

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 5/24/13, 5/28/13, 5/29/13, 5/30/13, 6/11/13 and 6/12/13.</p> <p>Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/20/13 by Ruth Shackelford, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #4), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility did not allow clients #1 and #4 to pay for prescription insurance coverage.</p> <p>Findings include:</p> <p>1. Client #1's financial record was reviewed on 5/29/13 at 3:00 PM. Client #1's RFMSS (Resident Fund Management Service Statement) dated 2/1/13 through 5/29/13 indicated the following transactions:</p> <p>-2/16/13 description of debit activity indicated, "Prescription bill, \$13.70."</p> <p>-3/25/13 description of debit activity indicated, "Medicare prescription, \$13.10."</p> <p>-5/13/13 description of debit activity indicated, "Medical insurance, \$25.60."</p> <p>2. Client #4's financial record was reviewed on 5/29/13 at 3:10 PM. Client #4's RFMSS dated 2/1/13 through 5/29/13</p>	W000104	<p>CORRECTION: <i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the governing body will begin paying Medicare premiums for Client #2 and Client #4 and both clients will be reimbursed for past premiums for which they have payed for with personal funds.</i></p> <p>PREVENTION: The Business Manager has received additional training regarding the governing body's responsibility to utilize the daily Medicaid per diem to provide necessary services. The business manager will review all Resident Financial Management System disbursements to assure withdrawals are made for personal expenditures only. Additionally, at least two members of the administrative team will sign all RFMS checks before they are released to provide for additional budgetary oversight.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Business Manager, Office Coordinator, Quality Assurance Team, Operations Team</p>	07/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated the following transaction:</p> <p>-3/6/13 description of debit activity indicated, "Prescription payment, \$18.10."</p> <p>AS (Administrative Staff) #1 was interviewed on 5/29/13 at 3:30 PM. AS #1 indicated clients #1 and #4 should not be paying for their prescription coverage. AS #1 stated, "The charges were an oversight by the finance department. Clients in our waiver program pay for their own coverage and she assumed the clients in this program did too."</p> <p>9-3-1(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 30 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to implement its policy and procedures to complete an investigation for an incident of client to client aggression regarding client #3, FC #1 (Former Client) and unspecified peers. The facility failed to implement its policy and procedures to report the results of an investigation of an allegation of verbal abuse and an injury of unknown origin regarding client #2.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, Follow up BDDS reports and investigations were reviewed on 5/29/13 at 3:07 PM. The review indicated the following:</p> <p>-BDDS report dated 12/10/12 indicated on 12/9/12, "[Client #3] was agitated about not seeing his sister. [Client #3] grabbed [FC #1] around his neck with his hands for a brief period of time." The 12/10/12 BDDS report indicated, "[Client</p>	W000149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i></p> <ol style="list-style-type: none"> The facility will investigate an incident of client to client aggression regarding client #3, Former Client #1 and unspecified peers that occurred on 12/9/12. The facility will provide documentation showing the date of investigation completion and a listing of appropriately notified parties for an investigation of staff mistreatment of Client #2 and the discovery on 1/24/13 that Client #2 had fractured his left small finger. <p>PREVENTION: 1. Professional staff will receive additional training regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than weekly to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical</p>	07/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>#3] continued to target staff and the other individuals, so staff notified the police. The police placed handcuffs on [client #3] but did not take him to jail." The 12/10/12 BDDS report indicated, "The QMRP (Qualified Mental Retardation Professional) will investigate the circumstances of the altercation. An IDT (Interdisciplinary Team Meeting) will be held and staff will be trained." The review did not indicate documentation of an investigation of the 12/9/12 incident.</p> <p>-BDDS report dated 1/19/13 indicated on 1/18/13, "[AS #1 (Administrative Staff)] received a report that [staff #1] yelled at [client #2] and used profanity towards him."</p> <p>-Follow up BDDS report dated 1/19/13 indicated, "Through investigation... substantiated allegations that [staff #1] yelled at [client #2] when he did not immediately comply with a staff request." The 1/19/13 Follow up BDDS report did not indicate if and/or who had been notified of the results of the investigation. The 1/19/13 Follow up BDDS report did not indicate the date the investigation was completed.</p> <p>-BDDS report dated 1/25/13 indicated on 1/24/13, "[Client #2] complained of discomfort in his pinky left finger to [PM</p>		<p>Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p>2. Professional staff will receive additional training regarding the need to provide documentation of investigation result reporting to medical surveyors and other appropriate parties on request. Members of the Operations team will remain in communication with medical surveyors throughout the survey process to assure available documentation is provided upon request.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>#1 (Program Manager)] upon entrance into the home. [PM #1] sent staff to have [client #2] checked at [clinic].... [Clinic] discovered that [client #2] had a fractured pinky finger." The 1/25/13 BDDS report indicated, "Team will investigate incident."