STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G243	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA CORPORATION OF INDIANA	408 N REED ST SOUTH WHITLEY, IN 46787

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for a pre-determined full recertification and state licensure survey. This visit was in conjunction to a post certification revisit to the investigation of complaint #IN00109991 completed on June 22, 2012. Dates of Survey: July 31, August 1, 2012. Facility number: 000766 Provider number: 15G243 AIM number: 100243280 Surveyor: Susan Reichert, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/7/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.			
	Based upon observation, record review and interview, the facility failed to provide sufficient staff to manage the identified behavioral needs of 1 of 4 sampled clients (client #1). Findings include: The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/31/12 at 3:05 PM. A report dated 6/24/12 indicated group home staff called police after client #1 became physically aggressive and was restrained for 10 minutes until police arrived. Client #1 was handcuffed by the police and after police talked to client #1 they released him when calm. A report dated 7/20/12 indicated the police had been called by group home staff after staff attempts to redirect client #1 from physically aggressive behavior failed. The police counseled him and left without taking other action. On 7/27/12, client #1 left	W0186	The facility will provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Additional direct care staff will be available Monday through Friday on 2 nd shift during the week. Client #1 will remain within eyesight of staff when he is outside of the home. House Manager and QMRP will complete weekly active habilitation observations to ensure that there is sufficient direct care staff provided in the home in accordance with client #1's individual program plan. House Manager and QMRP will complete weekly active habilitation observations to ensure client #1 is being kept within eyesight when outside the home.	08/31/2012

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	the group home property and began walking down the street while being followed by staff and picked up a limb and began to swing it at staff. A community member called police. Police handcuffed client #1, counseled him and when he became calm, returned him back to the group home. Observations at the group home were completed on 7/31/12 from 6:41 PM until 7:50 PM. Upon arrival at the group home, client #1 was outside the home without staff, and walked toward the trees in the yard. Staff #2 joined client #1 within a minute. The Qualified Mental Retardation Professional (QMRP), the House Manager (HM), and staff #6, #8, and #11 were present in the home during the observation period. Observations were completed at the group home on 8/1/12 from 6:30 AM until 8:10 AM. Client #1 left the group home without staff being within eyesight at 7:44 AM carrying a radio and a bag. Within a minute the house manager went outside to check on client #1. Client #1 left the group home without being within staff's eyesight at 7:50 AM, and returned within a minute. Client #1 left the group home without staff being within eyesight at 7:53 AM. Staff #7 noticed within a minute client #1 was gone and went outside to			

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	check on him. The QMRP, HM, and staff #8, #7 were present in the home during the observation period. Client #1's record was reviewed on 8/1/12 at 12:05 PM. A Behavior Support Plan revised 7/23/12 included target behaviors of verbal aggression, self injurious behavior, physical aggression, property destruction, and elopement. Interventions for physical aggression and property destruction included removing other people from the area, verbal de-escalation, redirection, verbally blocking, and physical intervention, and "Call police as a last resort: If [client #1] continues to exhibit physical aggression and will not calm down and is becoming a threat to himself or the other men in the home, then call the police ONLY after the above interventions have been followed." Client #1's Individual Support Plan dated 6/22/12 indicated he was able to cross streets safely. The Qualified Mental Retardation Professional (QMRP) was interviewed on 8/1/12 at 10:35 AM. When asked why client #1's plan included the use of calling police, she stated, "Because he is in danger." She indicated staff were trained in managing his behavior, and stated, "He is strong." She indicated on 7/27/12, client #1 crossed a highway and did not			

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	look for cars. When asked if there were adequate staff in the home if client #1 left the home's property, she indicated there were not enough staff if client #1 left the property as client #1 ran quickly. She indicated client #1's behavior changed rapidly when he encountered the police, and he became more compliant. She stated, "We are trying to get more staff." The QMRP was interviewed again on 8/1/12 at 11:16 AM and indicated client #1 does possess the skills to cross the street safely, but fails to use them when upset. She stated, "I can't manufacture a large amount of staff to be able to control him." 9-3-3(a)			

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based upon observation, record review and interview, the facility failed to implement objectives as written in his plan for 1 of 4 sampled clients (client #1). Findings include: Observations at the group home were completed on 7/31/12 from 6:41 PM until 7:50 PM. Upon arrival at the group home, client #1 was outside the home without staff, and walked toward the trees in the yard. Staff #2 joined client #1 within a minute. Observations were completed at the group home on 8/1/12 from 6:30 AM until 8:10 AM. Client #1 left the group home without staff being within eyesight at 7:44 AM carrying a radio and a bag. Within a minute the house manager went outside to check on client #1. Client #1 left the group home without being within staff's eyesight at 7:50 AM, and returned within a minute. Client #1 left the group home	W0249	The facility will ensure that as soon as the interdisciplinary team has formulated a client's individual program plan, each client will receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Client #1 will remain within eyesight of staff when he is outside of the home. Staff will be retrained on client #1's level of supervision by 8/31/12. House Manager and QMRP will complete weekly active habilitation observations to ensure client #1 is being kept within eyesight when outside the home.	08/31/2012

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	without staff being within eyesight at 7:53 AM. Staff #7 noticed within a minute client #1 was gone and went outside to check on him. Client #1's record was reviewed on 8/1/12 at 12:05 PM. A Lifestyle Plan dated 6/22/12 indicated client #1 was to be supervised every 15 minutes while in his home and within eyesight in his yard and in the community. Client #1's Behavior Support Plan updated 7/23/12 indicated a target behavior of elopement. The QMRP was interviewed on 8/1/12 at 10:35 AM and indicated client #1 was supposed to be within eyesight of staff. 9-3-4(a)			