program Manager will observe 2 times per month.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>were worn by client A. The investigation did not address why the one staff on duty was not assisting client A to get up from her bed based on her identified need in her risk plan. The investigation did not address what type of staff supervision client A required.</p> <p>Client A was observed on 5/12/16 from 5:25am until 7:45am and on 5/12/16 from 3:20pm until 5:35pm. During both observation periods client A walked throughout the group home, her feet dragging on the tile making a scraping sound, and was not prompted to pick up her feet to walk.</p> <p>Client A's record was reviewed on 5/13/16 at 12:15pm. Client A's 7/31/15 ISP (Individual Support Plan), 7/31/15 BSP (Behavior Support Plan), and 4/2016 Physician Orders indicated client A's diagnoses included, but were not limited to: Hydrocephalus, Seizures, and Scoliosis. Client A's record indicated she was at risk for falls related to her diagnoses. Client A's 3/29/16 and 6/29/15 "Fall Risk Plans" indicated client A was a "Fall Risk (because of) Seizures, Scoliosis...Interventions...PT (Physical Therapy) evaluation to be requested from PCP (Primary Care Physician). Staff will</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>assist [client A] when standing up to reach for things not within her reach and notify nurse with any changes. Staff will encourage [client A] to get up slowly when transferring from sitting to standing position. Staff will assist and encourage [client A] with daily movement to increase strength and mobility...Staff will assist [client A] with only using shoes that provide good support. Staff will ensure that they continuously remind [client A] of the importance of not walking across surfaces that could be potential safety hazards such as a wet surface...." Client A's record did not identify what type of staff supervision she required based on client A's identified need.</p> <p>On 5/13/16 at 10:45am, an interview with the PM (Program Manager) and the Residential Manager (RM) was conducted. The PM and the RM both indicated client A's injury on 3/28/16 was the result of a fall and client A's fall risk plan was updated after her fall. The PM and the RM both indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The PM indicated injuries should be thoroughly investigated. The PM indicated client A's injuries were not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>witnessed.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated client A's injuries were thoroughly investigated. The PM indicated client A was able to be alone inside her bedroom at the group home. The PM indicated no further information was available for review.</p> <p>2. On 5/12/16 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 3/1/16 through 5/12/16 were reviewed and indicated:</p> <p>For clients B, C, and G: -A 5/9/16 BDDS report for an incident on 5/6/16 at 2:45pm indicated a BDDS report reported by the contract workshop. The BDDS report indicated "A call was received after the [name of contract workshop] was closed from [Group Home Staff (GHS) #4]. [GHS #4] reported that when she and [GHS #2] picked up [clients B, C, and G who attended this contract workshop] a [Workshop Staff (WKS) #1] came out to their van and allegedly was yelling at the clients in the van. The clients included [Clients B, C, and G]. [GHS #4] added</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>that when they arrived at the [Workshop] at approximately 2:45pm, the clients seen (sic) the van pull up and they immediately came out to the van before [GHS #2 and GHS #4] could come in to pick them up and before a [workshop] staff member noticed they had arrived...A description of the staff member was given and [Workshop Staff #1] was identified. [Workshop Staff (WKS) #1] was contacted about the allegation. Per agency policy, [WKS #1] was suspended from duty pending the outcome of an investigation. When [WKS #1] was interviewed and per her written statement, she was working in the medication room checking medications. The medication room was open and she overheard another staff say [the name of the group home] ladies are walking out, their van is outside. [WKS #1] stated she went outside and all of the ladies were already in the van with their seatbelts on, and both staff were in their seats as if ready to leave. [WKS #1] stated she opened the van door and told the clients they knew they were not supposed to go out to their van without a [name of workshop] staff being with them or without their own staff coming in. She added that she told them they knew better. [WKS #1] admitted that she did</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>talk loud (sic) and was stern with the ladies. When interviewed she stated she always talks loud (sic), but she was stern with the ladies on this occasion due to the safety risks...[GHS #4] was questioned about coming in to the building at least to pick up the communication book for this home. [GHS #4] reported the ladies came out before they could come in...Clients [B and G] were interviewed about the incident. Their recall of the incident was similar in that they recalled the staff member came out to the van to remind them that they did not follow the dismissal procedures. [Client G] stated the staff was screaming and [client B] stated she was talking to them. Both admitted they did not follow the dismissal procedures and neither was upset about the incident when interviewed. After reviewing the information presented it was determined that the alleged abuse is not substantiated. [WKS #1] was provided retraining about [name of workshop] abuse/neglect policy and was counseled about watching her tone of voice when working with clients."