CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2021		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG W 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE		
Bldg. 00	#IN00345943. Complaint #IN0034 and state deficienciare cited at W149 and Dates of Survey: Market Ma	Tarch 4, 5, 8 and 10, 2021. 10453 15G814 1408320 also reflect state findings in	W 0000				
W 0149 Bldg. 00	The facility must of written policies are mistreatment, neg Based on record resumpled clients (A, clients (D, E, F, G a implement its policity the financial exploit to prevent the staff F, G and H and fail investigations regard of clients B and C. Findings include:	ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client. view and interview for 3 of 3 B and C) plus 5 additional and H), the facility failed to y and procedures to prevent tation of clients B and C, failed neglect of clients A, B, C, D, E, ed to conduct thorough rding the financial exploitation	W 0149	CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abusthe client. Specifically: All facility staff will be retraine abuse, neglect, mistreatment exploitation detection and prevention. All facility investigations will be completed by trained investigators. When incidents	d se of and and		

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

Disabilities Services) reports and investigations

TITLE

requiring investigation occur, the

(X6) DATE

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/10/2021	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	•	
					ASTLETON BLVD		
VOCA CO	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were reviewed on 3/4/21 at 9:57 AM.				QA manager or designee will		
	1 A DDDC	1-4-1 1/15/21 :1:4-1 !!			assign the investigation to a	. D	
	_	lated 1/15/21 indicated, " On guardian reported to the area			specific investigator. The QID		
		had given [client B] a \$100 gift			manager will conduct follow-u with the investigator to assure	-	
		hasing cigarettes and that the			completion within required	;	
	_	The card remains missing and			timeframes.		
		ed an investigation".			Copies of all investigations w	ill be	
					maintained by the Quality	50	
	-An IS (Investigativ	ve Summary) dated			Assurance Department to be		
		licated the following:			available for review, as requir	ed.	
					In addition to weekly face to f		
	-"Scope of Investigation:"				training and follow-up with the	•	
					Quality Assurance Manager,	the	
	-"1. Did anyone seen (sic) the card?"				investigators will receive ongo	oing	
					mentorship from the QIDP		
	-"2. Where was the	card last seen?'			Manager, including but not lin		
					to interview techniques, gathe	ering	
	-"3. What location v	was the card's last purchase?"			and analysis of documentary		
	H 4 3371 (1 1 1)	Cd 1 . 1 . 00			evidence. The emphasis of th		
	-"4. What is the dat	e of the last purchase?"			mentorship/training will include		
	"5 Did staff fallow	v [client B's] Plan(s)			documentation of factual findi	•	
	accordingly?"	V [CHEIR BS] Flan(S)			and development of conclusion as well as time management		
	accordingly:				to facilitate timely completion		
	-"6. Did staff follow	v ResCare's Polices and			investigations. The QIDP Mar		
	procedures accordir				will provide weekly follow-up	-	
	1				QA Manager regarding progre		
	-"Summary of Inter	views".			and additional training needs.		
	-				PREVENTION:		
	-"[AS(Area Supervi	isor)] #1, Area Supervisor:"			The QIDP Manager will main	ain a	
					tracking spreadsheet for incid		
		ll from [client B's] Mom saying			requiring investigation, follow-	-up	
	that his card was mi	issing."			and corrective/protective mea		
					will be maintained and distrib		
		the house and asked the guys			daily to facility supervisors an		
		could tell me where the card			Operations Team, comprised		
	was."				the Executive Director, Opera		
	!!ГАС #13 Т				Managers, Program Manager	s,	
	- [AS #1] I asked th	ne mom to keep a look out for			Area Supervisors, Quality		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE C A. BUILDING B. WING				
NAME OF T	DROVIDER OF GURRY YER		STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIER			CASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA	INDIAN	NAPOLIS, IN 46256		
(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 APPROPRI	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		and she would let me know if		Assurance Manager, QIDP		
	and when some one	makes a purchase."		Manager, Quality Assurance		
	-"[Client B's Mother], Mother:"			Coordinators, Nurse Manage		
	-"[Client B's Mothe	r], Motner:"		Assistant Nurse Manager. Th		
