

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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 a full annual recertification and state licensure survey which resulted in an Immediate Jeopardy.</p> <p>Dates of Survey: 2/13/14, 2/14/14, 2/17/14, 2/18/14, 2/19/14 and 2/20/14.</p> <p>Facility Number: 000927 Provider Number: 15G413 AIMS Number: 100244440</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/26/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8). The governing body failed to exercise general policy, budget and operating direction over the facility to</p>	W000102	CORRECTION: The facility must ensure that specific governing body and management requirements are met. Specifically the governing body will assure that: The interdisciplinary team assessed that due to an ongoing pattern of intimidation and aggression toward housemates, Client #1 no longer met the	03/22/2014

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: 15G413		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227			
(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>ensure the facility implemented its policy and procedures to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation, to ensure the facility conducted an investigation of an allegation of neglect and mistreatment for client #4 and to develop and implement corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation.</p> <p>The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility conducted an investigation regarding allegations of neglect and mistreatment of client #4, developed and implemented corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation, to ensure client #1's laboratory orders were followed and to ensure the facility ensured the health status of clients #1 and #2 was reviewed on a quarterly basis.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the</p>		<p>developmental, social and behavioral criteria for Supervised Group Living placement. Therefore the team coordinated with the Bureau of Developmental Disability Services and obtained an Emergency Medicaid Waiver, which enabled Client #1 to move into a more appropriate setting. Client #1 has been discharged from the facility. The Clinical Supervisor will complete and investigation summary detailing the findings of an investigation into allegations of neglect of Client #4. PREVENTION: The governing body will assist with screening referrals for admission to the facility to assure they possess similar developmental, social and behavioral needs to the other clients residing in the facility. Final approval for admission will be contingent on the ability to maintain safety and emotional stability at the facility. After the initial assessment period, QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to physical aggression and intimidation 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 Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>facility conducted an investigation regarding allegations of neglect and mistreatment of client #4, developed and implemented corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation, to ensure client #1's laboratory orders were followed and to ensure the facility ensured the health status of clients #1 and #2 was reviewed on a quarterly basis. Please see W104.</p> <p>2. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation, to ensure the facility conducted an investigation of an allegation of neglect and mistreatment for client #4 and to develop and implement corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation. Please see W122.</p> <p>9-3-1(a)</p>		<p>will meet weekly with the QIDP to review incidents which require interdisciplinary team action. When patterns of physical aggression and intimidation emerge, the Operations Team will assist the facility for assessing whether client(s) remain an appropriate fit for the facility and take action toward finding alternative placement when appropriate. When allegations of abuse, neglect or mistreatment are reported to the Operations Team, investigations will be initiated immediately. Based on the scope of the allegations, the Executive Director, Program Manager and Clinical supervisor will determine the appropriate team member to coordinate the investigation. Once the investigation is assigned, the lead investigator will provide updates on the investigations status until an investigation summary is completed and presented to senior management for a peer review to develop recommendations based on the investigation results. Investigations will be completed within five business days of discovery of the allegations. RESPONSIBLE PARTIES:QIDP, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227			
(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 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation, to ensure the facility conducted an investigation of an allegation of neglect and mistreatment for client #4 and to develop and implement corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation.</p> <p>The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility conducted an investigation regarding allegations of neglect and mistreatment of client #4, developed and implemented corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation, to ensure the facility nursing services</p>	W000104	<p>CORRECTION: The Governing body must exercise general policy, budget and operating direction over the facility. Specifically, the governing body has provided direction and oversight to assure that: The interdisciplinary team assessed that due to an ongoing pattern of intimidation and aggression toward housemates, Client #1 no longer met the developmental, social and behavioral criteria for Supervised Group Living placement. Therefore the team coordinated with the Bureau of Developmental Disability Services and obtained an Emergency Medicaid Waiver, which enabled Client #1 to move into a more appropriate setting. Client #1 has been discharged from the facility.</p> <p>The Clinical Supervisor will complete and investigation summary detailing the findings of an investigation into allegations of neglect of Client #4. PREVENTION: The governing body will assist with screening referrals for admission to the facility to assure they possess similar developmental, social and behavioral needs to the other clients residing in the facility. Final approval for admission will be contingent on the ability to maintain safety and emotional</p>	03/22/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227		
