12/29/2022 PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED					
	15G814	B. WING	11/28/2022					

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8307 CASTLETON BLVD VOCA CORPORATION OF INDIANA INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE W 0000 Bldg. 00 This visit was for a pre-determined full W 0000 recertification and state licensure survey. Survey dates: November 16, 17, 21, 22, 23 and 28, 2022. Facility Number: 010453 Provider Number: 15G814 AIMS Number: 201408320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #27547 on 12/7/22. W 0104 483.410(a)(1) **GOVERNING BODY** Bldg. 00 The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 3 of 3 W 0104 **CORRECTION:** 12/28/2022 sampled clients (#1, #2 and #3) plus 4 additional The governing body must exercise clients (#4, #5, #6 and #7), the governing body general policy, budget, and failed to exercise general policy, budget and operating direction over the operating direction over the facility to ensure the facility. Specifically, the facility's group home's sliding glass door locked and was in sliding glass door has been good repair. repaired and locks properly. PREVENTION: Findings include: Members of the Operations Team (comprised of the Executive Observations were conducted at the group home Director, Operations Managers, on 11/16/22 from 2:46 PM through 5:43 PM and on Program Managers, Quality 11/17/22 from 6:15 AM through 8:45 AM. Clients Assurance Manager, QIDP #1, #2, #3, #4, #5, #6 and #7 were observed Manager, QIDP, Quality

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

throughout the observation periods. At 4:18 PM

the group home's glass, sliding door in the kitchen

TITLE (X6) DATE

Assurance Coordinators, Area

Supervisors, Nurse Manager and

Bob Morris QIDP Manager 12/17/2022

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: XQ4911 Facility ID: 010453 Page 1 of 18 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G814	B. WI	NG		11/28/	2022
				CTDEET /	ADDRESS SITV STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
\/OCA C(INIDIANIA					
VOCA CO	DRPORATION OF	INDIANA		INDIAN	APOLIS, 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
		alarm. The sliding glass door			Assistant Nurse Manager) will		
	was off the sliding t	track and would not lock. AS			incorporate reviews of the faci	lity's	
	(Area Supervisor) #	1 indicated he would complete			egresses into scheduled mont	hly	
	a maintenance request form to repair the door. At 4:48 PM client #6 stated, "[Client #1] ran away this morning." QIDPM #1 was interviewed on 11/21/22 at 1:59				audits to assure they lock and		
					operate properly.		
					RESPONSIBLE PARTIES: QII	DP,	
					Area Supervisor, Residential		
					Manager, Direct Support Staff	,	
	PM. QIDPM #1 was asked how client #1 gained				Operations Team, Regional		
	entrance when no c	lients or staff were present at			Director		
	the group home. QI	DPM #1 stated, "Through the					
	broken sliding glass door." QIDPM #1 indicated the governing body should ensure the group						
		all doors were in good					
	working repair.						
	9-3-1(a)						
W 0149	483.420(d)(1)						
	STAFF TREATME	ENT OF CLIENTS					
Bldg. 00	The facility must d	levelop and implement					
	written policies an	d procedures that prohibit					
	mistreatment, neg	lect or abuse of the client.					
	Based on observation	on, record review and	W_0	149	CORRECTION:		12/28/2022
	interview for 1 of 3	sampled clients (#1), the			The facility must develop and		
		plement its policy and			implement written policies and	I	
		ent and immediately report to			procedures that prohibit		
		garding client #1 had left the			mistreatment, neglect, or abus	e of	
		s out of staff's supervision for			the client. Specifically, direct		
	a significant amoun	t of time.			support and supervisory staff l	nave	
					been retrained regarding requ	ired	
	Findings include:				reporting criteria and timelines	i,	
					and have been trained on clie		
		conducted at the group home			#1's revised elopement prever		
		:46 PM through 5:43 PM and on			protocols in client #1's Behavi	or	
		AM through 8:45 AM. Client #1			Support Plan.		
	was observed throughout the observation				PREVENTION:		
	_	22 at 2:50 PM client #1 was not			The Quality Assurance Manag	jer	
		At 4:18 PM the group home's			and the QIDP Manager will		
	glass, sliding door i	n the kitchen did not have a			carefully review all incidents		1

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Event ID:

XQ4911 Facility ID: 010453

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	WEDICAKE & WEDIC		772 7 7		OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		15G814	B. WING		11/28/2022	
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	NOTHER OF STATE		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	£	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	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ding glass door was off the		reported by the facility and out		
	-	ould not lock. AS (Area		entities, to assure that allegation		
	-	cated he would complete a		and other required incidents a	re	
	maintenance request form to repair the door. At			reported to the Bureau of		
	4:48 PM client #6 stated, "[Client #1] ran away this			Developmental Disabilities		
	morning."			Services as required by state I	law.	
				Each day, QIDP Manager or		
	The facility's BDDS	S (Bureau of Developmental		designee will compile a list of		
	Disabilities Service	s) reports and investigations		incidents requiring reports to tl	he	
	were reviewed on 1	1/17/22 at 9:49 AM.		Bureau of Developmental		
				Disabilities Services and distril	bute	
	-A BDDS report dated 11/16/22 indicated, " On			the list to administrative staff		
	11/15/22, [client #1] returned from work on his			(comprised of the Executive		
	own, changed cloth	es and told staff he was		Director, Operations Managers	s,	
	leaving to spend the	e night with friends. He exited		Program Managers, Area		
	the house at 12:00 A	AM. Staff reported the incident		Supervisors, Quality Assurance	e e	
	to the residential su	pervisor via text message, but		Manager, QIDP Manager, Qua	ality	
	administrative staff	later learned the text did not		Assurance Coordinators, Nurs	se l	
	go through. [Client	#1] returned to the residence		Manager, Assistant Nurse		
	at 1:00 PM (11/16/2	22) to get clean work clothes,		Manager and QIDP) for review	v and	
	and said he was retu	urning to work. He (client #1)		revision, as needed. The QIDF		
	returned to work. A	s result of his absence from		Manager or designee will assign	gn	
	the home, [client #1] did not receive his		reporting responsibilities daily.		
	One-A-Day vitamir			Supervisory staff will review al		
				facility documentation to assur		
	-"Plan to Resolve (1	Immediate and Long Term)."		incidents are reported as requ		
	,	,		Additionally, internal and day		
	-"[Client #1] was no	ot injured and was out of staff		service incident reports will be		
		imately 13 hours [Client #1]		sent via electronic fax directly		
	~	ute checks for the next 72 hours		administrative staff. The Quali		
	to prevent further in	ncidents".		Assurance Manager and the C	-	
	-			Manager will coordinate and		
	-A review of the BI	ODS report dated 11/16/22		follow-up with the Quality		
		left the group home at 12:00		Assurance Coordinators, QIDF	Ps	
		he review indicated client #1		and other staff responsible for		
		ne of sight for approximately 13		reporting to outside agencies,		
		lid not indicate when the		assure incidents are reported		
		or was notified of client #1's		state agencies as required.		
	absence/elopement.			A management staff will be		
	1			present, supervising active		
1	i		1	, , , , , , , , , , , , , , , , , , , ,	I	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	r í	UILDING	00	COMPL	ETED
		15G814	B. W	ING		11/28/	2022
		L		CTREET	ADDDECC CITY CTATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
V/OCA C/		ΙΝΓΙΑΝΙΑ			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	NCY 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
		ated 11/17/22 indicated, " On			treatment during no less than	five	
	_	l] changed into his work clothes			active treatment sessions per		
	and informed staff	that he was leaving for work.			week, on varied shifts to assu	ire	
		residence, called off from work,			staff implement behavior supp	oorts	
		visit a friend. Staff arrived at			as written.For the next 30 day	rs,	
		rk to pick up [client #1] after his			members of the Operations T	eam	
	shift and discovered he was not there. Staff were				(comprised of the Executive		
	able to contact [client #1] by phone and [client #1]				Director, Operations Manager	rs,	
	came back to [Name of Employer] restaurant,				Program Managers, Quality		
		[Client #1] stated that he			Assurance Manager, QIDP		
	went to a friend's house to play video games				Manager, QIDPs, Quality		
	instead of working. Staff returned to the residence				Assurance Coordinators, Area	a	
	with [client #1] at approximately 7 PM. He				Supervisors, and Nurse Mana	ager)	
	returned home with no problems."				will conduct twice weekly		
					administrative monitoring duri	ng	
	-"Plan to Resolve (Immediate and Long Term)."			varied shifts/times, to assure		
					interaction with multiple staff,		
		vas out of staff line of sight			involved in a full range of acti	ve	
		ours but was returned to the			treatment scenarios. After 30		
	residence with no i	njuries".			days, administrative monitorir	ng	
					will occur no less than weekly	,	
		DDS report dated 11/17/22			until all staff demonstrate		
		wed client #1 to leave the group			competence. After this period	of	
		rvision after client #1 had just			enhanced administrative		
		hour absence without leave.			monitoring and support, the		
		ed client #1 was not at work but			Executive Director and Regio		
	was with a friend a	t an unknown location.			Director will determine the lev		
					ongoing support needed at th		
		vas reviewed on 11/17/22 at 1:07			facility. Current Operations Te		
		2 at 10:31 AM. An IDT			members received training fro		
		Ceam) Meeting form dated			the QIDP Manager to assure	а	
	11/18/22 indicated	the following:			clear understanding of		
					administrative monitoring as		
		iscuss [client #1's] PM			defined below.		
		of leaving the house for Alone			· The role of the		
	Time past his allotted plan approved time of one				administrative monitor is not		
		nd calling off work and lying to			simply to observe & report.		
	staff."				· When opportunities for		
					training are observed, the mo	nitor	
	-"QIDP (Qualified	Intellectual Disabilities			must step in and provide the		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G814	B. W	ING		11/28/	/2022
		1		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ASTLETON BLVD		
VOCA C	ORPORATION OF	ΙΝΓΙΔΝΙΔ			IAPOLIS, IN 46256		
VOCAC	ORFORATION OF	INDIANA		INDIAN	AFOLIS, IN 40230		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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)		DATE
		e with [client #1] and had a			training and document it.		
		nim about leaving the home			 If gaps in active treatme 	nt	
	_	one time and about lying to			are observed the monitor is		
		e was going, and problem			expected to step in and mode		
	_	o increase his AT (Alone			appropriate provision of suppo	orts.	
	Time)".				· Assuring the health and		
	#5611				safety of individuals receiving		
	-"[Client #1] would like 4 hours of alone time				supports at the time of the		
	outside of work each day to spend some time with				observation is the top priority.		
		nd, and possibly go to a movie			· Review all relevant		
	every so often."				documentation, providing		
					documented coaching and tra	ining	
	-"Team agreed to the increase in AT as long as				as needed		
	,	sic) the AT procedures returns			Administrative oversight will		
		nely manner and works less			include speaking with staff and		
	than 20 hours per w	veek".			clients and reviewing progress		
	HOLDD 1 11	F 11			notes and behavior tracking to)	
		[client #1] about safe sex			assure all incidents and		
	practices".				allegations are reported as		
	l	2 2 2 1 1 1 1 1			required, and that behavior		
		stigation timeline dated			supports are implemented as		
	_	leted by QIDPM (Qualified ities Professional Manager) #1			written.		
		G ,			The QIDP Manager will maint		
	indicated the follow	ving:			tracking spreadsheet for incide		
	"(11/16/22) 9.16 A	AM DSP (Direct Support			requiring investigation, follow-	-	
	1	f #1] texted [AS (Area			and corrective/protective mea will be maintained and distribu		
		d asked him to call."					
	Supervisor) j #1 and	a asked min to can.			daily to facility supervisors and Operations Team. The Quality		
	"12:46 DM [Stoff :	#1] texted [AS #1] and asked if			Assurance Manager will meet		
	_	client #1] yet. [Staff #1]			his/her QA Department	WILLI	
		nt #1] was not in the home			investigators as needed but no	0	
	-	me on duty at 8:00 AM. [AS #1]			less than weekly to review the		
					progress made on all		
	gave [Staff #1] [client #1's] number and said to call him."				investigations, review incident	'S	
	liiii.				and assign responsibility for n		
	-"1:00 PM [Name o	of Group Home] staff left day			incidents/issues requiring		
	_				investigation. QA team memb	ers	
	service because [Staff #1] called [client #1] and [client #1] told him he was at home and had let				will be required to attend and		
		the sliding glass door since the			an in-service documentation a	-	
	I	and branch drawn about billion tile	1		an in convice accumentation a		I