	"[Cliant R's Mothe	-"[Client B's Mother] I had purchased my son a		Quality Assurance Manager was meet with his/her QA Departi		
	[name of store] prepaid cards (sic)."			investigators as needed but r		
	[hame of store] prepaid cards (sic).			less than weekly to review th		
	-"[Client B's Mothe	r] I got him (sic) so that I can		progress made on all		
	reload it fo (sic) his			investigations, review incider	nts	
	reload it to (sie) his eigarettes.			and assign responsibility for	l l	
	-"[Client B] called and told me that his card was			incidents/issues requiring		
	missing from his wallet."			investigation. QA team mem	bers	
				will be required to attend and		
	-"The staff had helped him (client B) look			an in-service documentation	_	
	everywhere but he could not find it."			these meetings stating that the		
				are aware of which investigate	-	
	-"[Client A], Indivi	dual:"		with which they are required	to	
				conduct, as well as the speci	fic	
	-"I don't know."			components of the investigation for		
				which they are responsible, v	vithin	
	-"[Client D], Indivi	dual:"		the five-business day timefra	l l	
				The QA Manager will review		
	-"Non-Verbal"			results of these weekly meeti	~	
				with the Executive Director to		
	-"[Client E], Individ	lual:"		assure appropriate follow thro	ough	
	UT 1 1.1 U			occurs.		
	-"I don't know."			The Quality Assurance Team		
	"[C1:4 E] I4::	11.11		review each investigation to		
	-"[Client F], Individ	iuai:		that they are thorough –meet	ing	
	-"I don't know."			regulatory and operational	nata	
	- I don't know.			standards, and will not design an investigation, as complete	l l	
	-"[Client B], Individ	tual:"		does not meet these criteria.	ru, ii il	
	[Chem b], marvio	auu.		Failure to complete thorough		
	-"I (client B) think of	someone stole my card."		investigations within the allow		
	(chem b) timik	semestic store my curu.		five business day timeframe	l l	
	-"I (client B) went t	o the stor (sic) and my card is		result in progressive corrective	-	
	missing."	(<i>)</i> a 11. y 12		action to all applicable team	. •	
	5			members.		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2021		
NAME OF I	PROVIDER OR SUPPLIER)	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	-ROVIDER OR SUFFLIER			8307 C	ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-"I (client B) looke	d everywhere for it."			Members of the Operations To	eam	
					(comprised of the Executive		
	-"[Client C], Indivi	dual:"			Director, Operations Manager	s,	
					Program Managers, Quality		
	-"I don't know."				Assurance Manager, QIDP		
					Manager, QIDP, Quality		
	-"[Client G], Individual:"				Assurance Coordinators, Area		
					Supervisors, Nurse Manager		
	-"Non-Verbal"				Assistant Nurse Manager) will		
					conduct administrative monito	ring	
	"Factual Findings:"				during varied shifts/times, to		
	W1 W (11 1)				assure interaction with multipl		
	-"1. " (blank)				staff, involved in a full range o		
	"Constraint				active treatment scenarios, no)	
	"Conclusion:"				less than weekly until all staff		
	H1 (1. 1)				demonstrate competence. After	er	
	-"1. (blank)				this period of enhanced		
	"Recommendations	"			administrative monitoring and		
	Recommendations				support, the Executive Director and Regional Director will	'I	
	1". (blank)				determine the level of ongoing		
	1 (Olalik)				support needed at the facility.	l	
	A review of the IS	dated 1/15/21-1/20/21 did not			• The role of the administra	ative	
		ation of an interview with client			monitor is not simply to observ		
		not indicate documentation of			Report.	,c u	
		ny staff members who worked			· When opportunities for		
		The review did not indicate			training are observed, the mor	nitor	
		n interview with the			must step in and provide the		
		er who worked at the group			training and document it.		
	_	B's \$100 gift card was missing.			If gaps in active treatmer	nt	
		indicate the IS came to a			are observed the monitor is		
	conclusion and mad	de no recommendations			expected to step in, and mode	el.	
	regarding client B's	missing gift card.			the appropriate provision of		
					supports.		
	2. A BDDS report of	dated 2/24/21 indicated, " On			· Assuring the health and		
	2/22/21, [client C]	requested to go to [name of			safety of individuals receiving		
	store] to get \$200 o	off his pay card to send to his			supports at the time of the		
		to purchase a card for her.			observation is the top priority.		
		vith obtaining the money and			Review all relevant		
	purchasing the card	l. [Client C] reported to staff on			documentation, providing		

