

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 06/21/2013
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W000000	<p>This visit was for investigation of complaint #IN00130731.</p> <p>Complaint #IN00130731: Substantiated. Federal and state deficiencies related to the allegation are cited at W149, W154, W157, W159, W312 and W331.</p> <p>Dates of Survey: June 19, 20 and 21, 2013.</p> <p>Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/1/13 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.

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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.</p> <p>Based on record review and interview for 7 of 8 BDDS (Bureau of Developmental Disabilities Services) reports and 1 of 8 internal incident/accident reports, the facility neglected to implement the facility's policy and procedure prohibiting client neglect by neglecting to provide adequate supervision for 3 of 4 sampled clients plus one additional client (clients A, B, C and E).</p> <p>Findings include:</p> <p>On 06/19/13 at 1:45 PM the facility's BDDS Reports, investigations and internal incident/accident reports were reviewed from 02/01/13 through 06/18/13 and indicated the following:</p> <p>For client A:</p> <p>1. An Incident/Accident Report on 02/24/13 at 7:45 PM. The report indicated, "[Client A] ask (sic) staff to give him cigarette, staff gave it to him. After that [client A] walk out (sic) from group home without imform (sic) staff. After 5 minute (sic) staff check (sic) on [client A]. Staff discovered that [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. The facility will implement measure to assure the safety of Clients A, B, C and E.</i></p> <p>1. The interdisciplinary team will evaluate current assessment and incident data and meet to develop revised strategies to increase personal safety for Client A to prevent elopement and assure adequate supervision. The team is developing specific guidelines for line-of site observation and 15 minute checks as well as assessing the potential efficacy of installing door and window alarms at the facility. All facility and day service staff will be trained on proper implementation of the revised protocols.</p> <p>2. The facility will revise Client B's wheelchair transferring protocols based on the guidance of a physical therapist. Staff across environments will be trained on proper implementation of the revised procedures. Day service staff will be trained regarding the need to contact nursing staff immediately when changes in Client B's health status including but not limited to range of motion are observed to assure timely medical intervention and investigation of discovered injuries.</p> <p>3. The team has revised Client C's behavior supports to more appropriately address elopement,</p>	07/21/2013			

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	<p>A] was not in group home. Staff look (sic) for [client A] and staff (sic) [client A] at come (sic) out from [store name] store. Staff drive (sic) [client A] back to group home."</p> <p>2. A BDDS report submitted 03/22/13 for an incident dated 03/21/13 at 4:00 PM indicated, "Staff noticed that [client A] ... had two monster Energy Drinks and a snicker wrapper when she arrived back on shift at 8am. Staff noticed that the items were not there when she left at 1 am. [Client A] told PM (Program Manager) that while staff was in living room that he left out the back door and went to [store] and was back before his staff could notice. Guardian has been notified as well as administration team. AWOL (Absent With Out Leave) and Elopement is addressed in BSP (Behavior Support Plan). Team met and [client A] will be put on 15 minute checks and this will be reviewed quarterly. Staff will continue to follow BSP. PM spoke with [client A] about safety and also the importance of asking staff to take him places when he feels the need to go."</p> <p>3. A BDDS report submitted 05/02/13 for an incident dated 05/01/13 at 6:00 PM indicated, "[Client A] ...left facility without knowledge of staff. Guardian as well as administration team were notified.</p>		<p>self-injurious behavior, physical aggression, property disruption/destruction and non-cooperation. Staff across environments have been trained on proper implementation of the plan. The team is developing specific guidelines for line-of site observation and 15 minute checks for client C as well as assessing the potential efficacy of installing door and window alarms at the facility. Staff across environments will be trained on proper implementation of the revised protocols.</p> <p>4. The interdisciplinary team has been working with Client E's attending psychiatrist to develop modifications to Client E's behavior supports to help reduce the anxiety that the team has assessed leads to Client E's agitation. As a result, the incidence of Client E's aggression toward his housemates and staff has diminished.</p> <p>PREVENTION:</p> <p>1. Professional staff will receive additional training regarding the need to develop supports that assure the safety of all individuals across environments as well as the need to assure appropriate levels of supervision.</p> <p>2. The QIDP and the Residential Manger will each perform active treatment observations on all shifts no less than twice weekly and members of the Operations and Quality Assurance Teams will review documentation and observe active treatment no less than monthly to assure that appropriate supervision, training and mentor shift of direct support</p>		