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G814	A. B B. W	UILDING ING	00	COMPI 11/28	
		130014	Б. W			11/20	
NAME OF I	PROVIDER OR SUPPLIEF	t .			ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA			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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	lock was broken."				these meetings stating that th	-	
	112 00 DM [CI]; 4 /	// 11 0 / 1 ' 1 ' DI C			are aware of which investigati		
		†1] left the site in his [Name of			with which they are required to		
		n and said he was going to			conduct, as well as the specif		
	work."				components of the investigation		
	-"3:45-5:45 PM [Name of Surveyor] discovered				which they are responsible, w		
		ght elopement while			the five-business day timefrar The QA Manager will review t		
	interviewing individ	-			results of these weekly meeting		
	interviewing individ	duais.			with the Executive Director to	igs	
	-"7:09 PM [AS #1]	informed OM (Operations			assure appropriate follow thro	uah	
		that [client #1] told him he			occurs.	agri	
	(client #1) spent the night at a friend's house."				The Quality Assurance Team	will	
		8			review each investigation to e		
	-"[AS #1] went to [client #1's] job, and he (client			that they are thorough –meeti		
		. [AS #1] called him (client #1),			regulatory and operational	9	
		s of a hotel where he was with			standards, and will not design	ate	
	friends and [AS #1]	picked him up".			an investigation, as completed		
					does not meet these criteria.		
	The review indicate	ed staff #1 was aware client #1			Failure to complete thorough		
	was not in the group	p home at 8:00 AM on			investigations within the allow	able	
	11/16/22. The revie	w indicated client #1 had			five business day timeframe n	nay	
		ip home and let himself in the			result in progressive corrective	е	
		h an unlocked door at an			action to all applicable team		
		The review did not indicate			members.		
		client #1 was unsupervised					
		me. The review did not			RESPONSIBLE PARTIES: QI		
		when AS #1 was notified			Area Supervisor, Direct Suppo		
	client #1 had eloped	d from the group home.			Staff, Operations Team, Region Director	onal	
	Client #1 was interv	viewed on 11/17/22 at 8:10 AM.					
		l if he had left the group home					
		iff in the early morning on					
		stated, "I came home to get					
		I left." Client #1 was asked					
	who he had left the group home with. Client #1						
	stated, "With friends, to the hotel." Client #1 was						
	asked when he had returned to the group home.						
		taff called me. He's here right					
	now, the little guy (staff #2). They came and					