</p> <p>-Follow up BDDS report dated 3/24/13 indicated the 1/25/13 incident was investigated. The 3/24/13 Follow up BDDS report did not indicate the date the investigation was completed. The 3/24/13 Follow up BDDS report did not indicate if and/or who was notified of the results of the investigation.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be investigated. QIDP #1 indicated the results of investigations of allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to the administrator within 5 business days of the date of the incident. QIDP #1 stated, "We didn't have a supervisor at the home for a while and they changed a few times. We went back to try to investigate some of the incidents after we found out later that they had been</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>missed." QIDP #1 indicated the facility's policy and procedures should be implemented.</p> <p>The facility's policy and procedures were reviewed on 6/11/13 at 9:00 AM. The facility's 9/14/07 policy and procedure entitled, "Investigations" indicated, "Practices: 3. (b) Ensure alleged incidents of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date the allegations were made and investigation was initiated."</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 30 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to complete an investigation for an incident of client to client aggression regarding client #3, FC #1 (Former Client) and unspecified peers.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, Follow up BDDS reports and investigations were reviewed on 5/29/13 at 3:07 PM. The review indicated the following:</p> <p>-BDDS report dated 12/10/12 indicated on 12/9/12, "[Client #3] was agitated about not seeing his sister. [Client #3] grabbed [FC #1] around his neck with his hands for a brief period of time." The 12/10/12 BDDS report indicated, "[Client #3] continued to target staff and the other individuals, so staff notified the police. The police placed handcuffs on [client #3] but did not take him to jail." The 12/10/12 BDDS report indicated, "The QMRP (Qualified Mental Retardation</p>	W000154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the facility will investigate an incident of client to client aggression regarding client #3, Former Client #1 and unspecified peers that occurred on 12/9/12.</p> <p>PREVENTION: Professional staff will be retrained regarding the criteria for conducting investigations at the facility and will receive an updated copy of the agency's incident-investigation tracking spreadsheet no less than weekly to assure thorough investigations are conducted within required timeframes. The QIDP will turn in copies of completed investigations to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion. The Executive Director will monitor the facility's incident – investigation tracking spreadsheet and follow-up as</p>	07/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Professional) will investigate the circumstances of the altercation. An IDT (Interdisciplinary Team Meeting) will be held and staff will be trained." The review did not indicate documentation of an investigation of the 12/9/12 incident.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be investigated.</p> <p>9-3-2(a)</p>		<p>needed with the clinical Supervisor and Program Manager to provide for increased accountability.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 2 of 30 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to report the results of investigations of an allegation of verbal abuse and an injury of unknown origin regarding client #2.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, Follow up BDDS reports and investigations were reviewed on 5/29/13 at 3:07 PM. The review indicated the following:</p> <p>-BDDS report dated 1/19/13 indicated on 1/18/13, "[AS #1 (Administrative Staff)] received a report that [staff #1] yelled at [client #2] and used profanity towards him."</p> <p>-Follow up BDDS report dated 1/19/13 indicated, "Through investigation... substantiated allegations that [staff #1] yelled at [client #2] when he did not</p>	W000156	<p>CORRECTION: <i>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</i> Specifically, the facility will provide documentation showing the date of investigation completion and a listing of appropriately notified parties for an investigation of staff mistreatment of Client #2 and the discovery on 1/24/13 that Client #2 had fractured his left small finger.</p> <p>PREVENTION: Professional staff will be retrained regarding the need to provide documentation of investigation result reporting to medical surveyors and other appropriate parties on request. Members of the Operations team will remain in communication with medical surveyors throughout the survey process to assure available documentation is provided upon request.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Quality Assurance Team, Operations Team</p>	07/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>immediately comply with a staff request." The 1/19/13 Follow up BDDS report did not indicate if and/or who had been notified of the results of the investigation. The 1/19/13 Follow up BDDS report did not indicate the date the investigation was completed.</p> <p>-BDDS report dated 1/25/13 indicated on 1/24/13, "[Client #2] complained of discomfort in his pinky left finger to [PM #1 (Program Manager)] upon entrance into the home. [PM #1] sent staff to have [client #2] checked at [clinic].... [Clinic] discovered that [client #2] had a fractured pinky finger." The 1/25/13 BDDS indicated, "Team will investigate incident."</p> <p>-Follow up BDDS report dated 3/24/13 indicated the 1/25/13 incident was investigated. The 3/24/13 Follow up BDDS report did not indicate the date the investigation was completed. The 3/24/13 Follow up BDDS report did not indicate if and/or who was notified of the results of the investigation.