(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>ensured client #1's laboratory orders were followed and to ensure the facility ensured the health status of clients #1 and #2 was reviewed on a quarterly basis.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation, to ensure the facility conducted an investigation of an allegation of neglect and mistreatment for client #4 and to develop and implement corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation. Please see W149. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility conducted an investigation regarding allegations of neglect and mistreatment of client #4. Please see W154. The governing body failed to exercise 		<p>stability at the facility. After the initial assessment period, QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to physical aggression and intimidation 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 Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. When patterns of physical aggression and intimidation emerge, the Operations Team will assist the facility for assessing whether client(s) remain an appropriate fit for the facility and take action toward finding alternative placement when appropriate. When allegations of abuse, neglect or mistreatment are reported to the Operations Team, investigations will be initiated immediately. Based on the scope of the allegations, the Executive Director, Program Manager and Clinical supervisor will determine the appropriate team member to coordinate the investigation. Once the investigation is assigned, the lead investigator will provide updates on the investigations status until an investigation summary is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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
W000122	<p>general policy, budget and operating direction over the facility to ensure the facility developed and implemented corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation. Please see W157.</p> <p>4. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services ensured client #1's laboratory orders were followed. Please see W331.</p> <p>5. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility ensured the health status of clients #1 and #2 was reviewed on a quarterly basis. Please see W336.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 3 of 4 sampled clients (#2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8).</p>	W000122	<p>completed and presented to senior management for a peer review to develop recommendations based on the investigation results. Investigations will be completed within five business days of discovery of the allegations. RESPONSIBLE PARTIES:QIDP, Operations Team</p> <p>CORRECTION:The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically: the interdisciplinary team</p>	03/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The facility failed to implement its policy and procedures to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation, to ensure the facility conducted an investigation of an allegation of neglect and mistreatment for client #4 and to develop and implement corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 1/29/14. The Immediate Jeopardy was identified on 2/18/14. The Clinical Supervisor was notified of the Immediate Jeopardy on 2/18/14 at 5:20 PM regarding the facility's system failure to prevent physical aggression and/or intimidation towards clients #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 2/20/14, the facility submitted the following Allegation for Removal of Immediate Jeopardy- Addendum: "(1.) The IDT (Interdisciplinary Team) has determined that due to his ongoing pattern of physical aggression and intimidation toward housemates, a standard (SGL) Supervised Group Living setting is no longer appropriate</p>		<p>assessed that due to an ongoing pattern of intimidation and aggression toward housemates, Client #1 no longer met the developmental, social and behavioral criteria for Supervised Group Living placement. Therefore the team coordinated with the Bureau of Developmental Disability Services and obtained an Emergency Medicaid Waiver, which enabled Client #1 to move into a more appropriate setting. Client #1 has been discharged from the facility.</p> <p>PREVENTION: The governing body will assist with screening referrals for admission to the facility to assure they possess similar developmental, social and behavioral needs to the other clients residing in the facility. Final approval for admission will be contingent on the ability to maintain safety and emotional stability at the facility. After the initial assessment period, QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to physical aggression and intimidation 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 Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227		
(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>for client, [client #1]. He was therefore moved into temporary housing on 2/18/14. (2.) [Facility]- [city] ICF... has informed the BDDS (Bureau of Developmental Services) that client, [client #1], may no longer reside at the [group home] or any other standard SGL facility operated by [facility]... being defined as 6.0, 8.0 and 10.0 residences. (3.) The IDT will not move client, [client #1], back into the [group home] or any other standard level SGL residence operated by [facility]. (4.) [Client #1] will continue to receive staff support and active treatment services in his temporary housing environment until such time as appropriate placement is secured."</p> <p>Observations were conducted at client #1's temporary housing environment (hotel) on 2/19/14 from 1:51 PM through 2:52 PM. Client #1 had been relocated to a hotel as temporary housing with facility staff.</p> <p>Interview with client #1 on 2/19/14 at 2:00 PM indicated he had relocated to the hotel on 2/18/14. Client #1 indicated he had moved his personal belongings with the assistance of facility staff from the group home to the hotel. Client #1 indicated the facility had informed him that he would not be returning to the</p>		<p>review incidents which require interdisciplinary team action. When patterns of physical aggression and intimidation emerge, the Operations Team will assist the facility for assessing whether client(s) remain an appropriate fit for the facility and take action toward finding alternative placement when appropriate. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>group home. Client #1 indicated he had meals at the hotel, clothing and his medications.</p> <p>Interview with staff #1 on 2/19/14 at 2:15 PM indicated client #1 had been moved from the group home to the hotel for temporary housing. Staff #1 indicated one staff would be present in the hotel with client #1 throughout his temporary stay. Staff #1 indicated client #1 would receive meals, showers, programming and medications at the hotel.</p> <p>Observations were conducted at the group home on 2/19/14 from 3:21 PM through 3:52 PM. Client #1 was not present in the group home. Clients #3, #4 and #7, CS (Clinical Supervisor) #1 and HM (Home Manager) #1 were present in the home throughout the observation period.</p> <p>CS #1 was interviewed on 2/19/14 at 3:21 PM. CS #1 indicated client #1 was moved from the group home to temporary housing at a local hotel. CS #1 indicated client #1 would continue to receive support and services while at the hotel.