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15G814	B. WING		11/28/2022
NAME OF 1	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD	
	00000471011.05			ASTLETON BLVD	
VOCA C	ORPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46256	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	picked me up."				
	Client #6 was interv	viewed on 11/16/22 at 4:48 PM.			
		have to tell you something.			
		y, today, this morning."			
		<i>5</i> , <i>5</i> ,			
	Client #3 was interv	viewed on 11/16/22 at 5:10 PM.			
		d if client #1 had eloped from			
		ently. Client #3 stated, "I didn't			
		I heard that he went			
		didn't come back, but he came			
	back today. That's v	why we left day service early."			
	Staff #1 was intervi	newed on 11/16/22 at 3:11 PM.			
		why the clients had to leave			
		rly on 11/16/22. Staff #1 stated,			
		had to be at work early." Staff			
	<u> </u>	re had been any of the clients			
		. Staff #1 stated, "Not that I			
	know of." Staff #1	was asked why there was a			
	door alarm on the fi	ront door. Staff #1 stated,			
	"That I couldn't tell	you."			
	Staff #1 was intowi	iewed a second time on			
		M. Staff #1 was asked if client			
		ne group home when he arrived			
	_	AM on 11/16/22. Staff #1			
		under the impression he (client			
		1]." Staff #1 was asked what			
	-	had told him. Staff #1 stated,			
	_	lient #1] didn't come home last			
		s asked what time he left Day			
		2 to pick up client #1. Staff #1			
	stated, "12 PM, I th	ink it was around that time."			
	Staff #2 was interest	iewed on 11/17/22 at 8:21 AM.			
		if client #1 was present in the			
		ne arrived for his shift at 8:00			
		taff #2 stated, "No he wasn't in			
			1	1	1

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the house yesterday." Staff #2 was asked if client

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XQ4911

Facility ID: 010453

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		15G814	B. W	ING		11/28/2	2022
	PROVIDER OR SUPPLIER		•	8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		e before. Staff #2 stated, "No,					
		I always see him in the house					
		was asked if he had called					
	client #1 from the Day Service Program to find out						
	where he was. Staff	#2 stated, "No [staff #1] called					
	him. When we were	at Day Service, [staff #1]					
	called him and he (c	client #1) said he was at home.					
	I	vice and rushed home." Staff #2					
		#1 was waiting outside the					
		2 stated, "No he was inside."					
		lient #1 entered the group					
	_	iding glass door. Staff #2 was					
	asked if they had notified AS #1 client #1 was						
		ome. Staff #2 stated, "Yes					
	[staff #1] notified [A	AS #1] immediately."					
	DCM (Day Campiage	Managan) #1 yyaa intamiayyad					
		s Manager) #1 was interviewed AM. DSM #1 was asked if					
		4, #5, #6 and #7 attended the					
		m. DSM #1 stated, "They are					
		and. Majority of the time,					
		not attend." DSM #1 was					
		as in attendance on 11/16/22.					
		o." DSM #1 was asked if the					
		early on 11/16/22. DSM #1					
		y understanding they left					
	because they found	out [client #1] was at the					
	house."						
		wed on 11/17/22 at 7:40 AM.					
		hen staff notified him client #1					
		ome unattended. AS #1					
		they sent me a text that [client					
	_	but I never received the text. It					
		was asked what time client #1					
	I -	p home. AS #1 stated, "At 1					
		2 PM, then he left work to hang					
		wants more freedom." AS #1					
	indicated he did not	-					
	admınıstrator until a	after the surveyor had left the				l	

