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prevent verbal abuse by staff both in the presence of and directed at the individuals in the group home.mistreatment, neglect or abuse of the client. Specifically: the employment of the direct support staff responsible for substantiated verbal abuse has been terminated.Findings include:Observations were conducted at the group home on 7/6/21 from 2:45 PM through 5:40 PM andPREVENTION: An Area Supervisor or Residential					implement written policies and	d	
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home. employment of the direct support staff responsible for substantiated verbal abuse has been terminated. Observations were conducted at the group home on 7/6/21 from 2:45 PM through 5:40 PM and PREVENTION: An Area Supervisor or Residential		-				se of	
Findings include: staff responsible for substantiated verbal abuse has been terminated. Observations were conducted at the group home on 7/6/21 from 2:45 PM through 5:40 PM and PREVENTION: An Area Supervisor or Residential			the individuals in the group				
Findings include: verbal abuse has been terminated. Observations were conducted at the group home on 7/6/21 from 2:45 PM through 5:40 PM and PREVENTION: An Area Supervisor or Residential		nome.					
Observations were conducted at the group home on 7/6/21 from 2:45 PM through 5:40 PM and PREVENTION: 7/7/21 from 2:45 PM through 5:40 PM and An Area Supervisor or Residential		Findings include:				ated	
Observations were conducted at the group home PREVENTION: on 7/6/21 from 2:45 PM through 5:40 PM and An Area Supervisor or Residential		i manigo metude.					
on 7/6/21 from 2:45 PM through 5:40 PM and An Area Supervisor or Residential		Observations were	e conducted at the group home				
					-	ntial	
			-		Manager will be present,		

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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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G814	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 07/09/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA		CASTLETON BLVD NAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	DEOLUDEDIS DI AN OF CORDECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLET	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	Clients A, B, C, E	and G were observed		supervising active treatment		
	throughout the obs	servation periods. On 7/6/21 at		during no less than five active		
	2:45 PM RM (Res	idential Manager) #1 was		treatment sessions per week,	on	
	sitting in the front	seat of the group home's van.		varied shifts to assist with and	1	
	RM #1 was talking	g on the telephone. At 2:46		monitor skills training, includin	ng	
	PM, RM #1 let the	surveyor into the group		but not limited to assuring an		
	home. At 2:55 PM	clients E, G and H were		environment free from abuse,		
	outside smoking c	igarettes. Staff #1 was outside		neglect, exploitation and		
	on the patio super-	vising clients E, G and H. At		mistreatment. For the next 30		
	3:04 PM, AS (Are	a Supervisor) #1 and staff #2		days, members of the Operati	ions	
	arrived at the grou	p home. At 3:07 PM AS #1		Team (comprised of the Exec	utive	
	asked staff #1 to "	clock out" and after a		Director, Operations Manager	S,	
	conversation with	AS #1, staff #1 left the group		Program Managers, Quality		
	home.			Assurance Manager, QIDP		
				Manager, QIDP, Quality		
	The facility's BDE	OS (Bureau of Developmental		Assurance Coordinators, Area	a	
	Disabilities Servic	es) reports and investigations		Supervisors, Nurse Manager	and	
	were reviewed on	7/7/21 at 9:49 AM.		Assistant Nurse Manager) will	l l	
				conduct administrative monito	pring	
	1. A BDDS report	dated 6/23/21 indicated, "		during varied shifts/times, no		
	-	t A] became upset with staff.		than twice weekly. After 30 Da	ays,	
		t staff and threatened to hit		administrative monitoring will		
		of wood. [Client A] then walked		occur no less than weekly unt		
	outside where he u	used the wooden stick to hit a		staff demonstrate competence	e.	
		repeatedly and attempted to		After this period of enhanced		
		Staff attempted unsuccessfully		administrative monitoring and		
	-	edirection, but [client A]		support, the Executive Director	or	
		ate. Staff contacted the		and Regional Director will		
	-	ere instructed to call 911		determine the level of ongoing		
		ces) for assistance. Police		support needed at the facility.		
		lence and spoke with [client A]		Administrative Monitoring is		
		veral minutes, staff		defined as follows:		
	-	ed [client A] to another area		• The role of the		
		he was able to calm himself.		administrative monitor is not		
	The police left wit	hout further action".		simply to observe & Report.		
				• When opportunities for		
		BDDS report dated 6/23/21		training are observed, the mo	nitor	
		became agitated, threatened		must step in and provide the		
	-	a staff member's vehicle. The		training and document it.		
	review indicated t	he staff member involved in the		 If gaps in active treatment 	ent	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G814	B. WING	07/09/20		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
				CASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA	INDIA	NAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLET	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	incident was staff #	#3.		are observed the monitor is		
				expected to step in, and mode		
	-	dated 7/1/21 indicated, " On		appropriate provision of suppo	rts.	
		ative staff received a report		Assuring the health and		
		staff [staff #3], yelled, used		safety of individuals receiving		
		e disrespectful remarks about		supports at the time of the		
		of [client C], [client G], [client		observation is the top priority.		
		Staff #3] was suspended		· Review all relevant		
		ion and the Executive Director		documentation, providing		
	was notified Res	Care's investigation into the		documented coaching and		
	allegations is ongo	ing and [staff #3] will remain		training as needed		
	suspended pending	the outcome".		Administrative support at the h	ome	
				will include but not be limited to	D I	
	-A review of the B	DDS report dated 7/1/21		assuring an environment free f	rom	
	indicated an allega	tion of verbal abuse was made		abuse, neglect, exploitation, ar	nd	
	regarding staff #3.	The review indicated the		mistreatment.		
	facility's investigat	ion into an allegation of verbal		RESPONSIBLE PARTIES: QI	DP,	
	abuse by staff #3 v	vas ongoing.		Area Supervisor, Residential		
				Manager, Direct Support Staff,		
	Client B was non-v	verbal and was not able to be		Operations Team, BDDS		
	interviewed.			Generalist, Regional Director		
	Client A was inter-	viewed on 7/7/21 at 7:00 AM.				
		l if he had observed staff #3				
		at him, in front of him or the				
		t A stated, "I got into it with				
		uple of times because he's got				
		ient A was asked if staff #3's				
		him. Client A stated, "Yes, I				
	-	ng and hit his car window and				
		l up a stick." Client A was				
		the had observed the incident.				
	Client A stated, "I					
	Client C was inter	viewed on 7/6/21 at 3:41 PM.				
		l if he had observed staff #3				
	-	front of client B. Client C				
		think so. I may have forgot."				
		l if he had observed staff #1				
	yell or curse in the	group home on 7/6/21. Client				