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	<p>[Client A] was found 5 minutes later lurking between [store name] and park. Staff will continue to Follow (sic) BSP where AWOL has been addressed. Team has met and there has been a decision to put [client A] on IN (sic) line of Site (sic) (be able to see him at all times). [Client A] was safe and there were no injuries. PM spoke with [client A] on the importance of leaving Facility (sic) without staff."</p> <p>4. A BDDS report submitted 06/11/13 for an incident dated 06/11/13 at 12:15 PM indicated, "At approximately 12:15 pm it was observed that [client A] was not in his work area following lunch. He was observed in the building at approximately 11:55 am trying to obtain cigarettes from a staff. It is believed that [client A] may have left the building during a changeover from lunch to work. After a multiple staff search of the premises both inside and out; it was believed that he may have eloped from the program. It's suspected that he may have eloped because he had been upset much of the morning over having no extra cigarettes and missing family. At approximately 12:40 pm [day service] Director of Safety was notified of the incident. [Day service] Manager [name] did a drive around search of the local neighborhood checking area stores that he might frequent per information</p>		<p>staff is occurring to guarantee the health and safety of all clients.</p> <p>3.The QIDP and the Residential Manager will each perform bi-monthly observations of active treatment at all day service locations –assuring at least weekly face to face contact between facility supervisory staff and day service providers. In addition to monitoring active treatment for effectiveness, facility supervisory staff will communicate with day service staff to assure up to date support documents and other necessary materials are present. Facility professional staff will turn in documentation of day service observations to the Program Manager so that the Operations and Quality Assurance Teams may track day service contacts and provide follow-up as needed.</p> <p>4.Members of the Operations and Quality Assurance Teams will conduct weekly audits of facility support documents and conduct active treatment observations for the next 90 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 home to no less than monthly observations designed to assure that the QIDP integrates, coordinates and monitors, the active treatment program effectively and will provide guidance, mentorship and</p>				

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	<p>received from his residential program. The Residential Director stated that he likes to frequent stores like convenient marts, [store name], and grocery outlets. [Day service Manager] also walked into numerous stores checking for [client A] as well. Other [Day service] staff continued monitoring and searching the premises in case he was hiding out somewhere on the premises. After not locating [client A], it was determined that 911 (approximately 1:35 pm) should be contacted to make a missing person's report. His residential program was also notified as well prior to this call being made. [Client A] currently works under a staffing ratio of 10:1 while at [day service]. [Client A] has not eloped from [day service] prior to this day. He reportedly has eloped multiple times from the residential program per information received from the residential program. At approximately 3:30 pm; (sic) the residential program called to report that [client A] had arrived home. He reportedly found someone from the community to take him home. He arrived home with no concerns noted from the reporting staff. Due to safety concerns, [client A] will remain on service interruption from [day service] until a meeting is scheduled to further discuss this incident and to review possible supports and programmatic changes to</p>		<p>corrective measures as needed. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>				

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	<p>help ensure his safety and well-being. Team will also review the behavior plan for any necessary changes that may need to be implemented as well."</p> <p>For client B:</p> <p>5. A BDDS report submitted 05/30/13 for an incident dated 05/29/13 at 9:15 AM indicated, "When [client B] ... returned from day service on 05/28/13, he complained of pain in his left shoulder. No swelling or bruising was present and [client B] was able to move his arm. Prior to leaving for day service, [client B] did not say he was in pain and had full range of motion in his arm. The nurse-on-call recommended applying ice to the affected area and giving Tylenol as needed for pain. On the morning of 05/29/13, when [client B] arrived at day service he complained of severe pain and staff noted a yellow bruise over the left shoulder and limited range of motion. Staff transported [client B] to the [hospital name] Emergency Department where X-rays revealed a closed fracture of the acromion and a glenoid fracture of the shoulder. When [client B] returned from the hospital and staff discussed the injury, a housemate approached the Program Manager and said that several days previously, he had observed Direct Support Staff [staff #1] hitting [client B]</p>				