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STATEMEN	NT 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	ETED
		15G814	B. W	ING	_	11/28/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	t .		1	ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA	_	INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	group home at 5:45	PM on 11/16/22.					
	OIDPM (Qualified	Intellectual Disabilities					
	QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on						
		M. QIDPM #1 indicated client #1					
		ome without staff supervision					
		2:00 AM on 11/16/22. QIDPM					
		If had notified the Area					
		me. QIDPM #1 stated, "Yes, I					
	_	ot from [staff #3's] phone."					
		ted how staff determined client					
	•	he group home on 11/16/22.					
	QIDPM #1 stated, "They called [client #1] on his						
	cell phone and he told them he was at home."						
	_	red how client #1 gained					
	entrance to the grou	ıp home. QIDPM #1 stated,					
	"Through the broke	n sliding glass door." QIDPM					
	#1 indicated AS #1	did not report client #1's					
	elopement until 7:0	0 PM on 11/16/22. QIDPM #1					
	indicated the facility	y's policy on the prevention of					
	abuse, neglect and i	mistreatment should be					
	_	tten. QIDPM #1 indicated all					
	_	e, neglect and mistreatment					
	•	to the facility administrator					
		BDDS within 24 hours of					
	knowledge.						
	The Facility's policy	y and procedures were					
		22 at 9:55 AM. The facility's					
	Abuse, Neglect, Ex	ploitation policy revised on					
	7/10/19 indicated, "	Policy: Adept staff actively					
	advocate for the rig	hts and safety of all					
	individuals. All alle	egations or occurrences of					
	abuse, neglect and o	exploitation shall be reported					
		uthorities through the					
	appropriate supervi	sory channels and will be					
		ated under the policies of					
	ADEPT, ResCare a	nd local, state and federal					
	guidelines"Emoti	onal/physical neglect: failure to					
	provide goods and/o	or services necessary for the					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G814	B. W	ING		11/28/	/2022
	PROVIDER OR SUPPLIER		•	8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD 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	.ΤΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
W 0153 Bldg. 00	provide the support psychological and someet the basic need shelter, clothing and environment." "Program interventi implement a support application of an accordate established proceed Based on record reventi allegations of abuse reviewed, the facility to the administrator the group home and for a significant amount of a significant a	on neglect:Failure to the plan, inappropriate vention with out (sic) a diffication/review". ENT OF CLIENTS ensure that all allegations of lect or abuse, as well as an source, are reported administrator or to other ance with State law through dures. Friew and interview for 2 of 12 to, neglect and mistreatment by failed to immediately report regarding client #1 had left to was out of staff's supervision	W	0153	CORRECTION: The facility must ensure that a allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, ar reported immediately to the administrator or to other officia in accordance with State law through established procedure Specifically, direct support and supervisory staff have been retrained regarding required reporting criteria and timelines PREVENTION: The Quality Assurance Managand the QIDP Manager will carefully review all incidents reported by the facility and out	re als es. d	12/28/2022

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12/29/2022 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/28/2022 15G814 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8307 CASTLETON BLVD VOCA CORPORATION OF INDIANA INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE to the residential supervisor via text message, but entities, to assure that allegations administrative staff later learned the text did not and other required incidents are go through. [Client #1] returned to the residence reported to the Bureau of at 1:00 PM (11/16/22) to get clean work clothes, **Developmental Disabilities** Services as required by state law. and said he was returning to work. He (client #1) returned to work. As result of his absence from Each day, QIDP Manager or the home, [client #1] did not receive his designee will compile a list of One-A-Day vitamin tablet." incidents requiring reports to the Bureau of Developmental -"Plan to Resolve (Immediate and Long Term)." Disabilities Services and distribute the list to administrative staff -"[Client #1] was not injured and was out of staff (comprised of the Executive line of sight approximately 13 hours... [Client #1] Director, Operations Managers, will receive 15-minute checks for the next 72 hours Program Managers, Quality to prevent further incidents...". Assurance Manager, QIDP Manager, QIDPs, Quality -A review of the BDDS report dated 11/16/22 Assurance Coordinators, Area indicated client #1 left the group home at 12:00 Supervisors, and Nurse Manager) AM on 11/16/22. The review indicated client #1 for review and revision, as needed. was out of staff's line of sight for approximately 13 The QIDP Manager or designee hours. The review did not indicate when the will assign reporting facility administrator was notified of client #1's responsibilities daily. absence/elopement. Supervisory staff will review all facility documentation to assure -A BDDS report dated 11/17/22 indicated, "... On incidents are reported as required. 11/16/22, [client #1] changed into his work clothes Additionally, internal and day and informed staff that he was leaving for work. service incident reports will be [Client #1] left the residence, called off from work, sent via electronic fax directly to and instead went to visit a friend. Staff arrived at administrative staff. The Quality his (client #1's) work to pick up [client #1] after his Assurance Manager and the QIDP shift and discovered he was not there. Staff were Manager will coordinate and able to contact [client #1] by phone and [client #1] follow-up with the Quality came back to [Name of Employer] restaurant, Assurance Coordinators, QIDPs located at [address]. [Client #1] stated that he and other staff responsible for went to a friend's house to play video games reporting to outside agencies, to instead of working. Staff returned to the residence assure incidents are reported to with [client #1] at approximately 7 PM. He state agencies as required. returned home with no problems." For the next 30 days, members of