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLE	
		15G814	B. W	ING		03/10/2	2021
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ASTLETON BLVD		
VOCA CO	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	Ţ	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION ced the money and card in an		TAG	documented coaching and tra	ining	DATE
	_	I the envelope, and put it in			as needed.	IIIIIIg	
	the mailbox outside. [Client C] reported that, prior				Administrative support will inc	lude	
	to arrival of the mail truck, the money and card				assuring the active treatment		
	were no longer in th	ne mailbox. The staff notified			milieu is free from abuse, neg	lect,	
	the supervisor and the nurse [Client C] has been				or mistreatment.		
		nvestigation into the incident			RESPONSIBLE PARTIES: QI	DP,	
	is underway".				Area Supervisor, Residential		
	A marriages - £41 - DE	DDC non-out data d 2/24/21			Manager, Direct Support Staff	,	
	-A review of the BDDS report dated 2/24/21 indicated staff assisted client C to withdraw \$200				Operations Team, BDDS Generalist, Regional Director		
	dollars from his account. The review indicated				Generalist, Neglonal Director		
	client C reported the \$200 was missing from the						
	group home's mail box. The review did not						
	indicate documenta	tion of an investigation					
	regarding the missing	ng \$200.					
	2 A DDDS report d	lated 2/28/21 indicated, " On					
		7/21, the Area Supervisor (#1)					
		visit to home and observed					
		, [staff #1], [staff #2] and [staff					
		oke marijuana in the garage.					
		staff #2], who was not on duty					
		leged incident, was reportedly					
		undry at the time. [Staff #1],					
		#3] were suspended pending					
	_	e of the individuals in the					
	nome were injured (or showed signs of distress".					
	-A review of the BI	DDS report dated 2/28/21					
		2 and #3 were in the garage of					
		ile clients A, B, C, D, E, F, G					
	and H were left una	ttended in the group home.					
	Client D's record w	as reviewed on 3/8/21 at 4:05					
		(Functional Assessment) dated					
	2021 indicated the f						
		G					
	" Decision Makir	ng Skills:"					