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	<p>in the bathroom. [Client B's] housemate has a recent history of making unsubstantiated allegations. Staff will assist [client B] with keeping his arm in a sling pending a follow-up appointment with an orthopedic specialist. The agency has initiated an investigation into the origin of the fracture and Direct Support Staff [staff #1] has been suspended pending investigation of the allegations against him."</p> <p>The Investigative Summary dated 05/30/13 indicated, "The evidence does not substantiate that [staff #1] hit [client B]...The evidence does not substantiate that the actions of [staff #1] resulted in [client B's] sustaining a fracture of his left clavicle. The evidence suggests that [client B] most likely sustained the fracture of his left clavicle in an unknown accident at ResCare Day Services on 05/28/13."</p> <p>For client C:</p> <p>6. A BDDS report submitted 05/29/13 for an incident on 05/28/13 at 5:00 PM indicated, "Staff (unidentified) went to [client C's] ...room to check on him and found that he was not there. Staff went looking for him and found him on [street name] and [street name] and drove him back to the group home. After a while the</p>			

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	<p>police came and said someone had called. [Client C] was being verbally aggressive with staff and was slamming doors and kicking the trash can. He finally calmed down and staff took him for a ride...will discuss with [client C] ways to cope with his moving to [group home name]."</p> <p>A BDDS Follow-up report dated 06/15/13 indicated, "...[client C] stated that he believed because he was grown that he should be able to come and go as he pleased. The elopements will be prevented by implementing 15 (minute) checks as well as Elopement is now addressed in [client C's] BSP. Currently [client C] is having a slight (sic) difficult time adjusting to his new environment but with constant reinforcement that things will get better and offering emotional support [client C] will become adjusted. Team will also consider along time to help ease the transition."</p> <p>7. A BDDS report submitted 06/12/13 for an incident on 06/11/13 at 12:03 PM indicated, "[Client C] ...became agitated because he was not able to visit his grandmothers home. [Client C] started breaking cds and attempting to scratch his arms with cds. [Client C] also went to kitchen looking for sharp items to attempt to self harm. [Client C] had a butter knife but caused no harm to self or others.</p>						

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	<p>Facility nurse administration team and health care rep[resentative] was (sic) notified of incident. [Client C] is still in his accessment (sic) period and this incident will be included in assessment to help develop behavior support plan...Staff will continue to follow all ResCare policies and procedures."</p> <p>8. A BDDS report submitted 06/13/13 for an incident on 06/12/13 at 1:50 PM indicated, "[Client C] ...was washing his laundry and [client E] ...was sitting in front of machine, when [client C] went to retrieve his laundry. [Client E] attempted to stop him because he wanted to take out the laundry. [Client E] tried to claw [client C] and [client C] hit [client E] in his left eye. Facility nurse was notified as well as health care reps and administration team. Facility nurse directed staff to take [client E] to [hospital] Emergency Room (ER). While at the ER it was determined that [client E] needed 3 sutures. Physical Aggression is addressed in [client E's] BSP. [Client C] is still in his initial assessment period and this incident will be added to his evaluation. [Client E] is complaining of no pain and [client C] has apologized to [client E] for striking him."</p> <p>A. Client A's records were reviewed on 06/20/13 at 11:50 AM. Client A's ISP</p>			

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	<p>(Individual Support Plan) was dated 01/22/13. The ISP indicated client A's diagnoses included but were not limited to: Mild Mental Retardation, Bipolar Disorder and ADHD (Attention Deficit Hyperactivity Disorder). Client A's BSP dated 1/22/13 indicated client A's behaviors included physical and verbal aggression and elopement. The BSP indicated what staff were to do if client A eloped but contained no guidance regarding his routine monitoring. Client A's record did not contain an addendum to the BSP with instructions to detail the 15 minute checks that were put into place according to the IDT meeting note dated 03/21/13.</p> <p>B. Client B's records were reviewed on 06/20/13 at 2:00 PM. Client B's ISP was dated 01/13/13. The ISP indicated client B's diagnoses included were were not limited to: Severe Mental Retardation, Intermittent Explosive Disorder, Seizure Disorder, and Psychosis. Client B's ISP indicated he was at risk for falls and, "Staff to provide assistance with ambulation (walking) and transfers and gait belt should be on. [Client B] should only ambulate short distances. Wheelchair must be used for long distances. Encourage [client B] to use wheelchair for mobility." The ISP indicated client B was not able to care for</p>						