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 15G814 B. WING 07/09/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8307 CASTLETON BLVD VOCA CORPORATION OF INDIANA INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C stated, "I saw it. We're not supposed to go in the office. [Staff #1] got mad at her (RM #1). That's when she (staff #1) cussed out [RM #1]." Client C was asked if staff's yelling had made him nervous. Client C stated, "No, I just was sort of shocked that she (staff #1) did that." Client E was interviewed on 7/6/21 at 4:01 PM. Client E was asked if he had heard staff #1 and RM #1 arguing on 7/6/21. Client E stated, "I didn't hear anything that was said, no." Client E was asked if he had observed staff #3 yell and curse at/in front of client B. Client E stated, "Sometimes, not all the time. I think he (client B) was trying to get in the refrigerator." Client E was asked if staff's yelling had made him nervous. Client E stated, "Sometimes, yeah it makes me nervous." RM #1 was interviewed on 7/6/21 at 3:09 PM. RM #1 was asked why staff #1 had been sent home from the group home. RM #1 stated, "She (staff #1) said '[expletive] you. She (staff #1) said I'll call [OM (Operations Manager)] #1 for you." RM #1 was asked if any of the clients were present when staff #1 was yelling/cursing. RM #1 stated, "[Client E], [client G] and [client C], they were having their lunch. They were all there." RM #1 was interviewed a second time on 7/6/21 at 5:10 PM. RM #1 was asked if she received a report staff #3 was cursing in front of the clients. RM #1 stated, "Yes I heard him (staff #3) cursing, he was talking to [AS #1]." AS #1 was interviewed on 7/6/21 at 4:11 PM. AS #1 was asked who had notified her regarding an incident between RM #1 and staff #1. AS #1 stated, "[RM #1] called [AS #2] and [RM #1] put FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: I6W211 Facility ID: 010453 If continuation sheet Page 4 of 7