</p> <p>HM #1 was interviewed on 2/19/14 at 3:30 PM. HM #1 stated, "With him,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[client #1], out of the house, I am excited to see what the other guys are capable of. Staff will have more time to spend with them and help them get to their goals. With [client #1] in the house, you know staff always had to be spending all of their time with him. If he didn't get his way or got mad we had problems. Now, the guys won't have to walk on eggshells around him. They won't have to give him stuff or do things for him to keep him from attacking them or having a behavior." HM #1 stated, "He would just tear things up. If the clients would clean up an area in the house. [Client #1] would go to that room and just destroy it. He would just sit in his mess until someone would come along and clean it up. Then he would go to a clean area and destroy it too. Now, the other guys can really not worry about [client #1] and we can really see what they are capable of."</p> <p>Client #4 was interviewed on 2/19/14 at 3:21 PM. Client #4 stated, "It's much better. I'm glad he's, [client #1], is gone."</p> <p>Client #7 was interviewed on 2/19/14 at 3:25 PM. Client #7 stated, "What roommate? He's gone." Client #7 indicated client #1, his roommate, had been moved from the house. Client #7</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>stated, "It's much better now."</p> <p>Observations were conducted at client #1's temporary housing environment (hotel) on 2/20/14 from 11:00 AM through 11:52 AM. Client #1 had been relocated to a hotel as temporary housing with facility staff.</p> <p>The CS #1, QIDP (Qualified Intellectual Disabilities Professional) #1, CS #2, GHD (Group Home Director) and ED (Executive Director) were notified of the removal of the Immediate Jeopardy on 2/20/14 at 11:36 AM. The facility remained out of compliance at the Condition level because the facility needed to demonstration ongoing implementation of the added safeguards to prevent further neglect of clients #2, #3, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to implement its policy and procedures to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation. Please see W149. 2. The facility failed to conduct an investigation of an allegation of neglect and mistreatment for client #4. Please see W154. 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227			
(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>3. The facility failed to develop and implement corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation. Please see W157.</p> <p>9-3-2(a)</p> <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 4 sampled clients (#2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to implement its policy and procedures to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation, to ensure the facility conducted an investigation of an allegation of neglect and mistreatment for client #4 and to develop and implement corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation.</p> <p>Findings include:</p>			W000149	<p>CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically: The interdisciplinary team assessed that due to an ongoing pattern of intimidation and aggression toward housemates, Client #1 no longer met the developmental, social and behavioral criteria for Supervised Group Living placement. Therefore the team coordinated with the Bureau of Developmental Disability Services and obtained an Emergency Medicaid Waiver, which enabled Client #1 to move into a more appropriate setting. Client #1 has been discharged from the facility. The Clinical Supervisor will complete and investigation</p>		03/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227			
(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. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/13/14 at 12:03 PM. The review indicated the following:</p> <p>-BDDS report dated 2/10/13 indicated, "Staff was attempting to redirect [client #7] away from a housemate who was upset with him. [Client #7] resisted and [client #1] entered the room and began yelling at [client #7]. Staff asked [client #1] to allow her to deal with the situation and [client #1] continued yelling and using profanity. Staff continued to attempt to keep [client #7] separated from his other housemates and [client #1] punched [client #7] in the chest. [Client #1] continued trying to hit [client #7] but staff was able to keep the two separated. [Client #7] entered a bathroom and shut the door and [client #1] began hitting the bathroom door with a chair." The 2/10/13 BDDS report indicated, "[Client #7] sustained a four inch in diameter red area on his chest."</p> <p>-BDDS report dated 4/3/13 indicated, "[Client #1] jumped up and stated that he was sick and tired of [client #2] being a hypochondriac (sic) and faking seizures just to get out of going to work. [Client #2] then said, 'How dare you' and</p>		<p>summary detailing the findings of an investigation into allegations of neglect of Client #4. PREVENTION: The governing body will assist with screening referrals for admission to the facility to assure they possess similar developmental, social and behavioral needs to the other clients residing in the facility. Final approval for admission will be contingent on the ability to maintain safety and emotional stability at the facility. After the initial assessment period, QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to physical aggression and intimidation 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 Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. When patterns of physical aggression and intimidation emerge, the Operations Team will assist the facility for assessing whether client(s) remain an appropriate fit for the facility and take action toward finding alternative placement when appropriate. When allegations of abuse, neglect or mistreatment</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[client #1] struck [client #2] in the face." The 4/12/13 follow-up BDDS report indicated, "[Client #2's] face was swollen and he complained of his head hurting. [Client #1] had no visible injuries. Staff notified the nurse and [client #2] was transported by staff to [hospital] emergency room." The 4/12/13 BDDS report indicated, "While at the emergency room a CT (Computed Tomography) scan was performed on [client #2]. The results of the CT scan were negative, however [client #2] was diagnosed with a mild concussion and recommended no contact sports or activities for a week."</p> <p>-BDDS report dated 4/11/13 indicated, "After being told that a package of hot dogs would not be thawed out in time for lunch, [client #1] went to his room. Shortly thereafter staff heard a loud noise and entered [client #1's] room and observed that his window was broken. [Client #1] told staff he had punched the window and then threw a chair through it."</p> <p>-BDDS report dated 4/12/13 indicated, "[Client #1] became upset when he misunderstood staff regarding plans for the evening. [Client #1] punched the van side mirror causing pieces of glass to become embedded in his right hand."