This visit was for a recertification and state licensure survey.

Dates of Survey: April 24, 25, 26, 27, 30 and May 1, 2018.

Facility Number: 000961
Provider Number: 15G447
AIMS Number: 100244750

These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/15/18.

### 483.420(b)(1)(i) CLIENT FINANCES

The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3, #4), the facility failed to assure a full and complete accounting of client #1, #2, #3 and #4's expenditures/purchases.

Findings include:

1. Client #1's financial record was reviewed on 4/26/18 at 9:55 AM. Client #1's RFMS (Resident Fund Management Service) form dated 1/25/18 to 4/2/18 indicated client #1 had a balance for $1032.37 on 4/2/18. The review indicated an incomplete record of client #1's funds from 1/25/18 to 4/2/18. There was no documentation of client #1's current cash balance.

### CORRECTION:

The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Specifically, for clients #1 and #4 and three additional clients, #5 - #8, personal financial ledgers will be updated by the Residential Manager and reviewed by the Area Supervisor and certified as accurate per facility protocol. A new Residential Manager is in place and will receive detailed training and will maintain an up to date system.

Laboratory Director's or provider/supplier representative's signature: [Signature]

Title: [Title]

(Date)
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 15G447

DATE SURVEY COMPLETED: 05/01/2018

NAME OF PROVIDER OR SUPPLIER: VOCAR CORPORATION OF INDIANA
STREET ADDRESS, CITY, STATE, ZIP CODE: 4114 KNOLLTON RD, INDIANAPOLIS, IN 46228

SUMMARY STATEMENT OF DEFICIENCY:

2. Client #2's financial record was reviewed on 4/26/18 at 9:55 AM. Client #2's RFMS (Resident Fund Management Service) form dated 1/25/18 to 4/23/18 indicated client #2 had a balance for $1270.07 on 4/23/18. The review indicated an incomplete record of client #2's funds from 1/25/18 to 4/23/18. There was no documentation of client #2's current cash balance.

3. Client #3's financial record was reviewed on 4/26/18 at 9:55 AM. Client #3's RFMS (Resident Fund Management Service) form dated 1/25/18 to 4/23/18 indicated client #3 had a balance for $1807.44 on 4/23/18. The review indicated an incomplete record of client #3's funds from 1/25/18 to 4/23/18. There was no documentation of client #3's current cash balance.

4. Client #4's financial record was reviewed on 4/26/18 at 9:55 AM. Client #4's RFMS (Resident Fund Management Service) form dated 1/25/18 to 4/2/18 indicated client #4 had a balance for $1099.97 on 4/2/18. The review indicated an incomplete record of client #4's funds from 1/25/18 to 4/2/18. There was no documentation of client #4's current cash balance.

QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 4/26/18 at 12:15 PM. QIDP #1 was asked if she had documentation of client #1, #2, #3 and #4's current cash balance and purchase receipts. QIDP #1 stated, "No, the ledgers were not completed. House Manager had receipts but no ledgers."

9-3-2(a)

date ledger to track purchases for all clients. All staff will assure that clients provide receipts for purchases as appropriate and the Residential Manager will maintain copies of receipts for purchases recorded on the ledgers.

PREVENTION:
The Residential Manager will maintain responsibility for maintaining client financial records and the Area Supervisor will audit these records no less than weekly. All staff will be retrained regarding the need to assist clients with budgeting and collecting receipts, with appropriate accompanying documentation. The Area Supervisor will turn in client financial records to the Business Manager no less than monthly for review and filing. Additionally, members of the Operations Team comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators, will include audits of client finances as part of an ongoing facility audit process. Operations Team audits will occur weekly until all staff and supervisors demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and
### Statement of Deficiencies and Plan of Correction

**Identification Number:** 15G447  
**Date Survey Completed:** 05/01/2018

**Name of Provider or Supplier:** VOCA CORPORATION OF INDIANA  
**Street Address, City, State, Zip Code:** 4114 KNOLLTON RD, INDIANAPOLIS, IN 46228