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	<p>his own needs and required staff assistance for his activities of daily living (bathing, toileting, grooming and dressing).</p> <p>C. Client C's records were reviewed on 06/20/13 at 3:00 PM. Client C's information indicated client C was admitted to the group home on 05/14/13. Client C's record included IDT meeting notes dated 06/08/13. The notes indicated, "Team has met to discuss [client C] aggression and walking off and his recent arrest. Team has concluded that [client C] will be on 15 minute check and that physical aggression and elopement be entered into his BSP upon completion...." Client C's BSP dated 06/14/13 indicated client C's diagnoses included but were not limited to: Mild Mental Retardation, Oppositional Defiant Disorder, Depressive Disorder, ADHD and Fetishism. His behaviors included physical aggression, verbal aggression, property disruption/destruction, sexually acting out, non-compliance and leaving assigned areas." The BSP did not contain the information for client C's 15 minute checks or how staff were to monitor him prior to any elopement.</p> <p>On 06/19/13 at 1:50 PM, a review of the facility's 09/14/07 Policy on "Abuse, Neglect, Exploitation" indicated, "Adept</p>						

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	<p>employees actively advocate for the rights and safety of all individuals...Intimidation/emotional abuse: the act or failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation. Discouraging or inhibiting behavior by threatening both actual or implied. Attitude or acts that interfere with the psychological and social well being of an individual. Exploitation: an act that deprives an individual of real or personal property by fraudulent or illegal means. Utilization of another person for selfish purposes. Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment. Program intervention neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan...Medical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide necessary medical attention, proper</p>			

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	<p>nutritional support or administering medications as prescribed. 3. All employees will be trained on the types of incidents that are reportable to BDDS...The incident types are: Suspected abuse, neglect or exploitation...Injuries of unknown origin, Significant injuries...Inadequate staff support...."</p> <p>On 06/20/13 at 4:15 PM an interview with the Program Manager (PM) was conducted. He indicated at the current time clients A and C were on 15 minute checks by the staff and the investigation was never able to determine how, or exactly when, client B's fracture occurred. The PM indicated staff failed to follow the policy/procedure as they failed to monitor clients A and C's elopement behavior, failed to ensure client B received timely medical intervention for evaluation of pain, failed to ensure client B's safety to prevent a fracture, and failed to ensure client safety by preventing client to client aggression.</p> <p>This federal tag relates to complaint #IN00130731.</p> <p>9-3-2(a)</p>				

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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 interview and record review for 5 of 8 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed for clients A, C and E to conduct an investigation and/or conduct thorough investigations in regard to repeated elopements of clients A and C, client to client aggression for clients C and E, and self-injurious behavior for client C by providing a lack of safety and supervision.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed on 06/19/13 at 1:45 PM. The reports indicated the following:</p> <p>For client A:</p> <p>1. An Incident/Accident Report on 02/24/13 at 7:45 PM. The report indicated, "[Client A] ask (sic) staff to give him cigarette, staff gave it to him. After that [client A] walk ut (sic) from group home without inform (sic) staff.</p>	W000154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the facility will investigate incidents of Client A's elopement that occurred on 2/24/13, 3/21/13 and 6/11/13; Client C's episode of attempted self-injurious behavior on 6/11/13 and an incident of aggression between Client C and Client E that occurred on 6/12/13.</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</p>	07/21/2013
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	<p>After 5 minute (sic) staff check (sic) on [client A]. Staff discovered that [client A] was not in group home. Staff look (sic) for [client A] and staff (sic) [client A] at come (sic) out from [store name] store. Staff drive (sic) [client A] back to group home." There was no investigation available for review of this incident.</p> <p>2. A BDDS report submitted 03/22/13 for an incident dated 03/21/13 at 4:00 PM indicated, "Staff noticed that [client A] ...had two monster Energy Drinks and a snicker wrapper when she arrived back on shift at 8am. Staff noticed that the items were not there when she left at 1 am. [Client A] told PM (Program Manager) that while staff was in living room that he left out the back door and went to [store] and was back before his staff could notice. Guardian has been notified as well as administration team. AWOL (Absent With Out Leave) and Elopement is addressed in BSP (Behavior Support Plan). Team met and [client A] will be put on 15 minute checks and this will be reviewed quarterly. Staff will continue to follow BSP. PM spoke with [client A] about safety and also the importance of asking staff to take him places when he feels the need to go." There was no investigation available for review of this incident.</p>		<p>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>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>				