</p>		<p>are reported to the Operations Team, investigations will be initiated immediately. Based on the scope of the allegations, the Executive Director, Program Manager and Clinical supervisor will determine the appropriate team member to coordinate the investigation. Once the investigation is assigned, the lead investigator will provide updates on the investigations status until an investigation summary is completed and presented to senior management for a peer review to develop recommendations based on the investigation results. Investigations will be completed within five business days of discovery of the allegations. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 4/21/13 indicated, "[Client #1] became upset with his housemate, [client #7], because [client #7] had used [client #1's] internet cord that was plugged in [client #1's] computer. [Client #1] asked to speak to staff in private. Staff offered to speak to [client #1] in the garage, however, [client #1] wanted to talk in private in the medication room. While in the medication room [client #1] started knocking over items one item (sic) was [client #7's] personal printer in which [client #1] broke. [Client #7] became upset and used his personal cellphone to report the incident to the police."</p> <p>-BDDS report dated 5/7/13 indicated, "[Client #1] became agitated with housemate, [client #6], after [client #6] had been verbally prompted by staff to get on the van to return home from an outing. [Client #1] the forcefully pushed [client #6] on the van."</p> <p>-BDDS report dated 7/23/13 indicated, "Staff witnessed a verbal dispute between [client #1] and [client #2] about a money issue. [Client #2] told [client #1] he wasn't going to pay him the \$3.00 that [client #1] claimed he owed him. [Client #1] then attacked [client #2] hitting him twice in the head before staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>intervened."</p> <p>-BDDS report dated 10/14/13 indicated, "[Client #1] hit [client #3] in the head 15 times because [client #1] said [client #3] was making fun of another consumer's girlfriend. [Client #1] then busted the light fixtures in the living room and glass was all over the room. The other consumers were directed to another part of the house to ensure their safety. [Client #3] was transported by staff to [hospital] emergency room. Emergency room findings were negative head CT and wrist x-rays. Recommended ice and ace bandage to right wrist and follow up with PCP (Primary Care Physician)."</p> <p>-BDDS report dated 11/21/13 indicated, "During medication administration [client #1] wanted to go to the store. [Client #1] was prompted by staff to wait until medication administration was over. [Client #1] became agitated and begin (sic) to hit the walls and throw the refrigerator in the medication room. During the incident [client #1] was transported to [hospital] for a (psychological) evaluation."</p> <p>-BDDS report dated 1/31/14 indicated, "On 1/29/14, [client #5], was walking out of his room with his peer, he began yelling at that individual. Then another</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>one of his housemates, [client #1], yelled at [client #5] and told him to stop yelling but [client #5] continued to yell.... [Client #1] threw a laptop table at [client #5]. [Client #5] used his had (sic) as a shield to protect himself, causing him to receive a 1/2 inch scrape on his left palm of his hand."</p> <p>-BDDS report dated 1/31/14 indicated, "During 5:00 PM medication administration (sic) it was time for [client #6] to take his medication. [Client #1] was ready to go to a dance that was held by the company for all the individuals to attend. [Client #1] became agitated when he had to wait for [client #6]. [Client #1] went into [client #6's] room and hit [client #6] on top of the head and began yelling at him. Staff quickly intervened removing [client #1] from [client #6's] room. Then [client #1] began throwing items at the wall attempting to damage it. [QIDP (Qualified Intellectual Disabilities Professional) #1] instructed staff to transport [client #1] to [hospital] behavior center for evaluation."</p> <p>Client #1's record was reviewed on 2/18/14 at 9:49 AM. Client #1's record indicated the facility's IDT (Interdisciplinary Team) had met on 11/21/13 and 2/12/14 to discuss and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>address client #1's physical aggression. Client #1's 11/21/13 IDT note indicated the recommendation for client #1 to go outside to smoke when he was agitated. Client #1's 2/12/14 IDT note indicated the recommendation for client #1 to have 4 hours of unsupervised alone time. The review did not indicate additional documentation of IDT discussion of client #1's behaviors or how to ensure the safety of client #1's peers. Client #1's BSP (Behavior Support Plan) dated 5/23/13 was updated on 2/7/14 to include additional physical management techniques.</p> <p>Clinical Supervisor (CS) #1 was interviewed on 2/13/14 at 12:07 PM. CS #1 stated, "We are trying to move him, [client #1], out of the house. We are in the process of getting him approved to go to an ESN (extensive special needs) home or [facility] or to the waiver program."</p> <p>CS #1 was interviewed on 2/18/14 at 11:30 AM. CS #1 stated, "[Client #1] has PA (Physical Aggression) and tears up everything. If the clients clean up an area of the house, [client #1] will go through the area and destroy it. He will go after his peers." CS #1 stated, "We had to move him out of being roommates with [client #2] and then</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[client #3]. [Client #1] makes threats towards [client #2] and [client #3]. It's usually about money or something he wants. He, [client #1], will try to manipulate the other clients to get things and then threaten them if they don't do it."</p> <p>QIDPD #1 (Qualified Intellectual Disabilities Professional Designee) was interviewed on 2/18/14 at 1:51 PM. QIDPD #1 stated, "[Client #1] is disruptive, he will throw things and tear things up in the house." QIDPD #1 stated, "[Client #1] will attack his peers if they get in his way. He instigates and will hit them." When asked if client #1 had injured any of his peers, QIDPD #1 stated, "Yes, he's sent them to the emergency room. I think [client #2] and [client #3]." When asked if clients #2, #3, #4, #5, #6, #7 or #8 were fearful or intimidated by client #1, QIDPD #1 stated, "I don't know if fearful but I would say uncomfortable. Some of the intensity of some of his, [client #1's], behaviors. Throwing things, screaming, threatening and breaking things." When asked how the facility had addressed client #1's behaviors, QIDPD #1 indicated he had assumed responsibility for the home in November 2013. When asked how the facility had addressed client #1's behaviors to protect clients</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>#2, #3, #4, #5, #6, #7 and #8, QIDPD #1 indicated he had conducted two IDT's and the facility was currently in process of moving client #1 out of the home due to his behaviors. When asked if the IDT recommendations or pending transfer had prevented client #1 from hitting or intimidating his peers, QIDPD #1 stated, "No."