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08/09/2021

	NT OF DEFICIENCIES	V1) DDOVIDED (CUDDUTED /CUTA	(\mathbf{V}_{2}) MIT T	IDI E CONT	STRUCTION	(V) DATE	CUDVEN	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G814	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			COMP	(X3) DATE SURVEY COMPLETED 07/09/2021	
NAME OF	PROVIDER OR SUPPLIEF	ι			DRESS, CITY, STATE, ZIP CODE			
VOCA	ORPORATION OF	INDIANA			STLETON BLVD POLIS, IN 46256			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECT	ON	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX AG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE DPRIATE	COMPLETI DATE	
	heard [RM #1] say then she (staff #1) s you,' and I could he them in the backgro present." AS #1 wa curse in front of the course not. That's a asked if she was pro- front of clients B, C was here to do a sit (Bowel Movement) came up to me and himself].' Thirty mi called me and said J himself again and 'I cleaning up [explet: (staff #3) yelling ar was talking to me (clients were around QIDPM (Qualified Professional Manag 7/7/21 at 1:39 PM. facility had substan cursed in the preser #1 stated, "I don't s it. I think we're goin why staff #1 was su #1 stated, "She alleg profanity towards h of some individuals staff should argue a individuals. QIDPM tense environment i QIDPM #1 indicate prevention of abuse should be implement	Intellectual Disabilities ger) #1 was interviewed on QIDPM #1 was asked if the tiated staff #3 had yelled and nee of the individuals. QIDPM ee how we can't substantiate ag to." QIDPM #1 was asked aspended on 7/6/21. QIDPM gedly yelled and used er supervisor in the presence s." QIDPM #1 was asked if and curse in front of the A #1 stated, "No it creates a in their home." ed the facility's policy on the e, neglect and mistreatment						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G814	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		СОМ 07/С	(X3) DATE SURVEY COMPLETED 07/09/2021	
	PROVIDER OR SUPPLIE		8	FREET ADDRESS, CITY, STATE, ZIP 307 CASTLETON BLVD	CODE		
VOCA C	ORPORATION OF	INDIANA		IDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	II PRE TA	PROVIDER'S PLAN OF CO	SHOULD BE	(X5) COMPLETION DATE	
	Abuse, Neglect, E 7/10/19 indicated, advocate for the ri individuals. All all abuse, neglect and to the appropriate appropriate superv thoroughly investi ADEPT, ResCare guidelines "Emo to provide goods a the individual to a provide the suppon psychological and meet the basic nee shelter, clothing an environment." "Program interven implement a suppo application of inte qualified person no 9-3-2(a)	I at 12:30 PM. The facility's exploitation policy revised on "Policy: Adept staff actively ghts and safety of all egations or occurrences of exploitation shall be reported authorities through the isory channels and will be gated under the policies of and local, state and federal tional/physical neglect: failure nd/or services necessary for void physical harm. Failure to t necessary to an individual's social well being. Failure to d requirements such as food, and to provide a safe					
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SEF	VICES provide or obtain preventive					
	and general med Based on record re sampled clients (A ensure clients A an examinations. Findings include: 1. Client A's recort 12:25 PM. Client A		W 0322	2 CORRECTION: The facility must prov preventive and gener care. Specifically, the obtain annual physica examinations for clier A review of facility me documentation indica deficient practice did additional clients.	al medical facility will al hts A and B. edical ted this	08/08/202	

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G814		A. BUILDING B. WING	00	COMPLETED 07/09/2021	
JAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE		
				ASTLETON BLVD		
/OCA C	ORPORATION OF	INDIANA	INDIAN	NAPOLIS, IN 46256		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		iew did not indicate		PREVENTION:		
		a current annual physical		• The Facility nurse will		
	examination in clie	ent A's record.		complete monthly audits of all		
				charts and turn in the audits to	o the	
		d was reviewed on 7/7/21 at		Nurse Manager for review.		
		B's record indicated		The Nurse Manager wil		
		an annual physical examination		review issues revealed in audi		
		view did not indicate		with the Executive Director an	a	
		a current annual physical		Department heads weekly for		
	examination in clie	ent B's record.		follow-up. • The Executive Director	and	
	OIDPM (Qualified	I Intellectual Disabilities		will follow-up with the Nurse	anu	
		ger) #1 was interviewed on		Manager as needed to addres	e	
		. QIDPM #1 indicated the		issues raised through audits,		
		ve documentation of current		incident reports or other conce	erns	
	-	aminations for clients A and B.		brought to management attent		
	0.2.(())			Manahana af tha Onevetiana Tr		
	9-3-6(a)			Members of the Operations Te	eam	
				comprised of the Executive	<u> </u>	
				Director, Operations Managers Program Managers, Quality	5,	
				Assurance Manager, QIDP		
				Manager, QIDP, Quality		
				Assurance Coordinators, Area	1	
				Supervisors, Nurse Manager a		
				Assistant Nurse Manager) and		
				nursing staff will incorporate		
				medical chart reviews into the	ir	
				formal audit process, which wi	ill	
				occur no less than monthly to		
				assure that medical follow-alo	-	
				including but not limited to anr		
				physical examinations take pla	ace	
				as required.		
				RESPONSIBLE PARTIES: QI	DP,	
				Area Supervisor, Residential		
				Manager, Heath Services Tea		
				Direct Support Staff, Operation	ns	
				Team, Regional Director		

FORM CMS-2567(02-99) Previous Versions Obsolete

l6W211 Facility ID: 010453

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