STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED
		15G447	A. BUILDING	- ,	10/18/2011
		<u> </u>	B. WING	ADDDECC CITY CTATE 7ID CORE	
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD	
VOCA C	ORPORATION OF	INDIANA		NOLLTON RD IAPOLIS, IN46208	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0000					
	This visit was fo	or an investigation of	W0000		
	complaint #IN00	0096931.			
	Complaint #IN0	0096931: Substantiated,			
	•	e deficiencies related to			
		are cited at W149, W154			
	and W157.				
	Unrelated Defic	iomoios oitod			
		iencies cited.			
		: 10/12, 10/13, 10/14 and			
	10/18/11.				
	Facility Number	:: 000961			
	Provider Numbe				
	Aim Number: 1				
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
	Surveyor:				
	1	edical Surveyor III-Team			
	· · · · · · · · · · · · · · · · · · ·	Laicar Burveyor III-Team			
	Leader	D 11' II 1/1 N			
		Public Health Nurse			
	Surveyor, RN (1	.0/13-10/14/11)			
	These deficienci	ies also reflect state			
	findings in accor	rdance with 460 IAC 9.			
		mpleted 11/7/11 by Chris			
	•	Surveyor Supervisor and Ruth			
	Shackelford, Medic	cal Surveyor III.			
******	The may remain a !	du manat anamaias			
W0104		dy must exercise general do operating direction over			
	the facility.	id operating direction over			
		ew and record review for	W0104	CORRECTION: The Govern	ning 11/20/2011
	Dased on intervi	tow and record review for	W 0104	body must exercise general	

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Event ID:

LW5N11

Facility ID:

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	ĺ	LDING	NSTRUCTION 00	î ´	e survey Pleted 2011
	PROVIDER OR SUPPLIER		B. WII	STREET A	DDRESS, CITY, STATE, ZIP CO	ODE	
	ORPORATION OF I			INDIAN	APOLIS, IN46208		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	3 of 3 sampled of for 3 additional of governing body is policy and operal facility to ensure infestation (bed by preventative mean which would preventative mean and/or to prevent carrying/spreading professional treated. Findings include The facility's repland/or investigated 10/13/11 at 11:20 reportable incided following: -8/26/11 "Knolling reported to PC (In [PC #1] that they [client C's] (indivented professional treated to PC (In [PC #1] that they exterminator continuous type of bug it was exterminator conto the house and bed bug. PC [PC implementation of standard protocoling infestations and of the standard protocoling standard standard protocoling standard stand	clients (A, B and C) and clients (D, E and F), the failed to exercise general ating direction over the exits policy for insect bugs) included assures/corrective actions event the spread of bed assures from any the bed bugs once atments started. Exercise to the house clients to there from any the bed bugs once atments started. Exercise to a contain the facility's contable incident reports the facility's contained the formula of the found a bug in the vidual we support) bed. Contacted [name of find from from from from from from from from			policy, budget and op direction over the facility. Specifically, The will incorporate prevestrategies in its insect infestation procedures PREVENTION: Profes will be trained on the supdated insect infestate prevention protocols. The members of the Operwill conduct periodic confessor of the facility on an oral to assure preventative are implemented per Responsible Parties: Consumers of the Support Associates, Consumers of the Parties: Consumers of the Parti	ne agency ntative ((bedbug)) s. ssional staff agency's ation Additionally, ations Team observations ngoing basis e measures policy QDDPD, Operations	
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	LW5N11	Facility I	D: 000961 If cont	inuation sheet P	age 2 of 24

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447		LDING	NSTRUCTION 00		SURVEY LETED 2011
	PROVIDER OR SUPPLIE ORPORATION OF		•	4114 KN	DDRESS, CITY, STATE, ZIP CODI NOLLTON RD APOLIS, IN46208	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	[PC #1] also impreparation Requexterminator concompleted prior exterminate the recently received belongings from mother], who had house. [Name or reports that her is bugs to the point and she thought cleaned prior to probable that the destroyed in [clicame from her in they were brought Knollton. Knoll clothing and further the guideline standard and the company] pre-tre [Name of extermination of Tuesday, 8/30/1 (Personal Protect be available to strestrict the spread	bugs. [Client C] had d some of her clothing and her mother, [name of d been living in a halfway f client C's mother] room in the house had bed at that she had to move out that everything had been her move. It is most beed bugs were not ent C's] belongings that nother's and that is how ht into her bed at ton staff cleaned all niture in [client C's] room es of the Adept operating [name of exterminator eatment requirements. ninator company] is arn to the home to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00		(X3) DATE COMPL		
		15G447		ILDING			10/18/2	
		1	B. WI		DDDESS CITY STAT	E ZID CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STAT NOLLTON RD	E, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN46208	}		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLA	N OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIAT	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICI	ENCY)		DATE
		ndividuals were relocated						
	-	hotel] in [name of city] on						
		as necessary due to the						
	_	val treatment by the						
		rid the house of bed bugs.						
		tment completed was heat						
		was not started until late						
	afternoon. The	ladies were relocated for						
	_	d returned to the group						
	home on 8/31/11	1. It is believed that the						
	bed bugs were b	rought into the home via						
	items brought to	the group home by one						
	of the individual	ls returning from a home						
	visit. All items	that were brought in were						
	removed from th	he home, destroyed and						
		ew. Pending the outcome						
	-	atment, staff will insure						
		and items are washed,						
	_	igh heat and bagged						
		d per the specifications of						
		r to limit further exposure						
	and spread of the	_						
	and spread of the	e pest						
	Interview with c	elient C on 10/12/11 at						
		ed she had problems with						
		at C indicated the bed bugs						
	_	s she received from her						
		to spend one month at						
		ome due to the bed bugs						
	in her room.	ome due to me oca ougs						
	111 1151 100111.							
	Interview with a	staff A on 10/12/11 at 6:15						
		roup home had bed bugs buse." Staff A indicated						
	l							<u> </u>
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Event ID:	LW5N1	1 Facility I	^{ID:} 000961	If continuation sl	neet Pa	ge 4 of 24