</p> <p>Client #4 was interviewed on 2/18/14 at 4:40 PM. Client #4 stated, "I get along with some of the guys and some not really... like I don't really get along with [client #1]. He's always throwing things or threatening people. We had one fight on the van." When asked if he felt safe in the group home, client #4 stated, "Not really. Not with [client #1]."</p> <p>Client #2 was interviewed on 2/18/14 at 4:45 PM. When asked how things were going in the group home, client #2 stated, "Okay, except [client #1] keeps punching me. I don't feel comfortable with him being around. He's always threatening me. He gets away with it, even when staff are right there. [Client #1] will say things and threaten me but staff don't really hear it. [Client #1] has hit me in the head. He likes to find people's weakness and then hit them there. Mine is my head. [Client #1] has given me like three concussions in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>last year. I feel like if I don't do what he asks me to, he will hit me." When asked if he felt safe in the group home, client #2 stated, "No, not with [client #1]. Very uncomfortable."</p> <p>Client #7 was interviewed on 2/18/14 at 4:55 PM. Client #7 indicated he was client #1's roommate. Client #7 stated, "I try to stay away from him, [client #1], I just try to stay in my bed when he's in the room." When asked if he felt safe in the group home, client #7 stated, "Safe? Not when [client #1] is having his behaviors. Not really."</p> <p>Client #5 was interviewed on 2/18/14 at 5:00 PM. Client #5 stated, "Things are going okay here. Except, [client #1]. [Client #1] has hit me and threw a table at me. See, I have a scar on my wrist from it." Client #5 indicated client #1 had hit and chased client #7 through the house. Client #5 stated, "[Client #1] chased [client #7] from the garage to the bathroom over here. [Client #1] had a chair and was hitting the door." Client #5 stated, "I think I would be afraid if he threatened me and chased me like that." When asked if he felt safe in the group home, client #5 stated, "Well, that's a tough question. Not really. Not with [client #1] I don't."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>Direct Care Staff (DCS) #1 was interviewed on 2/18/14 at 5:15 PM. DCS #1 stated, "Everything in the house is going fine except [client #1]. [Client #1] throws tables and tears things up. He threatens the guys and will hit them." When asked if any of the clients were afraid of client #1, DCS #1 stated, "Yes, I know they are." When asked how he knew clients were fearful of client #1, DCS #1 stated, "Every time [client #1] is around they want to stand by me, stay close to me so he, [client #1], can't get them." DCS #1 stated, "I think especially [client #2] and [client #7] are intimidated."</p> <p>2. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/13/14 at 12:03 PM. The review indicated the following:</p> <p>-BDDS report dated 1/10/14 indicated, "[Client #4's] mother and legal guardian, [guardian], contacted his BDDS Service Coordinator and voiced the following concerns: (1.) She noted a strong aroma of urine in [client #4's] room; (2.) [Guardian] noted housemates in [client #4's] room making use of his furniture and belongings while [client #4] was on therapeutic leave; (3.) [Guardian] is concerned that [client #4] is not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>following his diet and is joining in with his housemates and eating excessively through the night. Additionally, she believes [client #4] is not engaging in sufficient physical activity and needs more exercise; (4.) [Client #4] does not use his CPAP (Continuous Positive Airway Pressure) machine as ordered by his doctor and recently received a prescription to use supplemental oxygen at night and that he is not yet receiving it." The 1/10/14 BDDS report indicated, "Evidence gathered through investigation confirmed that the use of supplemental oxygen at night was prescribed for [client #4] on 12/10/13 and that the facility nurse had maintained possession of the order and not communicated it with the remainder of the team. The nurse is no longer employed."</p> <p>The review did not indicate documentation of an investigation regarding the 1/10/14 allegations.</p> <p>CS #2 (Clinical Supervisor) was interviewed on 2/18/14 at 1:14 PM. CS #2 stated regarding the 1/10/14 allegations "These were concerns presented by a guardian who visited the home. We took steps to address them. The only allegation was medical which we substantiated in an investigation we</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>had done a few days prior. The nurse was terminated for sleeping at the site." CS #2 stated, "We talked about this in a meeting and took steps immediately to fix the situation. We didn't need to investigate it."</p> <p>QIDPD #1 (Qualified Intellectual Disabilities Professional Designee) was interviewed on 2/18/14 at 1:51 PM. QIDPD #1 indicated the facility's abuse and neglect policy should be implemented. QIDPD #1 indicated the facility should investigate all allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin. QIDPD #1 indicated the facility should develop and implement corrective action to prevent further incidents of abuse, neglect or mistreatment. QIDPD #1 indicated the facility utilized the IDT and administrative peer review process upon completion of investigations of incidents of abuse, neglect and mistreatment to develop recommendations for corrective actions.</p> <p>The facility's policy and procedures were reviewed on 2/19/14 at 11:55 AM. The facility's 2/26/11 policy and procedure entitled, "Abuse, Neglect, Exploitation... Mistreatment" indicated, "Adept staff actively advocate for the rights and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>safety of all individuals." The 2/26/11 policy indicated, "(2.) Definitions: Physical abuse: the act or failure to act that results or could result in physical injury to an individual. Non-accidental injury inflicted by another person or persons; Verbal abuse: the act of insulting or profane language or gestures directed toward an individual that subjects him/her to humiliation or degradation. Coarse, loud tone or language that is perceived by an individual as offending or threatening... 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 or implied. Attitude or acts that interfere with the psychological and social well being of an individual... ; Emotional/physical neglect: failure to provide goods and/or service 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... and to provide a safe environment...."</p> <p>The facility's 9/14/07 policy and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>procedure entitled, "Investigations" indicated, "A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to, the following:... concerns and recommendations... (and) methods to prevent future incidents."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 59 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to conduct an investigation regarding allegations of neglect and mistreatment of client #4.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/13/14 at 12:03 PM. The review indicated the following:</p> <p>-BDDS report dated 1/10/14 indicated, "[Client #4's] mother and legal guardian,</p>	W000154	<p>CORRECTION:The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, the Clinical Supervisor will complete and investigation summary detailing the findings of an investigation into allegations of neglect of Client #4.</p> <p>PREVENTION:When allegations of abuse, neglect or mistreatment are reported to the Operations Team, investigations will be initiated immediately. Based on the scope of the allegations, the Executive Director, Program Manager and Clinical supervisor will determine the appropriate team member to coordinate the investigation. Once the investigation is assigned, the lead investigator will provide updates on the investigations status until</p>	03/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227			