<table>
<thead>
<tr>
<th>ID</th>
<th>Summary Statement of Deficiency</th>
<th>Prefix</th>
<th>Tag</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>W 0153</td>
<td>STAFF TREATMENT OF CLIENTS</td>
<td>Bldg. 00</td>
<td>483.420(d)(2)</td>
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<td>support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. Administrative support will include assuring a complete and accurate accounting of client finances is present.</td>
<td>05/31/2018</td>
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<td>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.</td>
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<td>Based on record review and interview for 2 of 26 allegations of abuse, neglect and mistreatment reviewed, the facility failed to immediately report to the facility's administrator regarding an allegation of staff neglect, a fall with significant injury to client #1 and an incident regarding an infection to client #2 which resulted in a hospitalization.</td>
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<td>Findings include:</td>
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<td>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/25/18 at 12:19 PM.</td>
<td></td>
<td>1. A BDDS report dated 12/16/17 indicated on</td>
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12/15/17, "...Staff (staff #3) observed [client #1] fall forward while getting up from a rocking chair, causing her to hit her mouth on the floor. The [Agency] nurse was notified and [client #1] was assessed and diagnosed with fractured teeth. The [urgent care] physician referred [client #1] to [Dental Practitioner] where she (client #1) had two teeth extracted...".

-A review of the BDCC report dated 12/16/17 indicated staff #3 observed client #1 fall. The review indicated client #1 sustained 2 fractured teeth from the fall which resulted in 2 teeth being extracted from client #1. The review did not indicate when staff #3 reported client #1's fall with injury. The review did not indicate if staff #3 reported client #1's fall with injury to the facility's administrator immediately.

-A FR (Final Report) dated 12/15/17 to 12/22/17 indicated, "...Summary of Evidence: How did the injury occur? [Client #1] was observed falling forward while getting up from her rocking chair in her bedroom...".

-"...(CWSF) Confidential Witness Statement Form Date: 12/18/17...Interviewee: [Staff #3]...Interviewer: Within the past 24 hours did you see [client #1] falling, walking or running into any objects outside or inside the home? Interviewee (staff #3): Yes, she fell while getting up from her chair... Interviewer: Where did you document what you saw/discovered? Interviewee (staff #3): Progress notes. When did you document what you saw/discovered? Interviewee: Who did you contact regarding what you observed/discovered and when did you tell them? Interviewee (staff #3): I (staff #3) told [staff #2] when she came in."
- A review of the CWSF by staff #3 dated 12/18/17 indicated he observed client #1 fall when she got up from her chair. The review did not indicate staff #3 notified the administrator or the nurse regarding client #1’s fall with significant injury. The review indicated staff #3 informed staff #2 when staff #2 came into the group home to start her shift.

"(CWSF) Confidential Witness Statement Form Date: 12/18/17... Interviewee (staff #2): [staff #3] told me he (staff #3) saw [client #1] fall forward while getting up from her chair. Interviewer: When did you document what you saw/discovered? Interviewee (staff #2): After I (staff #2) was informed... Interviewer: Who did you contact regarding what you observed/discovered and when did you tell them? Interviewee (staff #2): [RN (Registered Nurse #1), after I (staff #2) was informed."

- A review of the CWSF by staff #2 dated 12/18/17 indicated staff #2 indicated staff #3 had told her (staff #2) client #1 had fallen while getting up from her chair. The review indicated staff #2 notified the facility nurse when staff #2 was informed by staff #3 regarding client #1’s fall with significant injury. The review did not indicate staff #3 immediately notified the facility’s administrator regarding client #1’s fall with significant injury.

"...Conclusions: Evidence substantiates that consumer [client #1] did cause injury to him/herself...".

A review of the FR dated 12/22/17 indicated the investigation substantiated client #1 had injured herself from a fall. The review did not indicate staff #3 reported/notified the facility’s administrator immediately regarding client #1’s fall.
2. A BDDS report dated 3/9/18 indicated, "[Client #2] complained of pain on her right thigh to the residential manager. Upon assessment of [client #2's] thigh, a cyst was discovered on [client #2's] left, posterior upper leg. The [agency] nurse was notified and instructed staff to take [client #2] to [urgent care]. After being assessed at [urgent care], [client #2] was referred to the [Area] Hospital Emergency Department where she (client #2) was assessed and diagnosed with sepsis. [Client #2] was hospitalized so a surgical procedure could be conducted to drain the fluid in the affected area...".