</p> <p>-An undated "Investigation Summary" for the 5/6/16 incident indicated the investigation did not address why staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>were not present to supervise clients B, C, and G leaving the building unattended, two of three clients present were interviewed. Client C was not interviewed; One of two group home staff present during the incident was interviewed. GHS #2 was not interviewed; and a list of questions asked was not available for review. The witness statements were paraphrased and typed by the workshop.</p> <p>-A 5/9/16 at 11:03am, email from the PM to the Workshop Supervisor indicated the PM questioned the workshop supervision of the clients waiting to be picked up from workshop regarding: "Where were [workshop] staff that 3 clients could leave the building unattended? Why was only one of the [Group Home Staff] interviewed? There were 2 in the vehicle. It appears the [Group Home Staff] who was interviewed was only asked about the communication book and no asked if [WKS #1] was yelling or using a tone of voice that was not appropriate. Was she asked how the [workshop staff] interacted with the consumers? Is so, what was her response. Why was the other consumer [client C] not interviewed?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>-A 5/10/16 at 7:28am, email from the Workshop Supervisor indicated the following response: "...there were 3 staff on duty" during the incident, two staff were assisting other clients in the bathroom and the "3rd staff stepped into the medication room prior to the other 2 returning to the multipurpose room." "When I was talking to [GHS #4] on the phone, [GHS #2] could be heard in the background giving same information...The reason I asked about the communication book was because I found it curious that [GHS #2 and #4] kept repeating that they were going to come in and let us know they were leaving...I didn't feel I needed to ask whether the [workshop] staff was yelling or how they were interacting, because [GHS #4] had already told me. This was the reason she called initially...[Client C] was not interviewed as she was not at the [workshop] today..." and the workshop supervisor completed the investigation by telephone in another town. No further information was available for review.</p> <p>On 5/13/16 at 10:45am, an interview with the PM (Program Manager) and the Residential Manager (RM) was conducted. The PM and the RM both indicated the agency did not conduct an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>investigation into clients B, C, and G's verbal abuse allegation at the workshop on 5/6/16. The PM indicated the workshop reported the incident to BDDS on 5/9/16. The PM indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The PM indicated allegations should be thoroughly investigated. The PM indicated clients B, C, and D's allegation of verbal abuse was not thoroughly investigated by the workshop.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated clients B, C, and G's allegation of staff to client verbal abuse was not thoroughly investigated. The PM indicated no further information was available for review.</p> <p>This federal tag relates to complaint #IN00197035.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review, and interview, for 1 of 4 sampled clients</p>	W 0225	W225: The comprehensive	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(client D), the facility failed to reassess client D's vocational abilities related to her individual work history, work skills, and work interests for day services within the group home.</p> <p>Findings include:</p> <p>On 5/12/16 from 1:22pm until 1:55pm, client D was observed at the group home with GHS (Group Home Staff) #6. From 1:22pm until 1:55pm client D sat sideways on the sofa in the living room, had her head on GHS #6's lap, and client D was asleep. At 1:45pm, GHS #6 indicated client D had refused to lay down in her bed to rest. GHS #6 stated "Well we do activities" and was unable to list and/or provide evidence of the choice of activities offered to client D while at the home for day services. At 1:45pm, GHS #6 indicated there was no list of activities and/or a daily schedule for client D's at home day services. GHS #6 indicated client D attended day services in a contracted workshop but had a decline in 10/2015 and that was when client D was changed to have day services in the group home.</p> <p>On 5/13/16 from 10:45am until 3:05pm, client D was observed at the group home with the RM (Residential Manager). From 11:30am until 1:00pm, client D sat</p>		<p>functional assessment must include, as applicable, vocational skills. Client D will have a reassessment of her vocational abilities related to her individual work history, work skills and work interests for day services within the home. A schedule will be developed for activities within the home. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. Observations will include assuring that Client D has a schedule and it is being followed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>at the dining room table and ate a sandwich. During the observation period client D spoke on the telephone and slept on the sofa. No other activities were observed.</p> <p>Client D's record was reviewed on 5/13/16 at 1:00pm. Client D's record indicated she was admitted on 7/30/1990. Client D's 1/6/16 ISP (Individual Support Plan) and 1/2016 Risk Assessment did not include her work history and/or work interests. Client D's ISP indicated client D had a medical decline associated with her dementia and her day service location was changed. Client D's record did not indicate a reassessment after her change of day service providers in 10/2015. Client D's record indicated she had limited verbal skills, was to complete "activities of daily living" during the day services, and did not include client D's work history, work skills, and work interests. Client D's record included an undated schedule for Monday through Friday from 8:00am until 3:00pm, which indicated "Activities of daily living, leisure, in home," and did not include a list for client D to choose from and/or suggestions for day services.</p> <p>On 5/20/16 at 3:06pm, an interview was conducted with the PM (Program Manager). The PM indicated client D</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0240 Bldg. 00	<p>had her day services location changed because of a medical decline in 10/2015, and client D's skill was not reassessed for her vocational history, work skills, and work interests.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview, and record review, for 1 of 4 sampled clients (client B), the facility failed to address and develop written interventions/guidelines in client B's ISP (Individual Support Plan) for the use of a mastectomy bra.</p> <p>Findings include:</p> <p>During observations and interviews on 5/12/16 from 5:25am until 7:45am, client B did not wear a support bra and her left breast shape could be observed through her shirt. On 5/12/16 from 4:10pm, client B indicated indicated she wore a sports bra for support. On 5/12/16 at 3:45pm, GHS (Group Home Staff) #8 and client B both indicated she was not wearing her mastectomy bra.</p>	W 0240	<p>W240: The individual program plan must describe relevant interventions to support the individual toward independence. Client B has indicated to staff on many occasions that she does not want to wear her mastectomy bra and has torn up the prosthetic. A new prosthetic will be obtained and available if she chooses to wear her bra. The bra will be included in her ISP with written guidelines, however it will be noted that client B has the right to refuse to wear the bra. QIDP will do observations in the home 3 times weekly and a member</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>(clients A, B, C, and D), the facility failed to implement clients A, B, C, and D's Individual Support Plans (ISP) and client B's BSP (Behavior Support Plan) when opportunities existed.</p> <p>Findings include:</p> <p>1. On 5/12/16 from 5:25am until 7:45am, and on 5/12/16 from 3:20pm until 5:35pm, clients A, B, C, and D were observed at the group home. During both observation periods clients A, B, C, and D walked throughout the group home and the dining room clock and the living room clock were not functioning at the correct time.</p> <p>Client A's record was reviewed on 5/13/16 at 12:15pm. Client A's 7/31/15 ISP (Individual Support Plan) indicated a goal to write the numbers one through ten.</p> <p>Client B's record was reviewed on 5/13/16 at 2:10pm. Client B's 12/8/15 ISP indicated a goal/objective for client B to identify the correct time on a clock.</p> <p>Client D's record was reviewed on 5/13/16 at 1:00pm. Client D's 1/6/16 ISP indicated a goal/objective to identify the correct time on a clock.</p>		<p>program plan must describe relevant interventions to support the individual toward independence. Three new clocks have been purchased for the home. The staff have been trained that they are to change batteries immediately if needed. Staff will be re-trained on dining objectives for all clients in the home and implementing those objectives formally and informally. Staff will be retrained on Client B's BSP and redirecting her from digging in the trash. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. Observations will include dining times to assure that objectives are being implemented and client B's BSP is being followed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated the clocks inside clients A B, C, and D's group home were not functioning at the correct time. The PM indicated clients B and D had program objectives/goals to report the correct time to staff. The PM indicated clients A, B, C, and D could not use formal and informal opportunities to tell the correct time because the clocks inside the group home were not functioning.</p> <p>2. On 5/12/16 from 5:25am until 7:45am, and on 5/12/16 from 3:20pm until 5:35pm, clients A, B, and C were observed at the group home during dining opportunities. During the observation periods clients A, B, and C were provided a spoon and a fork to eat with. During the meals clients A, B, C, and D served themselves and consumed pieces of sausage patties, a cinnamon roll, toast with butter, meatloaf, and corn. During both observation periods client A received a mechanical soft diet and was asked by the facility staff to drink between every three (3) bites of food. During both observation periods client B scooped her food continuously without drinking between bites of pureed food and was not prompted to put her utensil down between bites. During both</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>observation periods client C received foods cut up into small bites, scooped her food into her mouth, and was not prompted to drink and/or pause between bites.