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				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G814					летер /2021	
		133014	Б. 11	_		03/10/	2021	
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD			
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	-" Identifies good	R LSC IDENTIFYING INFORMATION 1 vs. (versus) bad		TAG	Directive 17		DATE	
	_	Physical Assistance."						
	-"Identifies conseq Physical Assistance	uences to choices-Requires e."						
	-" Makes rational	l decisions-Requires Physical						
	Assistance".	. ,						
	-"Hazardous Produ	ects Skills:"						
		cedure if all purpose cleaner is swallowed-Requires Physical						
	-"can identify hazards of ingesting bleach-Requires Physical Assistance".							
	Client B was interviewed on 3/4/21 at 7:21 AM. Client B was asked if he had any property stolen or missing from the group home. Client B stated, "Just recently a mask I wore and one of my [video game] controllers has gone missing."							
	Client C was asked or missing from the	riewed on 3/4/21 at 7:55 AM. If he had any property stolen the group home. Client C stated, t \$200 dollars in the mail box						
	Staff #4 was asked clients' property/me	iewed on 3/4/21 at 8:12 AM. if there were reports of any oney stolen or missing from the #4 stated, "No, not in this						
	3/4/21 at 11:02 AM had seen when she	or) #1 was interviewed on f. AS #1 was asked what she pulled up to the group home stated, "When I got there the						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/10/2021	
	ROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD	
VOCA CO	ORPORATION OF	INDIANA	INDIAN	APOLIS, IN 46256	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	ed in the garage. When I (AS arage door was all the way up. I			
		the car." AS #1 was asked			
		ere at this time. AS #1 stated,			
		he laundry room and [client B]			
		io smoking a cigarette. And			
	the rest of the client	s were in bed. It was 9:30 (am)			
	when I got there. I s	aw three staff sitting inside			
		n the window. The girl (staff			
	· ·	window. I smelled it and said			
		arijuana? They didn't respond.			
		o's in the house with the			
	_] said 'nobody'''. AS #1 was			
		at that point. AS #1 stated, house to check on everybody.			
		he and [client B] had already			
		no one else had eaten." AS #1			
		ff were suspended. AS #1			
		ouse, then [staff #2] comes in			
		t be in here, you're suspended.'			
	She (staff #2) went	into the laundry room and she			
	got stuff out of the	washing machine and put it in			
		d [staff #3] got into somebody			
		n my mind if you're doing that			
	you've been doing i				
		1 was asked if she was aware			
	_	on regarding he had \$200			
	_	n the group home. AS #1 book him to the ATM to get			
		o his (client C's) Mom. He said			
	· ·	box. He said staff had helped			
	-	" AS #1 was asked what staff			
	· · · · · ·	AS #1 stated, "[Staff #1].			
	•	he mailbox the next morning			
		ne." AS #1 was asked if staff			
		sted client C to withdraw \$200			
	_	e money in a card in the group			
		S #1 stated, "No, he (staff #1)			
		aken him without notifying			
	somebody." AS #1	was asked if there were other			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G814	B. W	ING	<u> </u>	03/10/	/2021
				CTDEET A	DDDESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
\/OCA C		NIDIANA					
VOCA CO	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	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	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	reports of missing p	roperty. AS #1 stated, "Yes,					
	[client B] said the RM (Residential Manager) had						
	the card (\$100 gift of	eard) and was purchasing him					
	cigarettes." AS #1 v	vas asked which RM. AS #1					
	stated, "[RM #1]. Sl	he is no longer at this house.					
	We never found the card, no."						
	QIDPM (Qualified	Intellectual Disabilities					
	Professional Manag	er) #1 and QAM (Quality					
	Assurance Manager	r) #1 were interviewed on					
	3/4/21 at 1:56 PM.	QIDPM #1 indicated the					
	investigation regard	ing client B's missing \$100					
	dollar gift card, date	ed 1/15/21-1/20/21 did not					
	include documentation of interviews with any of						
	the staff members w	vorking at the time of the					
	incident, including l	RM #1. QIDPM #1 indicated					
	the investigation did	l not make a conclusion as to					
	what happened to cl	lient B's \$100 gift card and the					
	investigation did no	t make any recommendations					
	to ensure future inci	idents of missing					
	property/money cou	ıld be prevented. QIDPM #1					
	indicated the agency	y did not have documentation					
	_	regarding the incident on					
		lient C's missing \$200 dollars.					
	1	d staff #1 did not report he had					
	assisted client C in	withdrawing \$200 dollars and					
		n an envelope in the mailbox.					
	QAM #1 was asked	why staff #1, #2 and #3 left					
		the group home on 2/27/21 and					
	_	in the group home's garage.					
		ney were smoking marijuana."					
		what level of supervision the					
		home required. QAM #1					
		24 hour supervision. They					
		e house attending to them and					
	_	g weed. 2 of the 3 (staff) took					
		ended and they will all be					
		." QAM #1 indicated the					
		prevention of abuse, neglect,					
	mistreatment and ex	xploitation should be					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/10/2021			
	ROVIDER OR SUPPLIER		8307 C	STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI TAG DEFICIENCY)		(X5) COMPLETION DATE		
	allegations of abuse exploitation should The Facility's policy reviewed on 3/8/21 Abuse, Neglect, Ex. 7/10/19 indicated, "advocate for the rig						
	abuse, neglect and of to the appropriate and appropriate supervision thoroughly investig ADEPT, ResCare and guidelines "Emotion to provide goods and the individual to average provide the support psychological and so	egations or occurrences of exploitation shall be reported uthorities through the sory channels and will be ated under the policies of and local, state and federal sonal/physical neglect: failure d/or services necessary for oid physical harm. Failure to necessary to an individual's ocial well being. Failure to requirements such as food, d to provide a safe					
	implement a suppor application of interv qualified person not	ton neglect:Failure to t plan, inappropriate vention with out (sic) a tification/review".					
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATME The facility must h alleged violations Based on record rev allegations of abuse	ENT OF CLIENTS have evidence that all hare thoroughly investigated. hiew and interview for 2 of 21 h, neglect, mistreatment and hed, the facility failed to conduct	W 0154	CORRECTION: The facility must have evidence that all alleged violations are	04/09/2021		