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	<p>3. A BDDS report submitted 06/11/13 for an incident dated 06/11/13 at 12:15 PM indicated, "At approximately 12:15 pm it was observed that [client A] was not in his work area following lunch. He was observed in the building at approximately 11:55 am trying to obtain cigarettes from a staff. It is believed that [client A] may have left the building during a changeover from lunch to work. After a multiple staff search of the premises both inside and out; it was believed that he may have eloped from the program. It's suspected that he may have eloped because he had been upset much of the morning over having no extra cigarettes and missing family. At approximately 12:40 pm [day service] Director of Safety was notified of the incident. [Day service] Manager [name] did a drive around search of the local neighborhood checking area stores that he might frequent per information received from his residential program. The Residential Director stated that he likes to frequent stores like convenient marts, [store name], and grocery outlets. [Day service Manager] also walked into numerous stores checking for [client A] as well. Other [Day service] staff continued monitoring and searching the premises in case he was hiding out somewhere on the premises. After not locating [client A], it was determined that 911 (approximately 1:35 pm) should be</p>			

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	<p>contacted to make a missing person's report. His residential program was also notified as well prior to this call being made. [Client A] currently works under a staffing ratio of 10:1 while at [day service]. [Client A] has not eloped from [day service] prior to this day. He reportedly has eloped multiple times from the residential program per information received from the residential program. At approximately 3:30 pm; (sic) the residential program called to report that [client A] had arrived home. He reportedly found someone from the community to take him home. He arrived home with no concerns noted from the reporting staff. Due to safety concerns, [client A] will remain on service interruption from [day service] until a meeting is scheduled to further discuss this incident and to review possible supports and programmatic changes to help ensure his safety and well-being. Team will also review the behavior plan for any necessary changes that may need to be implemented as well." There was an investigation by the day service for this incident. There was no investigation by the agency available for review of this incident.</p> <p>For client C:</p> <p>4. A BDDS report submitted 06/12/13 for</p>						

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	<p>an incident on 06/11/13 at 12:03 PM indicated, "[Client C] ...became agitated because he was not able to visit his grandmothers home. [Client C] started breaking cds and attempting to scratch his arms with cds. [Client C] also went to kitchen looking for sharp items to attempt to self harm. [Client C] had a butter knife but cause no harm to self or others. Facility nurse administration team and health care rep[resentative] was (sic) notified of incident. [Client C] is still in his accessment (sic) period and this incident will be included in assessment to help develop behavior support plan...Staff will continue to follow all ResCare policies and procedures." There was no investigation available for review of this incident.</p> <p>5. A BDDS report submitted 06/13/13 for an incident on 06/12/13 at 1:50 PM indicated, "[Client C] ...was washing his laundry and [client E] ...was sitting in front of machine, when [client C] went to retrieve his laundry. [Client E] attempted to stop him because he wanted to take out the laundry. [Client E] tried to claw [client C] and [client C] hit [client E] in his left eye. Facility nurse was notified as well as health care reps and administration team. Facility nurse directed staff to take [client E] to [hospital] Emergency Room (ER). While</p>			