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-"Plan to Resolve (Immediate and Long Term)."

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the Operations Team (comprised

of the Executive Director,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/28/2022 15G814 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8307 CASTLETON BLVD VOCA CORPORATION OF INDIANA INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Operations Managers, Program -"[Client #1] was out of staff line of sight Managers, Quality Assurance approximately 4 hours." Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, -A review of the BDDS report dated 11/17/22 Area Supervisors, and Nurse indicated staff allowed client #1 to leave the group Manager) will conduct twice home without supervision after client #1 had just weekly administrative monitoring returned from a 13 hour absence without leave. during varied shifts/times, to The review indicated client #1 was not at work but assure interaction with multiple was with a friend at an unknown location. staff, involved in a full range of active treatment scenarios. After A preliminary investigation timeline dated 30 days, administrative monitoring 11/21/22 and completed by QIDPM (Qualified will occur no less than weekly Intellectual Disabilities Professional Manager) #1 until all staff demonstrate indicated the following: competence. After this period of enhanced administrative -"(11/16/22) 8:16 AM DSP (Direct Support monitoring and support, the Professional) [staff #1] texted [AS (Area Executive Director and Regional Supervisor)] #1 and asked him to call." Director will determine the level of ongoing support needed at the -"12:46 PM [Staff #1] texted [AS #1] and asked if facility. Current Operations Team he had spoken to [client #1] yet. [Staff #1] members received training from explained that [client #1] was not in the home the QIDP Manager to assure a when [Staff #1] came on duty at 8:00 AM. [AS #1] clear understanding of gave [Staff #1] [client #1's] number and said to call administrative monitoring as him." defined below. The role of the -"1:00 PM [Name of Group Home] staff left day administrative monitor is not service because [Staff #1] called [client #1] and simply to observe & report. [client #1] told him he was at home and had let When opportunities for himself in through the sliding glass door since the training are observed, the monitor lock was broken." must step in and provide the training and document it. -"2:00 PM [Client #1] left the site in his [Name of If gaps in active treatment Employer's] uniform and said he was going to are observed the monitor is work." expected to step in and model the appropriate provision of supports. -"3:45-5:45 PM [Name of Surveyor] discovered Assuring the health and [client #1's] overnight elopement while safety of individuals receiving

interviewing individuals."

supports at the time of the

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	LETED
		15G814	B. W	ING		11/28	/2022
	PROVIDER OR SUPPLIER			8307 C	ADDRESS, CITY, STATE, ZIP COD CASTLETON BLVD 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 APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-"7:09 PM [AS #1] Manager) [OM #1] (client #1) spent the -"[AS #1] went to [#1) was not present obtained the addres friends and [AS #1] The review indicate was not in the group 11/16/22. The revier returned to the group group home through undetermined time, the amount of time inside the group hor indicate specifically client #1 was interved. Client #1 was asked unsupervised by sta 11/16/22. Client #1 some clothes, then he	informed OM (Operations that [client #1] told him he enight at a friend's house." client #1's] job, and he (client [AS #1] called him (client #1), s of a hotel where he was with			observation is the top priority. Review all relevant documentation, providing documented coaching and tra as needed Administrative oversight will include speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. RESPONSIBLE PARTIES: QI Area Supervisor, Direct Suppostaff, Operations Team, Region Director	d s o DP, ort	
		returned to the group home.					
		taff called me. He's here right					
		staff #2). They came and					
	picked me up."	guar (2), riiej cuiiic uiiu					
	-	viewed on 11/16/22 at 4:48 PM.					
		have to tell you something.					1
	[Client #1] ran awa	y, today, this morning."					
	_	viewed on 11/16/22 at 5:10 PM. I if client #1 had eloped from					