A review of the BDDS report dated 3/9/18 indicated client #2 complained of pain in her left leg. The review indicated client #2 was hospitalized due to an infected cyst on her left leg. The review did not indicate for how long client #2 had the cyst before client #2 notified staff regarding the cyst to her left leg.

An FR dated 3/9/18 to 3/16/18 indicated 3 staff members were interviewed for the investigation: Staff #2 was interviewed on 4/25/18 at 8:51 AM. Staff #2 was asked if she was working when client #1 fell on 12/15/17. Staff #2 stated, "I (staff #2) discovered it when I came in the morning, between 6 am and 7 am. At that time she (client #1) was very much mobile. She (client #2) happened to be walking towards the kitchen. that's when I (staff #2) noticed her mouth was bloody. I (staff #2) applied pressure, it was pretty bad. I called the nurse. At the time there was 2 people (staff) on duty and they were giving showers. I'm not sure what happened in the gap between when it happened."
Staff #2, Staff #3 and RM (Resident Manager #1).

The FR dated 3/16/18 Conclusion indicated, "Evidence substantiates that consumer (client #2) did practice good personal hygiene techniques. Evidence substantiates that consumer (client #2) does have a history of skin infection and AHRP (Agency High Risk Protocol) in place which staff followed."

The FR dated 3/16/18 concluded client #2 practiced good personal hygiene and bathing and staff followed client #2's AHRP properly. The review did not indicate staff #5 was interviewed for the investigation dated 3/16/18.

A CAPN (Community Alternatives Progress Note) dated 3/7/18 and documented by staff #5 indicated, "[Client #2] had a good evening. She had a pulse (sic) in her leg which it resulted into bleeding this was hide (sic) by herself (client #2) for (sic) the DSP's (Direct Support Professionals) at house but this was notice by one of the DSP (sic). She (client #2) doesn't normally allow staff to shower for her (sic) in the evening, this need to look into (sic) by house manager...".

A review of the CAPN completed by staff #5 and dated 3/7/18 at 11:00 PM indicated staff #5 and an unidentified staff member observed a bleeding cyst on client #2's leg on 3/7/18. The review did not indicate staff #5 notified the facility administrator or the nurse regarding the bleeding cyst on client #2's leg on 3/7/18.

A CAPN dated 3/8/18 and documented by staff #5 indicated, "[Client #2] had part of her evening home as (sic) visit to the hospital. She (client #2) had no issues. She (client #2) ate before she left for the hospital."
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER 15G447

MULTIPLE CONSTRUCTION

A. BUILDING
B. WING

DATE SURVEY COMPLETED 05/01/2018

STATEMENT OF DEFICIENCIES

IDENTIFICATION NUMBER 15G447

STATEMENT OF DEFICIENCIES

IDENTIFICATION NUMBER 15G447

NAME OF PROVIDER OR SUPPLIER

VOCA CORPORATION OF INDIANA

STREET ADDRESS, CITY, STATE, ZIP CODE
4114 KNOLLTON RD
INDIANAPOLIS, IN 46228

A review of the CAPN dated 3/8/18 and documented by staff #5 at 11:00 PM indicated client #2 went to the Hospital after dinner on 3/8/18. QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 4/26/18 at 12:15 PM. QIDP #1 stated, "No they (staff) did not follow protocol of notifying the manager immediately. QIDP #1 stated, "No that's not the protocol. He (staff #5) should have been interviewed." QIDP #1 indicated all allegations of abuse, neglect and mistreatment should be reported immediately to the facility's administrator.

9-3-2(a)
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 2 of 26 allegations of abuse, neglect and mistreatment reviewed, the facility failed to thoroughly investigate an allegation of staff neglect regarding a fall with significant injury to client #1 and an incident regarding an infection to client #2 which resulted in a hospitalization.

Findings include:

The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/25/18 at 12:19 PM.

1. A BDDS report dated 12/16/17 indicated on 12/15/17, "...Staff (staff #3) observed [client #1] fall forward while getting up from a rocking chair, causing her to hit her mouth on the floor. The

CORRECTION:
The facility must have evidence that all alleged violations are thoroughly investigated.

Specifically:
The Quality Assurance Manager will meet weekly with the QIDP manager to review significant events to assure investigations occur for incidents as required.

The Operations Team, including the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators...
[Agency] nurse was notified and [client #1] was taken to [urgent care] where she (client #1) was assessed and diagnosed with fractured teeth. The [urgent care] physician referred [client #1] to [Dental Practitioner] where she (client #1) had two teeth extracted...