</p> <p>Client A's record was reviewed on 5/13/16 at 12:15pm. Client A's 7/31/15 ISP (Individual Support Plan) and 7/1/15 Registered Dietician (RD) review both indicated a goal/objective to take small bites of food, food cut up into bite size pieces, and to drink after two (2) bites of food. Client A's plans indicated she received a "Mechanical Soft Diet."</p> <p>Client B's record was reviewed on 5/13/16 at 2:10pm. Client B's 12/8/15 ISP and 4/29/15 RD review indicated a goal/objective for client B to receive a pureed diet because of her rapid spooning of food. Client B's ISP goal indicated client B will take small bites of food at meals. Client B's 12/7/15 "Risk Plan #5-Risk for Choke" indicated "Staff will encourage [client B] to slow down, take small bites, chew thoroughly and to alternate between solids and liquids..."</p> <p>Client C's record was reviewed on 5/13/16 at 1:45pm. Client C's 6/1/15 ISP and 7/14/15 RD review indicated goal/objective to have her foods cut in small bites, asked to slow her rate of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>spooning, and to put her fork down between bites of food.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated the facility staff should implement clients A B, and C's dining objectives when opportunities existed during formal and informal dining opportunities.</p> <p>3. On 5/12/16 from 5:25am until 7:45am, and on 5/12/16 from 3:20pm until 5:35pm, client B was observed at the group home. During both observation periods client B placed her hands inside the trash can in the kitchen without redirection from the facility staff.</p> <p>Client B's record was reviewed on 5/13/16 at 2:10pm. Client B's 12/8/15 ISP and 12/8/15 BSP indicated "...Inappropriate social behaviors associated with diagnosis of schizoaffective disorder and depression. Goal: to increase appropriate social interactions by decreasing episodes of inappropriate social behaviors defined as gorging, digging in the trash..." and indicated staff should redirect client B's behavior each time she dug in the trash can and offer a different activity.</p> <p>On 5/20/16 at 3:06pm, an interview with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0312 Bldg. 00	<p>the PM (Program Manager) was conducted. The PM indicated client B's ISP and BSP for digging in the trash can should have been redirected each time client B demonstrated the behavior. The PM indicated client B should have been offered a different activity by the facility staff when opportunities existed.</p> <p>This federal tag relates to complaint #IN00197035.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 4 sampled clients receiving medications to control behaviors (client D), the facility failed to include the use of Lexapro for anxiety in client D's Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>Client D's record was reviewed on 5/13/16 at 1:00pm. Client D's 1/6/16 ISP (Individual Support Plan) and 1/6/16 BSP</p>	W 0312	W312: Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. The QIDP has been retrained on assuring	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0356 Bldg. 00	<p>(Behavior Support Plan did not indicate she was receiving psychotropic medications for behaviors. Client D's 4/26/16 physician's orders indicated client D received "Lexapro 10mg (milligrams), give 1 tablet by mouth 1 time daily for anxiety." Client D's 7/28/15 Psych (Psychiatric) review indicated "Lexapro 5mg for anxiety." Client D's 8/25/15 Psych review indicated the Lexapro was increased to 10mg once daily for anxiety.</p> <p>Client D's 1/6/16 BSP indicated client D had targeted behaviors of anxiety with dementia, lying, and non compliance. Client D's BSP did not include the daily use of the Lexapro medication.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated client D's BSP did not include the daily use of Lexapro for client D's anxiety.</p> <p>9-3-5(a)</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on observation, record review, and</p>	W 0356	<p>that a medication reduction plan is developed for all clients who are receiving psychotropic medications. A drug reduction plan has been developed for Client D. The BSP has been updated to include the use of Lexapro. Program Manager has audited all program plans to assure that Medication reduction plans are in place for all consumers who require one. Program Manager will review all ISPs as they are completed to assure that medication reduction plans are developed as required.</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>interview, for 1 of 4 sampled clients (client A), the facility failed to ensure client A's dental treatment services included an evaluation for client A's missing front tooth.