PRINTED:	08/06/2020
FORM API	PROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(EACH DEFICIEN	INDIANA STATEMENT OF DEFICIENCIE	1222	ET ADDRESS, CITY, STATE, ZIP COD	
(EACH DEFICIEN			ANAPOLIS, IN 46219	
	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
#IN00322549. This	visit included a Covid-19	W 0000		
and state deficienci are cited at: W153 a	es related to the allegation(s) and W154.			
Dates of Survey: Ju and 7, 2020.	ne 24, 25, 29, 30, and July 1, 2,			
Provider Number: 1	5G494			
accordance with 46	0 IAC 9.			
The facility must e mistreatment, neg injuries of unknow immediately to the	ensure that all allegations of elect or abuse, as well as on source, are reported e administrator or to other			
Based on record rev investigations revie report an allegation involving clients A to BDDS (Bureau c	view and interview for 1 of 4 wed, the facility failed to of client mistreatment and D to the administrator and f Developmental Disabilities	W 0153	allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, reported immediately to the administrator or to other offi in accordance with State law	are icials
	 #IN00322549. This focused infection can be complaint #IN0032 and state deficiencies are cited at: W153 and state deficiencies are cited at: W153 and 7, 2020. Facility Number: 000 Provider Number: 1000 Provider Number: 1000 Provider Number: 1000 These deficiencies accordance with 46 Quality Review of 1 on 7/20/20. 483.420(d)(2) STAFF TREATMET The facility must emistreatment, neglinguries of unknow immediately to the officials in accordate stablished proce Based on record revinvestigations revier report an allegation involving clients A to BDDS (Bureau of Services) in accordate stablished proces) in accordate stables in condate stables and the services of the services	 Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/20/20. 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 4 investigations reviewed, the facility failed to report an allegation of client mistreatment involving clients A and D to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law. Findings include: 	 #IN00322549. This visit included a Covid-19 focused infection control survey. Complaint #IN00322549: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at: W153 and W154. Dates of Survey: June 24, 25, 29, 30, and July 1, 2, and 7, 2020. Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/20/20. 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 4 investigations reviewed, the facility failed to report an allegation of client mistreatment involving clients A and D to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law. Findings include: 	 #IN00322549. This visit included a Covid-19 focused infection control survey. Complaint #IN00322549: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at: W153 and W154. Dates of Survey: June 24, 25, 29, 30, and July 1, 2, and 7, 2020. Facility Number: 001008 Provider Number: 105494 AIMS Number: 100245080 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/20/20. 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 4 investigations reviewed, the facility failed to report an allegation of client mistreatment involving clients A and D to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with state law.