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	<p>at the ER it was determined that [client E] needed 3 sutures. Physical Aggression is addressed in [client E's] BSP. [Client C] is still in his initial assessment period and this incident will be added to his evaluation. [Client E] is complaining of no pain and [client C] has apologized to [client E] for striking him." There was no investigation available for review of this incident.</p> <p>On 06/20/13 at 4:15 PM an interview with the Program Manager (PM) was conducted. The PM indicated all incidents of abuse, neglect and injuries of unknown sources are to be investigated thoroughly. He indicated they failed to get the investigations conducted.</p> <p>This federal tag relates to complaint #IN00130731.</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 3 of 8 BDDS (Bureau of Developmental Disabilities Services) reports and 1 of 8 internal incident/accident report regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility neglected to initiate and document effective corrective action to prevent repeated elopement behavior by client A.</p> <p>Findings include:</p> <p>On 06/19/13 at 1:45 PM the facility's BDDS Reports, investigations and internal incident/accident reports were reviewed from 02/01/13 through 06/18/13 and indicated the following:</p> <p>For client A:</p> <p>1. An Incident/Accident Report on 02/24/13 at 7:45 PM. The report indicated, "[Client A] ask (sic) staff to give him cigarette, staff gave it to him. After that [client A] walk ut (sic) from group home without imform (sic) staff. After 5 minute (sic) staff check (sic) on [client A]. Staff discovered that [client A] was not in group home. Staff look (sic) for [client A] and staff (sic) [client</p>	W000157	<p>CORRECTION: <i>If the alleged violation is verified, appropriate corrective action must be taken.</i> Specifically, the interdisciplinary team will evaluate current assessment and incident data and meet to develop revised strategies to increase personal safety for Client A to prevent elopement and assure adequate supervision. The team is developing specific guidelines for line-of site observation and 15 minute checks as well as assessing the potential efficacy of installing door and window alarms at the facility. All facility and day service staff will be trained on proper implementation of the revised protocols. PREVENTION: The QIDP will bring all relevant elements of the interdisciplinary team together after significant incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Quality Assurance Manager to allow for appropriate oversight and follow-up. The Quality Assurance Manager will discuss corrective measures with the QIDP during weekly face to face meetings. RESPONSIBLE</p>	07/21/2013
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	<p>A] at come (sic) out from [store name] store. Staff drive (sic) [client A] back to group home." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent client A from repeating the behavior.</p> <p>2. A BDDS report submitted 03/22/13 for an incident dated 03/21/13 at 4:00 PM indicated, "Staff noticed that [client A] ...had two monster Energy Drinks and a snicker wrapper when she arrived back on shift at 8am. Staff noticed that the items were not there when she left at 1 am. [Client A] told PM (Program Manager) that while staff was in living room that he left out the back door and went to [store] and was back before his staff could notice. Guardian has been notified as well as administration team. AWOL (Absent With Out Leave) and Elopement is addressed in BSP (Behavior Support Plan). Team met and [client A] will be put on 15 minute checks and this will be reviewed quarterly. Staff will continue to follow BSP. PM spoke with [client A] about safety and also the importance of asking staff to take him places when he feels the need to go." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent client A from repeating the behavior.</p>		<p>PARTIES: Clinical Supervisor, Residential Manager, Quality Assurance Team, Operations Team</p>				

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	<p>3. A BDDS report submitted 05/02/13 for an incident dated 05/01/13 at 6:00 PM indicated, "[Client A] ...left facility without knowledge of staff. Guardian as well as administration team were notified. [Client A] was found 5 minutes later lurking between [store name] and park. Staff will continue to Follow (sic) BSP where AWOL has been addressed. Team has met and there has been a decision to put [client A] on IN (sic) line of Site (sic) (be able to see him at all times). [Client A] was safe and there were no injuries. PM spoke with [client A] on the importance of leaving Facility (sic) without staff." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent client A from repeating the behavior.</p> <p>4. A BDDS report submitted 06/11/13 for an incident dated 06/11/13 at 12:15 PM indicated, "At approximately 12:15 pm it was observed that [client A] was not in his work area following lunch. He was observed in the building at approximately 11:55 am trying to obtain cigarettes from a staff. It is believed that [client A] may have left the building during a changeover from lunch to work. After a multiple staff search of the premises both inside and out; (sic) it was believed that he may have</p>						