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated the results of investigations of allegations of abuse, neglect, mistreatment, exploitation and injuries of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>unknown origin should be reported to the administrator within 5 business days of the date of the incident. QIDP #1 stated, "We didn't have a supervisor at the home for a while and they changed a few times. We went back to try to investigate some of the incidents after we found out later that they had been missed."</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 4 sampled clients (#2 and #3), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure clients #2 and #3's training objectives were monitored and revised on a routine basis. The QIDP failed to ensure client #3's CFA (comprehensive functional assessment) was completed. The QIDP failed to ensure the facility failed to obtain client #2's guardian written approval before the use of behavior controlling medications. The QIDP failed to ensure the facility's HRC (Human Rights Committee) reviewed, monitored and approved the use of psychotropic medication for management of client #3's behavior.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 5/30/13 at 1:13 PM. Client #2's ISP (Individual Support Plan) dated 1/22/13 indicated the following formal training objectives: will choose a physical activity to participate in, will brush teeth twice daily, will make an independent purchase by handing his money to the cashier, will</p>	W000159	<p>CORRECTION: <i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, the QIDP will receive additional training to improve integration, coordination, and monitoring of Client #1 - #6's active treatment programs. The training will focus on:</i></p> <ol style="list-style-type: none"> Timely review and modification of learning objectives and other supports. Obtaining Human Rights Committee Approval for all restrictive programs including but not limited to the use of behavior controlling medications. Assuring prior written informed consent for all restrictive programs including but not limited to the use of behavior controlling medications. <p>PREVENTION: Members of the Operations and Quality Assurance Teams will conduct twice weekly audits of facility support documents and conduct active treatment observations for the next 60 days and twice monthly for an additional 30 days. After three months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the</p>	07/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>state the name of his medication, will choose an activity to participate in, will assist with meal preparation and will complete daily chores. Client #2's record indicated the QIDP had not monitored client #2's objectives as there were no monthly summaries and/or quarterly reviews from 1/1/13 through 5/30/13 to review to determine if client #2 had achieved the objectives since client #2's objectives were started on 1/22/13.</p> <p>2. Client #3's record was reviewed on 5/30/13 at 2:04 PM. Client #3's ISP dated 8/19/12 indicated the following formal training objectives: will brush his teeth, will assist with meal preparation, will read a paragraph from a book, will communicate his emotions without becoming physically aggressive, will make a purchase in the community, will participate in a physical activity, will participate in a leisure activity and will state the name of his medication. Client #3's record indicated the QIDP had not monitored client #3's objectives as there were no monthly summaries and/or quarterly reviews from 8/19/12 through 5/30/13 to review to determine if client #3 had achieved the objectives since client #3's objectives were started on 8/19/12.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed</p>		<p>home to no less than monthly observations designed to assure that the QIDP integrates, coordinates and monitors, the active treatment program effectively. Administrative staff will provide guidance, mentorship and corrective measures as needed.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>on 5/30/13 at 3:07 PM. QIDP #1 indicated clients #2 and #3's objectives should be monitored on a monthly basis to determine if revisions were needed. QIDP indicated the QIDP monthly and/or quarterly summaries should be completed and utilized to track and determine client's goals, progress and revisions.</p> <p>3. The QIDP failed to ensure client #3's CFA was completed. Please see W210.</p> <p>4. The QIDP failed to ensure the facility's HRC reviewed, monitored and approved the use of psychotropic medication for management of client #3's behavior. Please see W262.</p> <p>5. The QIDP failed to obtain client #2's guardian written approval before the use of behavior controlling medications. Please see W263.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's CFA (Comprehensive Functional Assessment) had been completed.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 5/30/13 at 2:04 PM. Client #3's record did not indicate documentation of a CFA.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated client #3's CFA should be completed and documented in client #3's record.</p> <p>9-3-4(a)</p>	W000210	<p>CORRECTION: <i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Specifically, the team has completed an update that of Client 3's Comprehensive Functional Assessment.</i></p> <p>PREVENTION: Professional staff will be retrained regarding assessment requirements for new admissions to the facility. The QIDP and Residential Manager will be provided with a tracking system to assure that all required assessments are completed within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations, Quality Assurance and/or Health Services Teams will review assessment data during and after the initial assessment period to assure assessments occur as needed and required.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations</p>	07/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 1 of 4 sampled clients (#3), the facility's HRC (Human Rights Committee) failed to review, monitor and approve the use of psychotropic medication for management of client #3's behavior.