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

TITLE

(X6) DATE

Any define cystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 07/07/2020 15G494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1222 N BOLTON AVE VOCA CORPORATION OF INDIANA INDIANAPOLIS. IN 46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The facility's BDDS (Bureau of Developmental Specifically, staff assigned to Disabilities Services) reports were reviewed on complete investigations will be 6/24/20 at 10:41 AM. retrained regarding required reporting allegations that emerge A BDDS report dated 3/30/20 indicated, "...On during the course of investigating 3/29/20, [client A] and [client D] informed staff other incidents and allegations. that they had a consensual intimate sexual **PREVENTION:** encounter in [client A's] bedroom."... The Quality Assurance Manager and the QIDP Manager will An IS (Investigative Summary) dated 4/3/20 carefully review all incidents indicated the following: reported by the facility and outside entities, to assure that allegations -"...Investigative Summary...". and other required incidents are reported to the Bureau of -"...Date(s) of Investigation 3/29/20 - 4/3/20...". **Developmental Disabilities** Services as required by state law. -" Introduction " Each day, QIDP Manager or designee will compile a list of -"On 3/29/20, Individual [client A] and Individual incidents requiring reports to the [client D] informed staff that they had a Bureau of Developmental consensual intimate sexual encounter in [client Disabilities Services, and A's] bedroom...". distribute the list to administrative staff (including the Quality -"...Summary of Interviews ... ". Assurance Manager, Program Managers, Quality Assurance -"...[Staff #1], DSP (Direct Support Coordinators, Operations Professional):...". Manager, Area Supervisors, QIDP, Nurse Manager and Assistant -"...[Client A] came to staff and complained that Nurse Manager) for review and [client D] had been blackmailing and forcing him revision, as needed. The QIDP for sexual favors ... ". Manager or designee will assign reporting responsibilities daily. A review of the IS dated 4/3/20 indicated client A Additionally, The QIDP Manager and client D had a consensual intimate encounter and Quality Assurance Manager on 3/29/20. The review indicated client A will review investigation summary indicated to staff #1 a complaint regarding client D drafts to assure all allegations are had been blackmailing and forcing him (client A) reported as required. for sexual favors. The review did not indicate Supervisory staff will review all further questioning into the accusation made by facility documentation to assure client A. The review did not indicate the allegation incidents are reported as required.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/07/2020 15G494 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1222 N BOLTON AVE VOCA CORPORATION OF INDIANA INDIANAPOLIS, IN 46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE if he is allowed in others room ... ". Client A was interviewed on 6/30/20 at 11:47 AM. Client A was asked about the incident on 3/29/20 between he (client A) and client D. Client A stated, "Yes, it was consensual. [Client D] had been asking me several times so I just gave in and said yes. We did it and that was it." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/1/20 at 9:31 AM. QIDP #1 was asked if the facility had documentation of a reported allegation of blackmailing and forcing sexual favors involving clients A and D. QIDP #1 stated, "No, we should have." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 7/1/20 at 11:52 AM. QIDPM #1 asked if the facility had documentation of a reported allegation of blackmailing and forcing sexual favors involving client A and D. QIDPM #1 stated, "No, we should have looked into it more." This federal tag relates to complaint #IN00322549. 9-3-2(a) W 0154 483.420(d)(3) STAFF TREATMENT OF CLIENTS Bldg. 00 The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 4 W 0154 CORRECTION: 08/06/2020 allegations of client mistreatment reviewed, the The facility must have evidence facility failed to complete a thorough investigation that all alleged violations are into an incident of peer to peer aggression thoroughly investigated. involving clients A, B, and C and an allegation of Specifically: All facility investigations will be completed by client mistreatment involving clients A and D. trained investigators. The facility G61H11 Event ID: Facility ID: 001008 Page 4 of 8 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE C	ONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G494		A. BUILDING 00			COMPLETED		
		B. WING			07/07	7/2020	
			s	TREET	ADDRESS, CITY, STATE, ZIP COD		
IAME OF	PROVIDER OR SUPPLIE	R			BOLTON AVE		
OCA C	CORPORATION OF	INDIANA	1	NDIAN	IAPOLIS, IN 46219		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	Findings include:				must have evidence that all		
					alleged violations are thorough	nly	
		S (Bureau of Developmental			investigated. Specifically:		
	Disabilities Servic			All facility investigations will be	;		
	6/24/20 at 10:41 A	.M.			completed by trained		
				investigators. Investigation for			
	1. A BDDS report			will include but not be limited t			
	3/12/20, during tra			interviewing all potential witne			
	while [client A] wa			and comparing documentary a			
	father, he (client A			testimonial evidence to identify			
	B] talking about hi			and clarify discrepancies, and	the		
	his seat and punch			need to expand the scope of			
	right hand. The two			investigations when new			
	causing staff to put			allegations emerge. Copies of			
	separate them. Stat			investigations will be maintaine	ed		
	separate them after			by the Quality Assurance			
	-	he house, [client C] began			Department to be available for		
		on the floor of the van. Staff			review, as required.		