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	<p>eloped from the program. It's suspected that he may have eloped because he had been upset much of the morning over having no extra cigarettes and missing family. At approximately 12:40 pm [day service] Director of Safety was notified of the incident. [Day service] Manager [name] did a drive around search of the local neighborhood checking area stores that he might frequent per information received from his residential program. The Residential Director stated that he likes to frequent stores like convenient marts, [store name], and grocery outlets. [Day service Manager] also walked into numerous stores checking for [client A] as well. Other [Day service] staff continued monitoring and searching the premises in case he was hiding out somewhere on the premises. After not locating [client A], it was determined that 911 (approximately 1:35 pm) should be contacted to make a missing person's report. His residential program was also notified as well prior to this call being made. [Client A] currently works under a staffing ratio of 10:1 while at [day service]. [Client A] has not eloped from [day service] prior to this day. He reportedly has eloped multiple times from the residential program per information received from the residential program. At approximately 3:30 pm; (sic) the residential program called to report that</p>						

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	<p>[client A] had arrived home. He reportedly found someone from the community to take him home. He arrived home with no concerns noted from the reporting staff. Due to safety concerns, [client A] will remain on service interruption from [day service] until a meeting is scheduled to further discuss this incident and to review possible supports and programmatic changes to help ensure his safety and well-being. Team will also review the behavior plan for any necessary changes that may need to be implemented as well." No record of documented effective corrective action was available for review in regard to staff monitoring or supervision to prevent client A from repeating the behavior.</p> <p>On 06/20/13 at 4:15 PM an interview with the Program Manager (PM) was conducted. The PM indicated there were new younger clients who had recently been admitted to that group home and they had more behaviors than the clients who used to live at the group home. He also indicated there had been staff changes within the home and they were trying to do what they should for the clients and they were still getting to know them. He indicated the agency neglected to implement and document effective corrective action for the incidents.</p>						

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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.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client A), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure the day service provider was included in the update and development of the clients' ISPs (Individual Support Plans) and (BSPs) Behavior Support Plans and communicated significant changes in the ISPs and BSPs to the day program they attended.</p> <p>Findings include:</p> <p>Client A's records were reviewed at the day program on 06/20/13 at 10:15 AM. The records did not contain any updated information after the ISP and BSP dated 01/22/13.</p> <p>An interview was conducted on 06/20/13 at 10:50 AM with client A's Team Leader (TL). The TL indicated this was the current information they had on client A and had not received any information since that time.</p> <p>Client A's record at the facility was reviewed on 06/20/13 at 11:50 AM.</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 A's active treatment programs. The training will focus on the need to ensure that all team members have access to and the necessary training to implement Client A's current support documents. Day service staff have been provided with copies of and inservice training on the implementation of Client A's Individual Support Plan and Behavior Support Plan. Additional training of day service staff will occur when the plans are revised.</i></p> <p>PREVENTION: Members of the Operations Team will conduct monthly checks of all day service operations utilized by the facility to assure that current support documents are available and that day service staff possess the skills necessary to implement the plans.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team</p>	07/21/2013	

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	<p>Client A's record indicated a BSP dated 01/22/13 which included elopement behavior. The record indicated an IDT (Interdisciplinary Team) Meeting had been conducted on 03/21/13 and client A was to be on 15 minute checks to ensure he was in a staff's vision at least every 15 minutes.</p> <p>Client A's record indicated he eloped from the day service program on 06/11/13 at 12:15 PM.</p> <p>An interview was conducted on 06/20/13 at 4:05 PM with the Program Manager (PM). The PM indicated the day service program had not been provided with the information regarding client A's elopement behavior after the ISP date and the day service program had not been notified of client A's 15 minute checks.</p> <p>This federal tag relates to complaint #IN00130731.</p> <p>9-3-3(a)</p>				