(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>[guardian], contacted his BDDS Service Coordinator and voiced the following concerns: (1.) She noted a strong aroma of urine in [client #4's] room; (2.) [Guardian] noted housemates in [client #4's] room making use of his furniture and belongings while [client #4] was on therapeutic leave; (3.) [Guardian] is concerned that [client #4] is not following his diet and is joining in with his housemates and eating excessively through the night. Additionally, she believes [client #4] is not engaging in sufficient physical activity and needs more exercise; (4.) [Client #4] does not use his CPAP (Continuous Positive Airway Pressure) machine as ordered by his doctor and recently received a prescription to use supplemental oxygen at night and that he is not yet receiving it." The 1/10/14 BDDS report indicated, "Evidence gathered through investigation confirmed that the use of supplemental oxygen at night was prescribed for [client #4] on 12/10/13 and that the facility nurse had maintained possession of the order and not communicated it with the remainder of the team. The nurse is no longer employed."</p> <p>The review did not indicate documentation of an investigation regarding the 1/10/14 allegations.</p>		<p>an investigation summary is completed and presented to senior management for a peer review to develop recommendations based on the investigation results. Investigations will be completed within five business days of discovery of the allegations. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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
--------------------	--	---------------	---	----------------------

W000157	<p>CS #2 (Clinical Supervisor) was interviewed on 2/18/14 at 1:14 PM. CS #2 stated regarding the 1/10/14 allegations "These were concerns presented by a guardian who visited the home. We took steps to address them. The only allegation was medical which we substantiated in an investigation we had done a few days prior. The nurse was terminated for sleeping at the site." CS #2 stated, "We talked about this in a meeting and took steps immediately to fix the situation. We didn't need to investigate it."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 3 of 4 sampled clients (#2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to develop and implement corrective actions to prevent neglect of clients #2, #3, #4, #5, #6, #7 and #8 regarding client #1's physical aggression and intimidation.</p> <p>Findings include:</p>	W000157	<p>CORRECTION:If the alleged violation is verified, appropriate corrective action must be taken. Specifically, the interdisciplinary team assessed that due to an ongoing pattern of intimidation and aggression toward housemates, Client #1 no longer met the developmental, social and behavioral criteria for Supervised Group Living placement. Therefore the team coordinated with the Bureau of Developmental Disability Services</p>	03/22/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/13/14 at 12:03 PM. The review indicated the following:</p> <p>-BDDS report dated 2/10/13 indicated, "Staff was attempting to redirect [client #7] away from a housemate who was upset with him. [Client #7] resisted and [client #1] entered the room and began yelling at [client #7]. Staff asked [client #1] to allow her to deal with the situation and [client #1] continued yelling and using profanity. Staff continued to attempt to keep [client #7] separated from his other housemates and [client #1] punched [client #7] in the chest. [Client #1] continued trying to hit [client #7] but staff was able to keep the two separated. [Client #7] entered a bathroom and shut the door and [client #1] began hitting the bathroom door with a chair." The 2/10/13 BDDS report indicated, "[Client #7] sustained a four inch in diameter red area on his chest."</p> <p>-BDDS report dated 4/3/13 indicated, "[Client #1] jumped up and stated that he was sick and tired of [client #2] being a hypochondriac (sic) and faking seizures just to get out of going to work. [Client #2] then said, 'How dare you' and [client #1] struck [client #2] in the face."</p>		<p>and obtained an Emergency Medicaid Waiver, which enabled Client #1 to move into a more appropriate setting. Client #1 has been discharged from the facility.</p> <p>PREVENTION: The governing body will assist with screening referrals for admission to the facility to assure they possess similar developmental, social and behavioral needs to the other clients residing in the facility. Final approval for admission will be contingent on the ability to maintain safety and emotional stability at the facility. After the initial assessment period, QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to physical aggression and intimidation 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 Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. When patterns of physical aggression and intimidation emerge, the Operations Team will assist the facility for assessing whether client(s) remain an appropriate fit for the facility and take action toward finding alternative placement when</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The 4/12/13 follow up BDDS report indicated, "[Client #2's] face was swollen and he complained of his head hurting. [Client #1] had no visible injuries. Staff notified the nurse and [client #2] was transported by staff to [hospital] emergency room." The 4/12/13 BDDS indicated, "While at the emergency room a CT (Computed Tomography) scan was performed on [client #2]. The results of the CT scan were negative, however [client #2] was diagnosed with a mild concussion and recommended no contact sports or activities for a week."</p> <p>-BDDS report dated 4/11/13 indicated, "After being told that a package of hot dogs would not be thawed out in time for lunch, [client #1] went to his room. Shortly thereafter staff heard a loud noise and entered [client #1's] room and observed that his window was broken. [Client #1] told staff he had punched the window and then threw a chair through it."</p> <p>-BDDS report dated 4/12/13 indicated, "[Client #1] became upset when he misunderstood staff regarding plans for the evening. [Client #1] punched the van side mirror causing pieces of glass to become embedded in his right hand."