-A review of the BDDS report dated 12/16/17 indicated staff #3 observed client #1 fall. The review indicated client #1 sustained 2 fractured teeth from the fall which resulted in 2 teeth being extracted from client #1. The review did not indicate when staff #3 reported client #1's fall with injury. The review did not indicate if staff #3 reported client 31's fall with injury to the facility's administrator immediately.

-A FR (Final Report) dated 12/15/17 to 12/22/17 indicated, "...Summary of Evidence: How did the injury occur? [Client #1] was observed falling forward while getting up from her rocking chair in her bedroom..."

-"...(CWSF) Confidential Witness Statement Form Date: 12/18/17...Interviewer: [Staff #3]...Interviewer: Within the past 24 hours did you see [client #1] falling, walking or running into any objects outside or inside the home? Interviewee (staff #3): Yes, she fell while getting up from her chair...Interviewer: Where did you document what you saw/discovered? Interviewee (staff #3): Progress notes. When did you document what you saw/discovered? Interviewer: Who did you contact regarding what you observed/discovered and when did you tell them? Interviewee (staff #3): I (staff #3) told [staff #2] when she came in."  

- A review of the CWSF by staff #3 dated 12/18/17 indicated he observed client #1 fall when she got up from her chair. The review did not indicate staff and QIDP Manager, will directly oversee all investigations. The QIDP and Quality Assurance Team (Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) will assure that conclusions are developed that match the collected evidence. The governing body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment and any allegations of sexual abuse. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the QIDP Manager (QA Manager responsible for ICF facilities) will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days, including but not limited to assuring the investigation reconciles discrepancies between witness testimony and documentary evidence. The Quality Assurance Manager and the QIDP Manager will review the scope of all open investigations to assure all allegations receive appropriate examination and analysis.

PREVENTION:
The QIDP Manager will maintain a tracking spreadsheet for incidents...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
VOCA CORPORATION OF INDIANA

STREET ADDRESS, CITY, STATE, ZIP CODE
4114 KNOLLTON RD
INDIANAPOLIS, IN 46228

<table>
<thead>
<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCY</th>
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<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>#3</td>
<td>notified the administrator or the nurse regarding client #1's fall with significant injury. The review indicated staff #3 informed staff #2 when staff #2 came into the group home to start her shift.</td>
<td></td>
<td>requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager. The QIDP Manager (Administrative level management) will meet with his/her QIDPs weekly to review the progress made on all investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The QIDP Manager will review the results of these weekly meetings with the Quality Assurance Manager to assure appropriate follow through occurs.</td>
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"-(CWSF) Confidential Witness Statement Form Date: 12/18/17... Interviewee (staff #2); [staff #3] told me he (staff #3) saw [client #1] fall forward while getting up from her chair. Interviewer: When did you document what you saw/discovered? Interviewee (staff #2); After I (staff #2) was informed... Interviewer: Who did you contact regarding what you observed/discovered and when did you tell them? Interviewee (staff #2); [RN (Registered Nurse #1), after I (staff #2) was informed."

- A review of the CWSF by staff #2 dated 12/18/17 indicated staff #2 indicated staff #3 had told her (staff #2) client #1 had fallen while getting up from her chair. The review indicated staff #2 notified the facility nurse when staff #2 was informed by staff #3 regarding client #1's fall with significant injury. The review did not indicate staff #3 immediately notified the facility's administrator regarding client #1's fall with significant injury.

"...Conclusions: Evidence substantiates that consumer [client #1] did cause injury to him/herself...".

A review of the FR dated 12/22/17 indicated the investigation substantiated client #1 had injured herself from a fall. The review did not indicate whether staff #3 reported/notified the facility's administrator immediately regarding client #1's fall with significant injury on 12/8/17. The review did not indicated 2 staff members were interviewed for the investigation. The review did not indicate all requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager. The QIDP Manager (Administrative level management) will meet with his/her QIDPs weekly to review the progress made on all investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The QIDP Manager will review the results of these weekly meetings with the Quality Assurance Manager to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough
### Summary Statement of Deficiency

Each deficiency must be preceded by full regulatory or LSC identifying information.