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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219		
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W000312	<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.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) who was on medications related to behaviors, by not ensuring the client's Behavior Support Plan (BSP) included the medication in the plan.</p> <p>Findings include:</p> <p>Client A's records were reviewed on 06/20/13 at 11:50 AM. Client A's June 2013 physician's orders indicated he was taking Topamax and Invega for his Bipolar Disorder and Psychosis.</p> <p>Client A's BSP dated 1/22/13 indicated client A's behaviors included physical and verbal aggression and elopement. The BSP did not include an addendum to include the Topamax.</p> <p>On 06/20/13 at 4:15 PM an interview with the Program Manager (PM) was conducted. The PM indicated client A's BSP should be accurate and reflect all of the behavior meds.</p>	W000312	<p>CORRECTION: <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 A's Behavior Support Plan will be updated to include reference to and reasons for the use of all of Client A's current psychotropic medications.</i></p> <p>PREVENTION: The QIDP will receive additional training on the development and components of Behavior Support Plans Plans. The training will focus on the need to include all restrictive behavior management programs including but not limited to behavior controlling medications. 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 currently used behavior controlling drugs. Operations and Quality Assurance Team</p>	07/21/2013	

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	This federal tag relates to complaint #IN00130731. 9-3-5(a)		members will conduct site visits that incorporate BSP reviews no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Quality Assurance Team, Operations Team		

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A), by not ensuring the client received a follow up medical appointment for his psychiatric medications as ordered.</p> <p>Findings include:</p> <p>Client A's records were reviewed on 06/20/13 at 11:50 AM. Client A's record contained the following dated documents:</p> <p>04/15/13: A Record of Visit form dated 04/15/13 indicated client A was seen by the psychiatrist for complaints of visual hallucinations and paranoid delusions. The visit indicated: 1. Continue Invega 9 mg (milligram) for now. 2. Discontinue Zyprexa. 3. Consider Invega IM (intramuscular) injections once a month. 4. Add Topamax." The Topamax was ordered for 25 mg twice daily, "for mood, behavior and anger control secondary to address psychotic symptoms." The form indicated, "Follow-up Appointment date: 2 weeks."</p> <p>April 2013: Medication Administration Record (MAR) indicated client A was to take the Topamax for 15 days (the amount</p>	W000331	<p>CORRECTION: <i>The facility must provide clients with nursing services in accordance with their needs. Specifically, Client A saw his attending psychiatrist on 7/5/13 and an appointment has been set for his next quarterly visit.</i></p> <p>PREVENTION: The facility nurse has begin incorporating psychiatric follow-along into the medical appointment tracking spreadsheet and will follow-up as needed to assure psychiatric follow-along occurs as recommended. Additionally, members of the Quality Assurance and Operations Teams will include review of psychiatric follow-along documentation as part of their routine audit process which will occur no less than monthly.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Quality Assurance Team, Operations Team</p>	07/21/2013			

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	<p>the order was written for) starting with the PM dose on 04/17/13.</p> <p>May 2013: MAR indicated the Topamax was completed 05/02/13. There was no further Topamax administration in May 2013.</p> <p>06/03/13: A Record of Visit form by the psychiatrist. dated 06/03/13. The form indicated, "increase of Topamax to 50 mg twice a day...."</p> <p>June 2013: MAR indicated client A started the increased dose of Topamax on 06/19/13.</p> <p>On 06/20/13 at 2:50 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client A was seen by the psychiatrist on 04/15/13 and was placed on Topamax for the hallucinations and paranoid delusions. She indicated client A was given a 15 day supply of the medication and was to be re-evaluated by the psychiatrist in two weeks as per his orders. She indicated the follow-up appointment did not occur, client A ran out of the Topamax and the psychiatrist was not contacted for further medication. She indicated she was unsure why the appointment did not occur as ordered. She indicated client A returned to the psychiatrist on 06/03/13 and was to</p>			

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	<p>have an increase in the Topamax. She indicated she had gone to the group home on 06/19/13 and discovered the medication was in the home, but had not yet been started and she did not know why. She indicated it was being looked into as to why the medication was not started when it was received from the pharmacy. She indicated it was immediately started on the PM of 06/19/13. The LPN indicated physician orders should be followed as written and client A should have been seen two weeks after the 04/15/13 appointment. She also indicated client A had behaviors after he stopped the medications and prior to receiving the dose increase which started 06/19/13.</p> <p>This federal tag relates to complaint #IN00130731.</p> <p>9-3-6(a)</p>						