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i i		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G814	B. W	ING		03/10/	2021
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
\(\(\alpha\)		INIDIANIA			ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46256		
(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	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
	thorough investigat	ions regarding the financial			thoroughly investigated.		
	exploitation of clients B and C.				Specifically: All facility		
	_				investigations will be complete	ed by	
	Findings include:				trained investigators. The faci	-	
					must have evidence that all	,	
	The facility's BDDS	S (Bureau of Developmental			alleged violations are thorough	hly	
	1	s) reports and investigations			investigated. Specifically:	<i>^</i>	
	were reviewed on 3				All facility investigations will be	e	
					completed by trained		
	1. A BDDS report dated 1/15/21 indicated, " On				investigators. When incidents		
	1/14/21, [client B's] guardian reported to the area				requiring investigation occur, t	the	
	supervisor that she had given [client B] a \$100 gift				QA manager or designee will		
	card to use for purchasing cigarettes and that the				assign the investigation to a		
	card was missing The card remains missing and				specific investigator. The QID	p	
	ResCare has initiated an investigation".				manager will conduct follow-u		
		2			with the investigator to assure	-	
	-An IS (Investigativ	ve Summary) dated			completion within required		
		licated the following:			timeframes.		
		S			Copies of all investigations will	ll be	
	-"Scope of Investig	ation:"			maintained by the Quality		
					Assurance Department to be		
	-"1. Did anyone see	en (sic) the card?"			available for review, as require	ed.	
					In addition to weekly face to fa		
	-"2. Where was the	card last seen?'			training and follow-up with the		
					Quality Assurance Manager, t	he	
	-"3. What location v	was the card's last purchase?"			investigators will receive ongo		
		-			mentorship from the QIDP		
	-"4. What is the dat	e of the last purchase?"			Manager, including but not lim	nited	
					to interview techniques, gathe	ring	
	-"5. Did staff follow	v [client B's] Plan(s)			and analysis of documentary		
	accordingly?"				evidence. The emphasis of thi	is	
					mentorship/training will include		
	-"6. Did staff follow	v ResCare's Polices and			documentation of factual finding	ngs	
	procedures accordir	ngly"			and development of conclusio	ns,	
					as well as time management s	skills	
	-"Summary of Inter	views".			to facilitate timely completion	if	
					investigations. The QIDP Man	ager	
	-"[AS(Area Supervi	isor)] #1, Area Supervisor:"			will provide weekly follow-up to	_	
		-			QA Manager regarding progre		
	-"[AS #1] I got a ca	ll from [client B's] Mom saying			and additional training needs.		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		15G814	B. WI	ING		03/10/	2021
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA		INDIANAPOLIS, IN 46256			
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	that his card was mi	issing."			PREVENTION:		
					The QIDP Manager will maint		
		the house and asked the guys		tracking spreadsheet for incidents			
		could tell me where the card			requiring investigation, follow-	-	
	was."				and corrective/protective mea		
	"[AS #1] I asked the mam to keep a look out for				will be maintained and distribu		
	-"[AS #1] I asked the mom to keep a look out for the spending history and she would let me know if				daily to facility supervisors and		
		makes a purchase."			Operations Team, comprised		
	and when some one	makes a purchase.			the Executive Director, Opera		
	"[Client R's Mothe	rl Mother:"			Managers, Program Manager Area Supervisors, Quality	5,	
	-"[Client B's Mother], Mother:"				Assurance Manager, QIDP		
	-"[Client B's Mother] I had purchased my son a				Manager, Quality Assurance		
	[name of store] prepaid cards (sic)."				Coordinators, Nurse Manager	and	
	[hame of store] prepara cards (sic).				Assistant Nurse Manager. The		
	-"[Client B's Mothe	r] I got him (sic) so that I can			Quality Assurance Manager w		
	reload it fo (sic) his		meet with his/her QA Department				
		6			investigators as needed but n		
	-"[Client B] called a	and told me that his card was			less than weekly to review the		
	missing from his wa				progress made on all		
					investigations, review incident	ts	
	-"The staff had help	oed him (client B) look			and assign responsibility for n		
	everywhere but he	could not find it."			incidents/issues requiring		
					investigation. QA team memb	pers	
	-"[Client A], Indivi	dual:"			will be required to attend and	sign	
					an in-service documentation a	at	
	-"I don't know."				these meetings stating that the	-	
					are aware of which investigati		
	-"[Client D], Indivi	dual:"			with which they are required to		
					conduct, as well as the specifi		
	-"Non-Verbal"				components of the investigation		
	"ICOL" A FRA T 11 1	1 1 11			which they are responsible, w		
	-"[Client E], Individ	iuai:"			the five-business day timefran		
	"I don't 1-n "				The QA Manager will review t		
	-"I don't know."				results of these weekly meeting	ıgs	
	"[Cliant El India:	huole"			with the Executive Director to	uab	
	-"[Client F], Individ	iuai.			assure appropriate follow thro	ugn	
	-"I don't know "				occurs. The Quality Assurance Team	\will	
	-"I don't know."				review each investigation to e		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G814	B. W	ING		03/10/	/2021
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	-"[Client B], Indivi	dual:"			that they are thorough -meetir	ng	
					regulatory and operational	Ü	
	-"I (client B) think	someone stole my card."			standards, and will not designa	ate	
		·			an investigation, as completed		
	-"I (client B) went t	to the stor (sic) and my card is			does not meet these criteria.	,	
	missing."	. , .			Failure to complete thorough		
	_				investigations within the allowa	able	
	-"I (client B) looked	d everywhere for it."			five business day timeframe m		
					result in progressive corrective	-	
	-"[Client C], Individual:"				action to all applicable team		
					members.		
	-"I don't know."				RESPONSIBLE PARTIES: QII	DP,	
					Area Supervisor, Residential		
	-"[Client G], Individual:"				Manager, Direct Support Staff	,	
					Operations Team, Regional		
	-"Non-Verbal"				Director		
	"Factual Findings:"						
	-"1. " (blank)						
	"Conclusion:"						
	-"1. (blank)						
	"Recommendations	y:"					
	1". (blank)						
		dated 1/15/21-1/20/21 did not					
		tion of an interview with client					
		not indicate documentation of					
		ny staff members who worked					
		The review did not indicate					1
		n interview with the					
		er who worked at the group					
		B's \$100 gift card was missing.					
		indicate the IS came to a					
		de no recommendations					
	regarding client B's	missing gift card.					