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<tr>
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<th>PREFIX</th>
<th>TAG</th>
<th>REGULATORY OR LSC IDENTIFYING INFORMATION</th>
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### Staff's Statement

Staff members who worked before, during or after client #1's fall with significant injury were interviewed for the investigation.

Staff #2 was interviewed on 4/25/18 at 8:51 AM. Staff #2 was asked if she was working when client #1 fell on 12/15/17. Staff #2 stated, "I (staff #2) discovered it when I came in the morning, between 6 am and 7 am. At that time she (client #1) was very much mobile. She (client #2) happened to be walking towards the kitchen. that's when I (staff #2) noticed her mouth was bloody. I (staff #2) applied pressure, it was pretty bad. I called the nurse. At the time there was 2 people (staff) on duty and they were giving showers. I'm not sure what happened in the gap between when it happened."

2. A BDDS report dated 3/9/18 indicated, "[Client #2] complained of pain on her right thigh to the residential manager. Upon assessment of [client #2's] thigh, a cyst was discovered on [client #2's] left, posterior upper leg. The [agency] nurse was notified and instructed staff to take [client #2] to [urgent care]. After being assessed at [urgent care], [client #2] was referred to the [Area] Hospital Emergency Department where she (client #2) was assessed and diagnosed with sepsis. [Client #2] was hospitalized so a surgical procedure could be conducted to drain the fluid in the affected area...".

A review of the BDDS report dated 3/9/18 indicated client #2 complained of pain in her left leg. The review indicated client #2 was hospitalized due to an infected cyst on her left leg. The review did not indicate for how long client #2 had the cyst before client #2 notified staff regarding the cyst to her left leg.

### Investigations

Investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.

**RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director
### Statement of Deficiencies and Plan of Correction

**Identification Number**: 15G447

**Date Survey Completed**: 05/01/2018

**Provider or Supplier Name**: VOCA CORPORATION OF INDIANA

**Address**: 4114 KNOLLTON RD, INDIANAPOLIS, IN 46228

#### Summary Statement of Deficiency

Each deficiency must be preceded by full regulatory or LSC identifying information.

#### Provider's Plan of Correction

Each corrective action should be cross-referenced to the appropriate deficiency.

---

**An FR dated 3/9/18 to 3/16/18 indicated 3 staff members were interviewed for the investigation:**

Staff #2, Staff #3 and RM (Resident Manager #1).

The FR dated 3/16/18 Conclusion indicated, "Evidence substantiates that consumer (client #2) did practice good personal hygiene techniques. Evidence substantiates that consumer (client #2) does have a history of skin infection and AHRP (Agency High Risk Protocol) in place which staff followed."

The FR dated 3/16/18 concluded client #2 practiced good personal hygiene and bathing and staff followed client #2's AHRP properly. The review did not indicated staff #5 was interviewed for the investigation dated 3/16/18.

A CAPN (Community Alternatives Progress Note) dated 3/7/18 and documented by staff #5 indicated, "[Client #2] had a good evening. She had a pulse (sic) in her leg which it resulted into bleeding this was hide (sic) by herself (client #2) for (sic) the DSP's (Direct Support Professionals) at house but this was notice by one of the DSP (sic). She (client #2) doesn't normally allow staff to shower for her (sic) in the evening, this need to look into (sic) by house manager...".

A review of the CAPN completed by staff #5 and dated 3/7/18 at 11:00 PM indicated staff #5 and an unidentified staff member observed a bleeding cyst on client #2's leg on 3/7/18. The review did not indicate staff #5 notified the facility administrator or the nurse regarding the bleeding cyst on client #2's leg on 3/7/18.

A CAPN dated 3/8/18 and documented by staff #5 indicated, "[Client #2] had part of her evening home as (sic) visit to the hospital. She (client #2)
had no issues. She (client #2) ate before she left for the hospital.

A review of the CAPN dated 3/8/18 and documented by staff #5 at 11:00 PM indicated client #2 went to the Hospital after dinner on 3/8/18.

QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 4/26/18 at 12:15 PM. QIDP #1 was asked if the facility's conclusion and recommendations regarding the investigation of client #1’s fall with significant injury was accurate. QIDP #1 stated, "No they (staff) did not follow protocol of notifying the manager immediately. QIDP #1 was asked if staff #5 was interviewed regarding the investigation of an infected cyst on client #2. QIDP #1 stated, "No that's not the protocol. He (staff #5) should have been interviewed. QIDP #1 indicated all witnesses and potential witnesses should be interviewed for an investigation.