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the group home recently. Client #3 stated, "I didn't

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		15G814	B. W	TNG		11/28/	/2022
NAME OF T	DROWNED OF CURPUSE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER				ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		I heard that he went					
		didn't come back, but he came					
	back today. That's v	why we left day service early."					
	Staff #1 was intervi	ewed on 11/16/22 at 3:11 PM.					
	Staff #1 was asked why the clients had to leave						
		ly on 11/16/22. Staff #1 stated,					
	"Because [client #1]] had to be at work early." Staff					
	#1 was asked if the	re had been any of the clients					
	had eloped recently	. Staff #1 stated, "Not that I					
	know of." Staff #1 v	was asked why there was a					
	door alarms on the front door. Staff #1 stated,						
	"That I couldn't tell you."						
	Stoff #1 was intomi	ewed a second time on					
		M. Staff #1 was asked if client					
		ne group home when he arrived					
	_	AM on 11/16/22. Staff #1					
		nder the impression he (client					
		1]." Staff #1 was asked what					
		nad told him. Staff #1 stated,					
	_	lient #1] didn't come home last					
	_	s asked what time he left Day					
	Service on 11/16/22	2 to pick up client #1. Staff #1					
	stated, "12 PM, I th	ink it was around that time."					
	Staff #2 was intervi	ewed on 11/17/22 at 8:21 AM.					
		if client #1 was present in the					
		ne arrived for his shift at 8:00					
		taff #2 stated, "No he wasn't in					
		." Staff #2 was asked if client					
	1	e before. Staff #2 stated, "No,					
		I always see him in the house					
	sleeping." Staff #2	was asked if he had called					
	client #1 from the D	Day Service Program to find out					
	where he was. Staff	f#2 stated, "No [staff#1] called					
		e at Day Service, [staff #1]					
	,	client #1) said he was at home.					
	I -	vice and rushed home." Staff #2					
	was asked if client	#1 was waiting outside the					

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STATEMENT OF DEFICIENCIES X1) F		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
15G814		B. W	ING		11/28	/2022	
		<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ASTLETON BLVD		
VOCA CORPORATION OF INDIANA				INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION FACE CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	C 1	[‡] 2 stated, "No he was inside."					
		lient #1 entered the group liding glass door. Staff #2 was					
	-	otified AS #1 client #1 was					
	-	ome. Staff #2 stated, "Yes					
		AS #1] immediately."					
	[- tarr 1] Houriou [r	1					
	DSM (Day Services	s Manager) #1 was interviewed					
	` •	AM. DSM #1 was asked if					
		4, #5, #6 and #7 attended the					
		m. DSM #1 stated, "They are					
		end. Majority of the time,					
		not attend." DSM #1 was					
		as in attendance on 11/16/22.					
		o." DSM #1 was asked if the					
		t early on 11/16/22. DSM #1					
	stated, "Yes from my understanding they left because they found out [client #1] was at the						
	house."						
	AS #1 was interview	wed on 11/17/22 at 7:40 AM.					
		hen staff notified him client #1					
		ome unattended. AS #1					
		they sent me a text that [client					
	#1] had left the site but I never received the text. It was 12 AM." AS #1 was asked what time client #1 returned to the group home. AS #1 stated, "At 1						
	PM, then he left at 2 PM, then he left work to hang						
	with his friends. He wants more freedom." AS #1						
	indicated he did not notify the facility's						
	administrator until after the surveyor had left the						
	group home at 5:45	PM on 11/16/22.					
		Intellectual Disabilities					
	QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 11/21/22 at 1:59 PM. QIDPM #1 indicated client #1 had left the group home without staff supervision at approximately 12:00 AM on 11/16/22. QIDPM						
	#1 was asked if staff had notified the Area						
		me. QIDPM #1 stated, "Yes, I					
	Saper into at that th	2121111111 000000, 100,1					1