</p> <p>Findings include:</p> <p>On 5/12/16 from 5:25am until 7:45am, and on 5/12/16 from 3:20pm until 5:35pm, client A was observed at the group home and was missing one of two of her front teeth. During the observation periods client A watched television, cooked in the kitchen, wrote on paper, walked throughout the group home, consumed meals, completed medication administration, and was missing her front tooth. During both observation periods client A smiled and spoke. On 5/12/16 at 4:50pm, client A indicated she was missing one of her front teeth and stated "they (the group home) are going to get me a new front tooth." Client A indicated since the group home was looking into a new front tooth that she was not concerned that she had a missing front tooth.</p> <p>Client A's record was reviewed on 5/13/16 at 12:15pm. Client A's record indicated a dental assessment completed on 9/15/15 with her Oral Surgeon for the extraction of tooth #24. Client A's record</p>		<p>W356: The facility must insure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental teeth. A dental appointment will be made for Client A for evaluation of her missing front tooth. Nurse will monitor</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0368 Bldg. 00	<p>included assessments completed by the Oral Surgeon on 9/9/15 and 8/13/15. Client A's record included assessments of her oral health and a plan for referral to the Oral Surgeon on 7/23/15 because of an abscess. Client A's record did not include an evaluation for client A's missing front tooth.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM stated client A "had been missing her front tooth longer than 6 months." The PM indicated she was unsure of the status for client A's missing front tooth.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION 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 3 of 4 sampled clients (clients A, C, and D) and 2 additional clients (clients E and F), the facility failed to ensure clients A, C, D, E, and F's medications were administered according to physician's orders.</p> <p>Findings include:</p>	W 0368	<p>W368: The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. All staff have been re-trained by the nurse on all aspects of the Living in the Community curriculum including</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>On 5/12/16 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 3/1/16 through 5/12/16 were reviewed and included the following:</p> <p>For client A: -A 4/25/16 BDDS report for an incident on 4/24/16 at 8:00pm indicated client A did not receive her "Zantac (for GERD, Gastroesophageal reflux disease, a chronic digestive disease) 150mg (milligrams) as the medication had not been delivered by the pharmacy."</p> <p>For client C: -A 4/11/16 BDDS report for an incident on 4/10/16 at 7:00pm indicated client C did not "receive her ordered doses of Lithium Carb (for mood disorder/impulse control disorder) 300mg (milligrams), Quetiapine (for Impulse Control Disorder) 300mg, and Risperdal 4mg" for behaviors.</p> <p>For client D: -A 4/8/16 BDDS report for an incident on 4/8/16 at 7:00am indicated "it was discovered on 4/7/16 [client D] was given two doses of Vimpat 150mg (for Seizure Disorder) at 8:00pm instead of the prescribed one dose." -A 4/3/16 BDDS report for an incident on</p>		accurately passing medications per physicians orders and assuring that all consumers are receiving the right dose, right med, right route, right time, right consumer and correct documentation. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. MAR will be checked to assure that meds are being passed correctly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>4/2/16 at 7:00am indicated client D "did not receive Namenda 21mg as prescribed" for dementia.</p> <p>For client E: -A 4/11/16 BDDS report for an incident on 4/9/16 at 7:30pm indicated client E "did not receive her scheduled dose of Abilify 5mg" for behaviors. -A 4/3/16 BDDS report for an incident on 4/2/16 at 7:00am indicated client E "did not receive Ferrous Sulfate 325mg as prescribed" for anemia.</p> <p>For client F: -A 4/11/16 BDDS report for an incident on 4/9/16 at 7:30pm indicated client F "did not receive her 11:00pm dose of Acetaminophen 500mg (for Arthritis pain) on 4/6 through 4/8/16."</p> <p>On 5/13/16 at 11:15am, clients A, C, D, E, and F's 5/2016 MAR (Medication Administration Records) and 4/2016 "Physician's Orders" were reviewed which indicated the following:</p> <p>-Client A's 5/16 MAR and 4/16 Physician's Order both indicated "Zantac 150mg (milligrams), give one tablet by mouth twice daily for GERD."</p> <p>-Client C's 5/16 MAR and 4/16 Physician's Order both indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>"Lithium Carb 300mg, give one capsule by mouth three times daily for Mood Disorder/Impulse Control Disorder,"</p> <p>"Quetiapine 300mg, give one tablet by mouth twice daily for Impulse Control Disorder/Mood Disorder," and Risperdal 4mg, give one half tablet by mouth three times daily for Impulse Control Disorder."</p> <p>-Client D's 5/16 MAR and 4/16 Physician's Order both indicated "Vimpat 150mg, give one tablet by mouth twice daily for Seizure Disorder" and Namenda 21mg, give one capsule by mouth once daily for dementia."</p> <p>-Client E's 5/16 MAR and 4/16 Physician's Order both indicated "Ferrous Sulfate 325mg, give on tablet by mouth twice daily for Anemia." Client E's "Abilify 5mg" for behaviors had been changed.</p> <p>-Client F's 5/16 MAR and 4/16 Physician's Order indicated "Acetaminophen 500mg, take 2 tablets every 4 hours as needed for pain...."