9-3-2(a)

483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE
The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.

Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure the HRC (Human Rights Committee) approved the use of door

W 0264
Bldg. 00

CORRECTION:
The committee should review, monitor and make suggestions to the facility about its practices and

05/31/2018
alarms for clients #1, #2, #3 and #4 in the group home.

Findings include:

Observations were conducted at the group home on 4/24/18 from 3:40 PM through 6:00 PM and on 4/25/18 from 6:15 AM through 9:09 AM. Clients #1, #2, #3 and #4 were observed throughout the observation period. At 3:40 PM staff #1 opened the front door to the group home for the surveyor. A door alarm chimed when the front door was opened. At 3:52 PM the surveyor opened the back door of the group home which triggered an alarm to sound off. Staff #1 indicated she was instructed by QIDPM (Qualified Intellectual Disabilities Professional Manager #1) to keep the door alarms on.

1. Client #1's record was reviewed on 4/25/18 at 1:30 PM. Client #1's BSP (Behavioral Support Plan) dated 8/14/17 did not indicate documentation of HRC (Human Rights Committee) approval for the usage of door alarms for the common entry ways to the group home.

2. Client #2's record was reviewed on 4/26/18 at 9:55 AM. Client #2's BSP dated 12/7/17 did not indicate documentation of HRC approval for the usage of door alarms for the common entry ways to the group home.

3. Client #3's record was reviewed on 4/26/18 at 11:32 AM. Client #3's BSP dated 5/13/17 did not indicate documentation of HRC approval for the usage of door alarms for the common entry ways to the group home.

4. Client #4's record was reviewed on 4/26/18 at 10:48 AM. Client #4's BSP dated 7/24/17 did not

programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. A review of facility incident documentation and behavior tracking indicates door alarms are no longer necessary to assure the safety of the clients who currently reside in the home. Therefore, the door alarms will be removed.

PREVENTION:
The QIDP has been retrained regarding the need to assure restrictive measures are implemented only when an assessed need has been identified and informed consent has been obtained. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, Quality Assurance Coordinators, QIDP Manager and Nurse Manager) will review facility support documents no less than twice monthly to assure that accurate informed consent assessments are in place and that prior written informed consent is obtained for all restrictive programs.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 15G447

DATE SURVEY COMPLETED: 05/01/2018

NAME OF PROVIDER OR SUPPLIER: VOCA CORPORATION OF INDIANA
STREET ADDRESS, CITY, STATE, ZIP CODE: 4114 KNOLLTON RD, INDIANAPOLIS, IN 46228

SUMMARY STATEMENT OF DEFICIENCY:

(W 0352 Bldg. 00)

INDICATE DOCUMENTATION OF HRC APPROVAL FOR THE USAGE OF DOOR ALARMS FOR THE COMMON ENTRY WAYS TO THE GROUP HOME.

QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 4/26/18 at 12:15 PM. QIDP #1 was asked if the facility had documentation of HRC approval for the usage of door alarms for the common entry ways to the group home. QIDP #1 stated, "No I do not."

9-3-4(a)

483.460(f)(2)

COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE

Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.

Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure client #2 was assessed by a Dentist annually as recommended.

Findings include:

Client #2's record was reviewed on 4/26/18 at 9:55 AM. Client #2's record had a ROV (Record Of Visit) form completed on 3/16/17. The ROV dated 3/16/17 indicated, "Continue with 3-month cleanings...". The review did not indicate documentation of a current dental examination for client #2.

RN (Registered Nurse #1) was interviewed on 4/26/18 at 12:15 PM. RN #1 indicated the facility did not have documentation of a current dental examination by a Dentist for client #2.

9-3-6(a)

CORRECTION:

Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Specifically, the facility will obtain a dental examination for Client #2. An audit of facility medical charts indicated this deficient practice did not affect additional clients.