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 5/30/13 at 2:04 PM. Client #3's BSP (Behavior Support Plan) dated 8/18/12 indicated the use of Clozapine .50 milligrams (intermittent explosive disorder), Cogentin 4 milligrams (intermittent explosive disorder), Ativan 1 milligram (intermittent explosive disorder), Haldol 10 milligrams (intermittent explosive disorder) and Haldol Injection 200 milligrams. Client #3's Physicians Order Form (POF) dated 4/25/13 indicated daily use of Cogentin 2 milligram tablet, Clozapine 25 milligram tablet, Depakote 500 milligram tablet (intermittent explosive disorder), Haloperidol injection 100 milligram/milliliter, Haloperidol 5</p>	W000262	<p>CORRECTION: <i>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Specifically, the use of behavior controlling medications for Client #3 will be reviewed and approved consensually by the Human Rights Committee.</i></p> <p>PREVENTION: The QIDP will be retrained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly. The Program Manager –Lead will incorporate monitoring of annual HRC approvals of restrictive programs into the current tracking process.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	07/12/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>milligram tablet, Lorazepam 1 milligram tablet and Olanzapine/Zyprexa 10 milligram tablet (intermittent explosive disorder). Client #3's record did not indicate approval by the facility's HRC for the use of psychotropic medications.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated the use of psychotropic medications should be reviewed and approved by the facility's HRC committee.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to obtain the client's guardian written approval before the use of behavior controlling medications.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 5/30/13 at 1:13 PM. Client #2's ISP (Individual Support Plan) dated 1/22/13 indicated client #2 had a legal guardian. Client #2's Physicians Order Form (POF) dated 4/23/13 included the following behavior control medications: Invega (bipolar/hyperactivity) and Olanzapine (bipolar/hyperactivity). Client #2's Consents for medications form dated 4/3/13 was not signed by client #2's guardian and did not list/indicate specific medications for consent.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated the use of psychotropic medications required guardian approval before use.</p>	W000263	<p>CORRECTION: The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically, the team will obtain written consent from Client #</p> <p>PREVENTION: Professional staff will be retrained regarding the need to obtain prior written informed consent from guardians, advocates and healthcare representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human Rights Committee will obtain confirmation that the facility has received prior written informed consent from Guardian or other legal representatives. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. Administrative</p>	07/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	9-3-4(a)		staff will conduct visits to the facility as needed but no less than monthly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
---	--

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

W000312	<p>483.450(e)(2) DRUG USAGE</p> <p>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 (#3), who used behavior controlling medications, the facility failed to ensure the client's program included the use of the medication and withdrawal criteria for psychotropic medication used for behavior management.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 5/30/13 at 2:04 PM. Client #3's Physicians Order Form (POF) dated 4/25/13 indicated daily use of Cogentin 2 milligram tablet, Clozapine 25 milligram tablet, Depakote 500 milligram tablet (intermittent explosive disorder), Haloperidol injection 100 milligram/milliliter, Haloperidol 5 milligram tablet, Lorazepam 1 milligram tablet and Olanzapine/Zyprexa 10 milligram tablet (intermittent explosive disorder). Client #3's BSP (Behavior Support Plan) dated 8/18/12 did not include Olanzapine/Zyprexa 10 milligram tablet and/or Depakote 500 milligram</p>	W000312	<p>CORRECTION:</p> <p><i>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. Specifically, Client #3's Behavior Support Plan will be updated to include short term and long term plans for the reduction of psychotropic medications.</i></p> <p>PREVENTION:</p> <p>The QIDP will be retrained on the development of Medication Reduction Plans. The retraining will focus on the need to target a specific medication for reduction, prioritize the order in which attempts will be made to reduce behavior controlling medications as well as the need to maintain current behavior data with which to determine the criteria for reduction attempts. Members of the Operations and Quality Assurance Teams will review Behavior Support Plans as part of an ongoing internal audit process that will include assuring that behavior support programs include specific plans to reduce</p>	07/12/2013
---------	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/12/2013
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>tablet as current psychotropic medications. Client #3's BSP dated 8/18/12 did not indicate a plan of reduction/titration for the use of Olanzapine/Zyprexa 10 milligram tablet and/or Depakote 500 milligram tablet as a current psychotropic medication.</p> <p>QIDP #1 (Qualified Intellectual Disabilities Professional) was interviewed on 5/30/13 at 3:07 PM. QIDP #1 indicated the use of psychotropic medications should be included in a behavior support plan and include a plan of reduction/titration.</p> <p>9-3-5(a)</p>		<p>the use of behavior controlling drugs. Operations and Quality Assurance Team members will conduct site visits that incorporate BSP reviews no less than monthly.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>		