</p> <p>On 5/13/16 at 2:00pm, an interview with the PM (Program Manager) was conducted. The PM indicated staff should ensure clients A, C, D, E, and F's physician's orders were followed. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0369 Bldg. 00	<p>PM indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration.</p> <p>On 5/13/16 at 11:00am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders.</p> <p>On 5/20/16 at 3:06pm, the PM indicated no further information was available for review.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, for 1 of 8 medications administered (for client B) during the evening medication administration, the facility failed to administer medication without error for client B.</p>	W 0369	W369: The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Staff have been trained that	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings include:</p> <p>On 5/12/16 at 3:50pm, RM/GHS (Residential Manager/Group Home Staff) #1 selected client B's "Calcium Tablet w/vit D (with vitamin D) 600mg (milligrams), 1 tablet twice daily with food" for nutritional health/supplement. RM/GHS #1 dispensed the tablet into a medication cup, client B took the medication with water, and no food or a meal was provided. At 5:32pm, client B consumed her first bite of food. At 5:32pm, client B indicated she had not eaten food since lunch at the contracted workshop. At 5:32pm, GHS #2 indicated client B's first bite of food was at 5:32pm.</p> <p>On 5/12/16 at 4pm, client B's 5/2016 MAR (Medication Administration Record) and 6/2015 "Physician's Order" both indicated "Calcium 600mg (milligrams) = vit D (plus vitamin D), give 1 tablet by mouth twice daily with food for Nutritional Support."</p> <p>On 5/20/16 at 3:06pm, an interview with the Program Manager (PM) was conducted. The PM indicated staff should ensure client B's physician's orders were followed for administering medications with food and/or a meal. The PM indicated the facility followed</p>		<p>Client B is to receive food with her medication and a snack will be provided to her when the medication is given. All staff have been re-trained by the nurse on all aspects of the Living in the Community curriculum including accurately passing medications per physicians orders and assuring that all consumers are receiving the right dose, right med, right route, right time, right consumer and correct documentation. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. MAR will be checked to assure that meds are being passed correctly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0382 Bldg. 00	<p>the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. The PM indicated staff did not follow physician's orders.</p> <p>On 5/13/16 at 11:00am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 4 of 4 clients (clients A, B, C, and D) and 3 additional clients (clients E, F, and G), the facility failed to ensure client A, B, C, D, E, F, and G's medications were kept secured when not being administered.</p> <p>Findings include: Observations and interviews were</p>	W 0382	W382: The facility must keep all drugs and biological locked except when being prepared for administration. All staff have been re-trained that the medication door is to be locked at all times when no one is in the room. They were trained on securing all cabinets in the medication	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>conducted at the group home on 5/12/16 from 5:25am until 7:45am. During the observation period clients A, B, C, D, E, F, and G were observed at the group home. During the observation period clients A, B, C, D, E, F, and G were observed to walk and access rooms throughout the group home. During the observation period from 5:25am until 7:45am, the medication cabinet located inside the unsecured medication/activity room was left unlocked. On 5/12/16 at 6:22am, Residential Manager (RM) GHS (Group Home Staff) #8 both indicated the medication cabinet was unlocked. At 6:22am, GHS #2 started the medication administration and the cabinet was "not locked" until 7:45am. GHS #2 indicated staff do shut the door and the medication room door was not kept locked.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated the medication cabinet should be kept locked. The PM indicated clients A, B, C, D, E, F, and G's medications were kept inside the cabinet. The PM indicated the facility followed Core A/Core B Living in the Community for medication administration and medication security. The PM indicated clients A, B, C, D, E, F, and G had access to the unsecured medications inside the unlocked cabinet.</p>		<p>room before leaving the room. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. Observations will include checking to assure that the medication cabinets and doors are secured.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0383 Bldg. 00	<p>On 5/13/16 at 11:00am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, the facility failed to secure the medication cabinet keys for 4 of 4 sampled clients (A, B, C, and D) and 3 additional clients (clients E, F, and G) who resided in the home.</p> <p>Findings include:</p> <p>Observations and interviews were conducted at the group home on 5/12/16 from 5:25am until 7:45am. During the observation period clients A, B, C, D, E, F, and G were observed at the group home. During the observation period clients A, B, C, D, E, F, and G were observed to walk and access rooms throughout the group home. During the</p>	W 0383	<p>W383: Only authorized persons may have access to the keys to the drug storage area. All staff have been re-trained that their keys are to be secured or on their person at all times. They are not to leave keys on counters, etc. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. Observations will include assuring that keys are secured at all times</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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>observation period from 5:25am until 7:45am, the medication cabinet keys laid unsecured on the counter inside the unsecured medication room was left unlocked. On 5/12/16 at 6:22am, Residential Manager (RM) GHS (Group Home Staff) #8 both indicated the medication cabinet keys was unlocked. At 6:22am, GHS #2 started the medication administration and the cabinet keys were left out on the counter.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated medication cabinet keys for clients A, B, C, D, E, F, and G's medication cabinet keys should be kept secured by the facility staff. The PM indicated the facility followed Core A/Core B Living in the Community for medication administration and medication key security. The PM indicated clients A, B, C, D, E, F, and G had access to the unsecured medication cabinet keys which were left hanging on the bulletin board.</p> <p>On 5/13/16 11:00am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medication cabinet keys should be kept</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0436 Bldg. 00	<p>secure.</p> <p>9-3-6(a)</p> <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 1 of 4 sampled clients (client C) with adaptive equipment, the facility failed to teach and encourage client C to wear her prescribed eye glasses at the group home.</p> <p>Findings include:</p> <p>On 5/12/16 from 5:25am until 7:45am, and on 5/12/16 from 3:20pm until 5:35pm, client C was observed at the group home. During the observation period client C watched television, cooked in the kitchen, wrote on paper, walked throughout the group home, consumed meals, completed medication administration, and did not wear her prescribed eye glasses. During both observation periods client C was not encouraged to wear her prescribed eye glasses.</p>	W 0436	<p>W436: 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 communication aids, braces, and other devices identified by the IDT as needed by the client. Staff have been trained to encourage Client C to wear her glasses. A goal/objective will be written for staff to prompt Client C to wear her glasses. QIDP will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(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 0475 Bldg. 00	<p>Client C's record was reviewed on 5/13/16 at 1:45pm. Client C's 10/29/15 vision assessment indicated she wore prescribed eye glasses. Client C's 6/1/15 ISP (Individual Support Plan) indicated she wore prescribed eye glasses and did not indicate a goal/objective for client C to be taught and encouraged to wear her eye glasses.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated client C wore prescribed eye glasses. The PM indicated client C should have been taught and encouraged to wear her prescribed eye glasses during formal and informal opportunities.</p> <p>9-3-7(a)</p> <p>483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and 3 additional clients (clients E, F, and G), the facility failed to teach and encourage a full set of standard utensils and salt/pepper available for use during dining opportunities.</p>	W 0475	<p>Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. Observations will include assuring that Client C has her glasses or is prompted to wear her glasses.</p> <p>W475: Food must be served with appropriate utensils. All staff have been trained that a full set of utensils are to be provided to the clients at all meals. Salt and Pepper will be available for their use. QIDP</p>	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 395 N WESTCHESTER DR COLUMBIA CITY, IN 46725
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings include:</p> <p>On 5/12/16 from 5:25am until 7:45am, and on 5/12/16 from 3:20pm until 5:35pm, clients A, B, C, D, E, F, and G were observed at the group home. During the observation period clients A, B, C, D, E, F, and G were provided a spoon and a fork to eat with and no knives were offered by the facility staff during dining. During the observation periods clients A, B, C, D, E, F, and G served themselves and consumed pieces of sausage patties, a cinnamon roll, toast with butter, meatloaf, and corn. During both observation periods clients E, and F used a fork and spoon to spread butter on their toast and to cut their meat. Client B served self a pureed blend of food. No knives and no salt/pepper were offered for use.</p> <p>On 5/20/16 at 3:06pm, an interview with the PM (Program Manager) was conducted. The PM indicated clients A B, C, D, E, F, and G should use a full set of utensils and salt/pepper at the group home during dining opportunities.</p> <p>9-3-8(a)</p>		<p>will do observations in the home 3 times weekly and a member of the management team (Executive director, Quality Manager, Nurse Manager or Program Manager) will observe in the home 2 times weekly. Observations will include meal time to assure that utensils and condiments are offered to all consumers.</p>	