PREVENTION:

The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to dental examinations, occur within required time frames. Supervisory staff will review medical charts on an ongoing basis but no less than monthly to...
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>CORRECTION:</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>W0368</td>
<td>483.460(k)(1) DRUG ADMINISTRATION</td>
<td>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #4), the facility failed to ensure clients #1, #2 and #4 received their prescription medications as ordered.</td>
<td>vollcode=0368 CORRECTION: The system for drug administration must assure that all drugs are administered in</td>
</tr>
</tbody>
</table>
Findings include:

The facility’s BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/25/18 at 12:19 PM.

1. A BDDS report dated 2/27/18 indicated, "...A review of medication and documentation indicated [client #1] was not administered her physician prescribed medication, Doxycycline Hyclate (Antibiotic) 100mg, at 9:00 AM on 2/23/18-2/26/18. The [Agency nurse was notified...]".

2. A BDDS report dated 3/26/18 indicated on 3/24/18, "... Staff reported to the [Agency] nurse that upon review of the medication supply [client #2] was not administered her antibiotic Doxycycline Hyclate 100 mg at 9:00 AM on 2/23/18, 2/24/18, 2/25/18 and 2/26/18 as ordered by her physician.

Client #2's record was reviewed on 4/26/18 at 9:55 AM. Client #2's Physician's Orders dated 4/1/18 to 4/30/18 indicated, "...Buspirone Tab 15MG Take 1 compliance with the physician's orders. Specifically, in order to assure medications are administered as ordered, the facility will consistently implement the policy described below.

1. A medication error is defined as a deviation from a physician and/or deviation from the “Rights of Medication of Administration” per LIC training.

2. AT ANY TIME, THE DIRECTOR OF HEALTH SERVICES MAY RESTRICT MEDICATION ADMINISTRATION PRIVILEGES DUE TO THE SEVERITY OF AN ERROR/INCIDENT.

2. One medication error will equal one occurrence per medication pass.

1. Repeated, uncorrected, occurrences of an identical medication error will be treated as one medication error for the purposes of this policy.

2. An error occurring during medication administration observation/training is the responsibility of the trainer.

3. One medication error by an individual within 180 days will result in written corrective action and individualized training by the RM, AS, or nurse, which will be documented on an individual training sheet.

4. Two medication errors within 180 days will result in suspension of medication privileges, written
### SUMMARY STATEMENT OF DEFICIENCY

**TAG**
- tablet by mouth three times daily for Anxiety Disorder... to be taken on March 24, 2018.

3. A BDSS report dated 3/26/18 indicated on 3/24/18, "... Staff reported to the [Agency] nurse that upon review of the medication supply [client #4] was not administered Atorvastatin (Hypercholesterolemia) tab 10mg, Benztropine (Bipolar Disorder) tab 1 mg, Lorazepam (Anxiety Disorder) tab 0.5mg... to be taken on March 24, 2018."

-A review of the BDSS report dated 3/26/18 indicated client #2 was not administered her: Atorvastatin tab 10mg, Benztropine tab 1 mg and Lorazepam tab 0.5mg as ordered by her physician.

Client #4's record was reviewed on 4/26/18 at 10:48 AM. Client #4's Physician's Orders dated 4/1/18 to 4/30/18 indicated, "...Atorvastatin Tab 10mg Give one tablet by mouth once daily for Hypercholesterolemia, Benztropine Tab 1mg give one tablet by mouth twice daily for Bipolar Disorder... Lorazepam Tab 0.5MG Give one tablet by mouth three times daily for anxiety...".

-A review of the BDSS report dated 3/26/18 indicated client #4 was not administered her: Atorvastatin tab 10mg, Benztropine tab 1 mg and Lorazepam as ordered by her physician.

RN (Registered Nurse #1) was interviewed on 4/26/18 at 12:15 PM. RN #1 was asked if clients #1, #2 and #4 should have received their prescription medications as ordered by their Physicians. RN #1 stated, "Definitely yes."

### PROVIDER'S PLAN OF CORRECTION

**ID**
- corrective action, and the employee will be scheduled for a supervised medication pass.

1. Medication pass privileges will remain suspended until the supervised medication pass is successfully completed.

2. If an employee fails to regain certification it may result in termination of employment.

5. Three medication errors by an individual within 180 days will result in suspension of medication pass privileges, written corrective action, and the employee will be scheduled to attend the next available Core A module and medication administration practicum and held to the same standards as a new employee.

1. Following the successful completion of Core A and medication administration practicum the employee will begin medication training at the work site as if he/she were a new employee and follow the same medication administration certification procedures as a new hire.