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	COMPLETED	
15G814		B. WING 11/28/2022				2022		
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 provinces by an of correction			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	THE APPROPRIATE		
W 0436	viewed a screen shot from [staff #3's] phone." QIDPM #1 was asked how staff determined client #1 had returned to the group home on 11/16/22. QIDPM #1 stated, "They called [client #1] on his cell phone and he told them he was at home." QIDPM #1 was asked how client #1 gained entrance to the group home. QIDPM #1 stated, "Through the broken sliding glass door." QIDPM #1 indicated AS #1 did not report client #1's elopement until 7:00 PM on 11/16/22. QIDPM #1 indicated all allegations of abuse, neglect and mistreatment should be reported to the facility administrator immediately and to BDDS within 24 hours of knowledge. 9-3-2(a) 483.470(g)(2)							
Bldg. 00	repair, and teach of informed choices a eyeglasses, hearin communications a	urnish, maintain in good clients to use and to make about the use of dentures, ng and other iids, braces, and other by the interdisciplinary						
	for 1 of 3 sampled censure client #2's prepair. Findings include: Observations were con 11/16/22 from 2: 11/17/22 from 6:15 was observed throug periods. On 11/16/2 wearing a blue, soft	conducted at the group home 46 PM through 5:43 PM and on AM through 8:45 AM. Client #2 ghout the observation 2 at 3:03 PM client #2 was shell protective helmet. Client inch vertical tear on the left	WO	436	CORRECTION: The facility must furnish, main in good repair, and teach client use and to make informed choices about the use of dentures, eyeglasses, hearing other communications aids, braces, and other devices identified by the interdisciplinat team as needed by the client. Specifically, the facility will replace client #2's damaged helmet. Additionally, the facility nurse has updated client #2's	ts to and ry	12/28/2022	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
15G814		B. WING 11/28/2022			2022		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
VOCA CORROBATION OF INDIANA					ASTLETON BLVD		
VOCA CORPORATION OF INDIANA				INDIAN	APOLIS, 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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	front side of the hel	met and a 1 centimeter tear on			comprehensive High-risk plan	to	
	the front right side	of the helmet.			address the use of client #2's		
					protective helmet. A review of	w of	
	Client #1's record w	Client #1's record was reviewed on 11/21/22 at			adaptive equipment needs at	the	
	12:19 PM. Client #2	2's CHRHP (Comprehensive			facility indicated this deficient	eficient	
	High Risk Health P	lan) for Falls dated 6/24/22 did			practice did not affect addition		
	not indicate client #	² 2 was required to wear a			clients.		
	helmet during waki	ng hours. Client #2's CHRHP			PREVENTION:		
	for Seizures dated 6	5/24/22 did not indicate client		Facility staff will track cleaning			
	#2 was required to	wear a helmet during waking			and repair needs for all adapti	ve	
	hours.				equipment on an adaptive		
					equipment cleaning checklist.		
	Staff #1 was intervi	lewed on 11/16/22 at 3:11 PM.			A management staff will be		
	Staff #1 was asked	why client #2 had to wear a			present, supervising active		
	protective helmet. S	Staff #1 stated, "He has			treatment during no less than five		
	seizures, he had a mini-one earlier today, but he				active treatment sessions per		
	was already sitting down." Staff #1 indicated				week, on varied shifts to moni	tor	
client #2 had to wear his helmet at all times during		ar his helmet at all times during			the use of adaptive equipmen	t to	
	waking hours.				assure it is in good repair. For	the	
					next 30 days, members of the		
	, , ,	tellectual Disabilities			Operations Team (comprised	of	
	Professional) #1 was interviewed on 11/21/22 at				the Executive Director, Opera		
	-	was asked when client #2			Managers, Program Managers		
should wear his protective helmet. QID					Quality Assurance Manager, 0	QIDP	
	stated, "During waking hours." QIDP #1 indicated				Manager, QIDPs, Quality		
	client #2's helmet should be in good repair. 9-3-7(a)				Assurance Coordinators, Area		
					Supervisors, and Nurse Mana	• ,	
					will conduct daily administrative	/e	
					monitoring during varied		
					shifts/times, to assure interact		
					with multiple staff, involved in	a full	
				range of active treatment			
					scenarios, including weekend		
					observations. After 30 days,		
					administrative monitoring will		
					occur no less than three times		
					weekly until all staff demonstra		
					competence. After this period	of	
					enhanced administrative		
					monitoring and support, the		

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

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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 11/28/2022	
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
VOCA CO	ORPORATION OF	INDIANA			ASTLETON BLVD IAPOLIS, IN 46256		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`			CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE	
TAG	REGULATORY OF	LISC IDENTIFYING INFORMATION		TAG	Executive Director and Regio Director will determine the lev ongoing support needed at the facility. Current Operations To members received training from the QIDP Manager to assure clear understanding of administrative monitoring as defined below. The role of the administrative monitor is not simply to observe & Report. When opportunities for training are observed, the monust step in and provide the training and document it. If gaps in active treatment are observed the monitor is expected to step in and mode appropriate provision of supposapports at the time of the observation is the top priority. Review all relevant documented coaching and training and training and documented coaching and training and trai	vel of e e e am om a nitor e t the orts. I aining	DATE

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

Event ID: XQ4911

Facility ID: 010453

If continuation sheet

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