</p>		appropriate. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 4/21/13 indicated, "[Client #1] became upset with his housemate, [client #7], because [client #7] had used [client #1's] internet cord that was plugged in [client #1's] computer. [Client #1] asked to speak to staff in private. Staff offered to speak to [client #1] in the garage, however, [client #1] wanted to talk in private in the medication room. While in the medication room [client #1] started knocking over items one item (sic) was [client #7's] personal printer in which [client #1] broke. [Client #7] became upset and used his personal cellphone to report the incident to the police."</p> <p>-BDDS report dated 5/7/13 indicated, "[Client #1] became agitated with housemate, [client #6], after [client #6] had been verbally prompted by staff to get on the van to return home from an outing. [Client #1] the forcefully pushed [client #6] on the van."</p> <p>-BDDS report dated 7/23/13 indicated, "Staff witnessed a verbal dispute between [client #1] and [client #2] about a money issue. [Client #2] told [client #1] he wasn't going to pay him the \$3.00 that [client #1] claimed he owed him. [Client #1] then attacked [client #2] hitting him twice in the head before staff intervened."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 10/14/13 indicated, "[Client #1] hit [client #3] in the head 15 times because [client #1] said [client #3] was making fun of another consumer's girlfriend. [Client #1] then busted the light fixtures in the living room and glass was all over the room. The other consumers were directed to another part of the house to ensure their safety. [Client #3] was transported by staff to [hospital] emergency room. Emergency room findings were negative head CT and wrist x-rays. Recommended ice and ace bandage to right wrist and follow up with PCP (Primary Care Physician)."</p> <p>-BDDS report dated 11/21/13 indicated, "During medication administration [client #1] wanted to go to the store. [Client #1] was prompted by staff to wait until medication administration was over. [Client #1] became agitated and begin (sic) to hit the walls and throw the refrigerator in the medication room. During the incident [client #1] was transported to [hospital] for a (psychological) evaluation."</p> <p>-BDDS report dated 1/31/14 indicated, "On 1/29/14, [client #5], was walking out of his room with his peer, he began yelling at that individual. Then another one of his housemates, [client #1],</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>yelled at [client #5] and told him to stop yelling but [client #5] continued to yell.... [Client #1] threw a laptop table at [client #5]. [Client #5] used his had (sic) as a shield to protect himself, causing him to receive a 1/2 inch scrape on his left palm of his hand."</p> <p>-BDDS report dated 1/31/14 indicated, "During 5:00 PM medication administration (sic) it was time for [client #6] to take his medication. [Client #1] was ready to go to a dance that was held by the company for all the individuals to attend. [Client #1] became agitated when he had to wait for [client #6]. [Client #1] went into [client #6's] room and hit [client #6] on top of the head and began yelling at him. Staff quickly intervened removing [client #1] from [client #6's] room. Then [client #1] began throwing items at the wall attempting to damage it. [QIDP (Qualified Intellectual Disabilities Professional) #1] instructed staff to transport [client #1] to [hospital] behavior center for evaluation."</p> <p>Client #1's record was reviewed on 2/18/14 at 9:49 AM. Client #1's record indicated the facility's IDT (Interdisciplinary Team) had met on 11/21/13 and 2/12/14 to discuss and address client #1's physical aggression.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Client #1's 11/21/13 IDT note indicated the recommendation for client #1 to go outside to smoke when he was agitated. Client #1's 2/12/14 IDT note indicated the recommendation for client #1 to have 4 hours of unsupervised alone time. The review did not indicate additional documentation of IDT discussion of client #1's behaviors or how to ensure the safety of client #1's peers. Client #1's BSP (Behavior Support Plan) dated 5/23/13 was updated on 2/7/14 to include additional physical management techniques.</p> <p>Clinical Supervisor (CS) #1 was interviewed on 2/13/14 at 12:07 PM. CS #1 stated, "We are trying to move him, [client #1], out of the house. We are in the process of getting him approved to go to an ESN (extensive special needs) home or [facility] or to the waiver program."</p> <p>CS #1 was interviewed on 2/18/14 at 11:30 AM. CS #1 stated, "[Client #1] has PA (Physical Aggression) and tears up everything. If the clients clean up an area of the house, [client #1] will go through the area and destroy it. He will go after his peers." CS #1 stated, "We had to move him out of being roommates with [client #2] and then [client #3]. [Client #1] makes threats</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>towards [client #2] and [client #3]. It's usually about money or something he wants. He, [client #1], will try to manipulate the other clients to get things and then threaten them if they don't do it."</p> <p>QIDPD #1 (Qualified Intellectual Disabilities Professional Designee) was interviewed on 2/18/14 at 1:51 PM. QIDPD #1 stated, "[Client #1] is disruptive, he will throw things and tear things up in the house." QIDPD #1 stated, "[Client #1] will attack his peers if they get in his way. He instigates and will hit them." When asked if client #1 had injured any of his peers, QIDPD #1 stated, "Yes, he's sent them to the emergency room. I think [client #2] and [client #3]." When asked if clients #2, #3, #4, #5, #6, #7 or #8 were fearful or intimidated by client #1, QIDPD #1 stated, "I don't know if fearful but I would say uncomfortable. Some of the intensity of some of his, [client #1's], behaviors. Throwing things, screaming, threatening and breaking things." When asked how the facility had addressed client #1's behaviors, QIDPD #1 indicated he had assumed responsibility for the home in November 2013. When asked how the facility had addressed client #1's behaviors to protect clients #2, #3, #4, #5, #6, #7 and #8, QIDPD #1</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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 he had conducted two IDT's and the facility was currently in process of moving client #1 out of the home due to his behaviors. When asked if the IDT recommendations or pending transfer had prevented client #1 from hitting or intimidating his peers, QIDPD #1 stated, "No." QIDPD #1 indicated the facility should develop and implement corrective action to prevent further incidents of abuse, neglect or mistreatment. QIDPD #1 indicated the facility utilized the IDT and administrative peer review process upon completion of investigations of incidents of abuse, neglect and mistreatment to develop recommendations for corrective actions.