2. If an employee fails to regain certification it may result in termination of employment.

3. An employee is permitted to repeat LIC training once in a 365-day period. Any medication error committed that would mandate the retaking of LIC for a second time within 365 days may result in termination of employment.
### Statement of Deficiencies and Plan of Correction

**Identification Number**: MULTIPLE CONSTRUCTION A. BUILDING 00  B. WING

**Date Survey Completed**: 05/01/2018

**Name of Provider or Supplier**: VOCA CORPORATION OF INDIANA

**Street Address, City, State, Zip Code**: 4114 KNOLLTON RD INDIANAPOLIS, IN 46228

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>Summary Statement of Deficiency</th>
<th>ID</th>
<th>Providers' Plan of Correction</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>(Each deficiency must be preceded by full regulatory or LSC identifying information)</td>
<td>PREFIX</td>
<td>(Each corrective action should be cross-referenced to the appropriate deficiency)</td>
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**Summary Statement of Deficiency**:

6. Four medication errors by an individual within 180 days will result in suspension of medication pass privileges, written corrective action, and may result in termination of employment.

1. Any employee who has been responsible for an error, which causes, or could potentially cause serious harm to a consumer, may be subject to disciplinary action up to and including termination of employment depending on the nature and severity of the error.

**Prevention**: The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring medications are available and administered as ordered. The Area Supervisor will be present at the facility observing the staff’s provision of skills training and documentation no less than weekly. Members of the Operations Team comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and the QIDP will conduct observations during active employment.
treatment sessions and
documentation reviews no less
than weekly until staff
demonstrate competence. At the
conclusion of this period of
intensive administrative monitoring
and support, the Executive
Director will determine the level of
ongoing support needed at the
facility, which will occur no less
than twice monthly. Active
Treatment sessions to be
monitored are defined as:

Mornings: Beginning at 6:30 AM
and through morning transport and
including the following: Medication
administration, meal preparation
and breakfast, morning hygiene
and domestic skills training
through transport to work and day
service. Morning active treatment
monitoring will include staff from
both the day and overnight shifts.

Evenings: Beginning at
approximately 4:30 PM through
the evening meal and including the
following: domestic and hygiene
skills training, leisure skills
training, medication
administration, meal preparation
and dinner. Evening monitoring will
also include unannounced spot
checks later in the evening toward
bed time.

In addition to active treatment
observations, Operations Team
Members and/or the Residential
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<tr>
<th>ID</th>
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<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| W 0440 | Bldg. 00 | 483.470(i)(1) | EVACUATION DRILLS  
The facility must hold evacuation drills at least quarterly for each shift of personnel. 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 facility failed to conduct fire drills quarterly for each shift of personnel. | W 0440 |       |       | CORRECTION:  
The facility must hold evacuation drills at least quarterly for each shift of personnel. Specifically, the facility has conducted additional evacuation drills on each shift. |
Findings include:

The facility’s fire evacuation drills were reviewed on 4/25/18 at 7:39 AM. The review did not indicate documentation of a fire evacuation drill being conducted on the 6:00 AM to 2:00 PM shift and the 10:00 PM to 8:00 AM shift for the second quarter of 2017 (April, May, June) for clients #1, #2, #3, #4, #5, #6, #7 and #8. The review did not indicate documentation for the 2:00 PM to 10:00 PM for the third quarter of 2017 (July, August, September). The review did not indicate documentation of a fire evacuation drill being conducted on the 2:00 PM to 10:00 PM shift for the fourth quarter of 2017 (October, November, December) for clients #1, #2, #3, #4, #5, #6, #7 and #8.

QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 4/26/18 at 12:15 PM. QIDP #1 indicated the facility should complete fire evacuation drills for every shift of personnel and every quarter of the year. QIDP #1 indicated she did not have documentation of fire evacuation drills for the 6:00 AM to 2:00 PM shift and the 10:00 PM to 8:00 AM shift for the second quarter of 2017 (April, May, June), the 2:00 PM to 10:00 PM for the third quarter of 2017 (July, August, September) and for the 2:00 PM to 10:00 PM shift for the fourth quarter of 2017 (October, November, December) for clients #1, #2, #3, #4, #5, #6, #7 and #8.

9-3-7(a)