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Event ID:

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

PRINTED: 04/07/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G814		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/10/2021			
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	2/22/21, [client C] I store] to get \$200 o mother as a gift and Staff assisted him were purchasing the card 2/23/21, that he plaenvelope, addressed the mailbox outside to arrival of the mail were no longer in the supervisor and treimbursed and an is underway". -A review of the BI indicated staff assist dollars from his accelient C reported the group home's mail to indicate documenta regarding the missin Client B was intervent Client B was asked or missing from the "Just recently a mas game] controllers he Client C was intervent Client C was asked or missing from the "Actually yes, I put and it was gone." Staff #4 was intervent Staff #4 was asked clients' property/model.	iewed on 3/4/21 at 7:21 AM. if he had any property stolen group home. Client B stated, sk I wore and one of my [video						

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Event ID:

SMH311 Facility ID: 010453

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/10/2021			
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA		8307 C	STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION house."		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	AS (Area Supervisor) #1 was interviewed on 3/4/21 at 11:02 AM. AS #1 was asked if she was aware of client C's allegation regarding he had \$200 dollars missing from the group home. AS #1 stated, "[Staff #1] took him to the ATM to get cash, \$200 to send to his (client C's) Mom. He said he put it in the mailbox. He said staff had helped him (client C) do it." AS #1 was asked what staff had helped client C. AS #1 stated, "[Staff #1]. [Client C] went to the mailbox the next morning and the card was gone." AS #1 was asked if staff #1 should have assisted client C to withdraw \$200 in cash and place the money in a card in the group home's mailbox. AS #1 stated, "No, he (staff #1) should never have taken him without notifying somebody." AS #1 was asked if there were other reports of missing property. AS #1 stated, "Yes, [client B] said the RM (Residential Manager) had the card (\$100 gift card) and was purchasing him cigarettes." AS #1 was asked which RM. AS #1 stated, "[RM #1]. She is no longer at this house. We never found the card, no." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 were interviewed on 3/4/21 at 1:56 PM. QIDPM #1 indicated the investigation regarding client B's missing \$100 dollar gift card, dated 1/15/21-1/20/21 did not include documentation of interviews with any of the staff members working at the time of the incident, including RM #1. QIDPM #1 indicated the investigation did not make a conclusion as to what happened to client B's \$100 gift card and the investigation did not make any recommendations to ensure future incidents of missing property/money could be prevented. QIDPM #1 indicated the agency did not have documentation	1					

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2021				
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL					COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	TAG DEFICIENCY)		DATE		
	_	regarding the incident on							
	2/23/21 regarding c	elient C's missing \$200 dollars.							
	QIDPM #1 indicated staff #1 did not report he had								
	assisted client C in withdrawing \$200 dollars and placing the money in an envelope in the mailbox.								
	QAM #1 indicated all allegations of abuse,								
	neglect, mistreatme	ent and exploitation should be							
	thoroughly investig	ated.							
	This federal tag rela	ates to complaint #IN00345943.							
	9-3-2(a)								

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