	successfully separa			The agency's trained investiga	itors		
	assessed both cons			will receive additional training			
	and discovered [cl			regarding investigation timelin			
	lacerations on the			and components of a thorough			
		he exited the van. [Client B]			investigation, including weekly		
		ggressive towards staff and			face to face training and follow	/-up	
	-	hey arrivedhe (client B) was			with the Quality Assurance		
		ne of hospital] for a 24-hour			Manager. The training will include		
		oral issues. [Client C] was			but not limited to assuring that		
		ne of hospital] for a complete			applicable demonstrative evide		
		tending physician diagnosed			is evaluated. The emphasis of		
		eial laceration, initial encounter			training will be development of		
		and released him to ResCare			appropriate scope, conclusion	5,	
		orders[Client B] remains in the			and recommendations for		
	nospital with a pro	jected release on 3/13/20".			corrective and protective		
	A marrier - Cult. Th	DDC			measures. The QIDP Manage		
		DDS report dated 3/13/20			provide weekly follow-up to the		
		B, and C were involved in a			Manager regarding progress of	n	
	· ·	ation in the company van. The			current investigations.		
		lient B was transported to the			PREVENTION:		
	· ·	bur hold with a projected release			The QIDP Manager will mainta		
	from hospital date			tracking spreadsheet for incide	ents		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		15G494	B. WING			07/07/2020		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	t			BOLTON AVE			
	ORPORATION OF	ΙΝΠΙΔΝΔ			IAPOLIS, IN 46219			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		to the hospital on $3/12/20$ and			requiring investigation, follow-	•		
	diagnosed and relea	used on the same date.			and corrective/protective mea			
					will be maintained and distribution			
		e Summary) dated 3/20/20			daily to facility supervisors an			
	indicated the follow	ving:			Operations Team, comprised	of		
					the Operations Managers,			
	-"Investigative Su	immary".			Program Managers, Area			
					Supervisors, Nurse Manager,			
	-"Date(s) of Inves	stigation 3/12/20 - 3/19/20"			Registered Nurse, Quality			
	NT - 1 - 1 N				Assurance Manager, Quality			
	-"Introduction."				Assurance Coordinators, and			
	"O 0/10/00 1 ·				QIDP. The Quality Assurance			
	-"On 3/12/20, during transport on the company van, while [client A] was on the telephone with his father, he (client A) believed he overheard [client B] talking about him. [Client A] turned			Manager will meet with his/he	r QA			
				Department investigators as				
				needed but no less than week				
					review the progress made on			
		nd punched [client B] in the			investigations, review incident			
	-	and. The two individuals			and assign responsibility for n	ew		
		ing staff to pull over to the			incidents/issues requiring			
	side of the road to s	-			investigation. QA team memb			
		le to separate them after			will be required to attend and	-		
	·	redirection. After arriving to			an in-service documentation a			
	-] began choking [client B] on			these meetings stating that th	-		
	the two consumers.	Staff successfully separated			are aware of which investigati			
					with which they are required t			
	consumers for any bodily injuries and discovered [client B] had 3- 1/2 inch lacerations on the right				conduct, as well as the specif			
		ient C] (sic) a 1- inch laceration			components of the investigation			
	-	eft eye, 2 bite marks on his			which they are responsible, w the five-business day timefrar			
		inch superficial lacerations on			The QA Manager will review t			
	-	called 911 as he exited the van.			results of these weekly meeting			
		verbally aggressive towards the			with the Executive Director to	iyə		
		cers as they arrivedhe (client			assure appropriate follow thro	uah		
	-	to [name of hospital] for a			occurs.	agn		
		behavioral issues. [Client C]			The Quality Assurance Manag	her		
		name of hospital] for a			and QIDP Manager will develop	-		
		1The attending physician			training template to assist	-		
	-] with Facial laceration, initial			investigators with developing	а		
		wound,and released him to			sufficient scope to investigation			
	ResCare staff with	-			of peer to peer aggression, fa			
						-		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G494	A (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/07/2020	
	PROVIDER OR SUPPLIE		1222 N	ADDRESS, CITY, STATE, ZIP CO NBOLTON AVE NAPOLIS, IN 46219	DD	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE PPROPRIATE	(X5) COMPLETIC DATE
	to being in the hos -"[Client C] was u to being in the hos -"[Client A] was u due to being in the incident". 2. A BDDS report 3/29/20, [client A] that they had a cor encounter in [client An IS (Investigative indicated the follor -"Investigative S -"Date(s) of Invection." -"Introduction." -"On 3/29/20, Indi [client D] informed consensual intimat A's] bedroom". -"[Staff #1], DSI Professional):". -"[Client A] cam [client D] had been for sexual favors	nable to provide a statement due pital." nable to provide a statement hospital for an unrelated dated 3/30/20 indicated, "On and [client D] informed staff isensual intimate sexual at A's] bedroom." we Summary) dated 4/3/20 wing: fummary". estigation 3/29/20 - 4/3/20". vidual [client A] and Individual d staff that they had a te sexual encounter in [client iterviews". P (Direct Support the to staff and complained that n blackmailing and forcing him		resulting in injury, injuri unknown origin and elo The Quality Assurance and QIDP Manager will investigations to ensure are thorough –meeting and operational standar RESPONSIBLE PARTI Area Supervisor, Resid Manager, Direct Suppo Operations Team, Regi Director	pement. Manager spot check that they regulatory rds. ES: QIDP, ential rt Staff,	
	A review of the IS	dated 4/3/20 indicated client A				

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