</p> <p>Client #4 was interviewed on 2/18/14 at 4:40 PM. Client #4 stated, "I get along with some of the guys and some not really... like I don't really get along with [client #1]. He's always throwing things or threatening people. We had one fight on the van." When asked if he felt safe in the group home, client #4 stated, "Not really. Not with [client #1]."</p> <p>Client #2 was interviewed on 2/18/14 at 4:45 PM. When asked how things were going in the group home, client #2 stated, "Okay, except [client #1] keeps punching me. I don't feel comfortable</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>with him being around. He's always threatening me. He gets away with it, even when staff are right there. [Client #1] will say things and threaten me but staff don't really hear it. [Client #1] has hit me in the head. He likes to find people's weakness and then hit them there. Mine is my head. [Client #1] has given me like three concussions in the last year. I feel like if I don't do what he asks me to, he will hit me." When asked if he felt safe in the group home, client #2 stated, "No, not with [client #1]. Very uncomfortable."</p> <p>Client #7 was interviewed on 2/18/14 at 4:55 PM. Client #7 indicated he was client #1's roommate. Client #7 stated, "I try to stay away from him, [client #1], I just try to stay in my bed when he's in the room." When asked if he felt safe in the group home, client #7 stated, "Safe? Not when [client #1] is having his behaviors. Not really."</p> <p>Client #5 was interviewed on 2/18/14 at 5:00 PM. Client #5 stated, "Things are going okay here. Except, [client #1]. [Client #1] has hit me and threw a table at me. See I have a scar on my wrist from it." Client #5 indicated client #1 had hit and chased client #7 through the house. Client #5 stated, "[Client #1] chased [client #7] from the garage to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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
W000331	<p>bathroom over here. [Client #1] had a chair and was hitting the door." Client #5 stated, "I think I would be afraid if he threatened me and chased me like that." When asked if he felt safe in the group home, client #5 stated, "Well, that's a tough question. Not really. Not with [client #1] I don't."</p> <p>Direct Care Staff (DCS) #1 was interviewed on 2/18/14 at 5:15 PM. DCS #1 stated, "Everything in the house is going fine except [client #1]. [Client #1] throws tables and tears things up. He threatens the guys and will hit them." When asked if any of the clients were afraid of client #1, DCS #1 stated, "Yes, I know they are." When asked how he knew clients were fearful of client #1, DCS #1 stated, "Every time [client #1] is around they want to stand by me, stay close to me so he, [client #1], can't get them." DCS #1 stated, "I think especially [client #2] and [client #7] are intimidated."</p> <p>9-3-2(a) 483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 sampled clients (#1), the</p>	W000331	CORRECTION: The facility must provide clients with nursing services in accordance with their	03/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227			
(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			
W000336	<p>facility nursing services failed to ensure client #1's laboratory orders were followed.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/18/14 at 9:49 AM. Client #1's Physician's Orders Form (POF) dated 1/30/14 indicated, "Valproic Acid Level every 3 months." Client #1's record indicated client #1 had Valproic Acid levels checked on 1/12/13 and 9/16/13. Client #1's record did not indicate additional documentation of Valproic Acid Level laboratory results.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 2/18/14 at 11:23 AM. LPN #1 indicated client #1's Valproic Acid levels should be checked as ordered. LPN #1 indicated there was not additional documentation of laboratory screenings of client #1's Valproic Acid levels.</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p>		<p>needs. Specifically, the team obtained current Valproic Acid Levels for Client #1. PREVENTION: The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments and testing, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure appropriate medical follow-up takes place as required. Additionally, the Nurse Manager has developed a data base to track facility medical appointments and lab testing and will provide nursing and facility staff with coaching and follow-up to assure that appointments and lab work occur as directed. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227			
(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>Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility failed to ensure the health status of clients #1 and #2 was reviewed on a quarterly basis.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 2/18/14 at 9:49 AM. Client #1's Physician's Orders Form (POF) dated 1/30/14 indicated client #1's diagnoses included but were not limited to PTSD (Post Traumatic Stress Disorder), chronic oppositional defiant disorder, ADHD (Attention Deficit Hyperactivity Disorder), mild intellectual developmental disorder, constipation, hypothyroidism, hypertension, ulcerative colitis, depression, low magnesium level, solitary rectal ulcer syndrome and mood disorder. Client #1's record indicated documentation of nursing review of client #1's health status with physical examination on 8/30/13 and 2/10/14. The review did not indicate additional documentation of nursing review with physical examination.</p> <p>2. Client #2's record was reviewed on 2/18/14 at 11:00 AM. Client #2's POF dated 1/30/14 indicated client #2's diagnoses included but were not limited to mild intellectual developmental</p>	W000336	<p>CORRECTION:Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Specifically, the facility has a new nurse that has been trained on expectations for quarterly nursing physicals and nursing physicals for the current quarter. PREVENTION:Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Additionally, Administrative Team members will review nursing documentation while conducting routine audits in the home, no less than monthly, to assure records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse manager to facilitate appropriate follow-up. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p>	03/22/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G413	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 MCFARLAND RD INDIANAPOLIS, IN 46227
---	--

(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>disorder, ADHD, depression, IED (Intermittent Explosive Disorder), constipation and acne. Client #2's record indicated documentation of nursing review of client #2's health status with physical examination on 8/30/13 and 2/10/14. The review did not indicate additional documentation of nursing review with physical examination.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 2/18/14 at 11:23 AM. LPN #1 indicated nursing physical assessments of clients' health status and medical needs should be conducted on a quarterly basis.</p> <p>9-3-6(a)</p>			