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		A. BUII	LDING	ONSTRUCTION 00	(X3) DATE COMPL 10/18/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF I	PROVIDER OR SUPPLIER	8			NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		had undergone 3		TAG			DATE
	1 0 1	Far. Staff A stated "They					
		tresses where the bed					
	•	t they have spread					
	through house."	Staff A stated she last					
	saw a bed bug in	the medication room on					
	10/11/11 that wa	s "brownish in color with					
	a flat top."						
		taff B on 10/12/11 at 6:35					
		oup home had bed bugs h." Staff B indicated he					
		esterday when passing the					
		tions. Staff B stated the					
		mpany come in and "spray					
	<u> </u>	" Staff B indicated the					
		in client C's bedroom.					
	_	l client C complained					
		oiting her and that is when					
	they discovered	the bed bugs.					
	Interview with s	taff C on 10/12/11 at 6:46					
		e facility had bed bugs.					
		I the facility was in the					
	process of treating	ng the bed bugs. When					
	_	ents' mattresses had been					
	changed, staff C	stated only clients A and					
	C as the bed bug	s were in their bedrooms.					
	The facility's po	licy and procedures were					
		13/11 at 11:51 AM. The					
	facility's 5/24/11	policy entitled					
	Emergency, Disa	aster, Evacuation Plans					
	and Responses in	ndicated the policy					

PRINTED: 11/23/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447			LDING	NSTRUCTION 00	(X3) DATE COMPL 10/18/2	ETED	
NAME OF L	PROVIDER OR SUPPLIER	<u>l</u>	D. WIIV		DDRESS, CITY, STATE, ZIP CODE		
					NOLLTON RD		
VOCA C	ORPORATION OF	Indiana 		INDIAN	APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		on entitled "Emergency					
		ifestation (bed bugs)."					
	•	cy indicated "bed bugs					
	(Cimex lectulario						
	· ·	oval shaped, flattened and					
	about 3/16 to 1/5	inch long. Their flat					
	shapes enables th	nem to readily hide in					
	cracks and crevio	ces. Newly hatched bugs					
	are nearly colorle	ess. Nymphs can					
	immediately beg	in to feed. They require a					
		der to mold. The adult's					
		compass 12-18 months.					
		enerations can occur each					
	year. Bed bugs l	hide in dark, protected					
	sitesB. Check	mattresses, box springs					
	and bed frame, a	s well as crack and					
		bed bugs may hide in					
		r when digesting a blood					
		24/11 bed bug policy					
		ility would treat the					
		he policy indicated "2.					
		um the mattresses and					
	_	pedding and clothing in					
		y on high heat for 30					
		e a stiff brush to scrub the					
		and box springs to					
	_	gs and their eggs. 4.					
		ss and box springs are					
		cuumed, put each in a					
		s encasement. Leave the					
	_	r a year7. Insecticide					
		e completed by a					
	^	erminator using currently					
	excepted bed bug	g removal practices. Be					

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

Event ID:

LW5N11 Facility ID:

000961

If continuation sheet

Page 6 of 24

PRINTED: 11/23/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/18/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	10, 10,2	
NAME OF I	PROVIDER OR SUPPLIEF	2			NOLLTON RD		
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	prepared to vaca		_	TAU			DATE
		ours after arrival of the					
		n." The facility's 5/24/11					
		ecifically indicate what					
		d do to prevent the spread					
	1	thers while undergoing					
	_	tments to eliminate the					
	bed bugs.						
	Interview with a	dministrative staff #3 on					
	10/13/11 at 1:05	PM and at 2:55 PM					
	indicated client (C went to another group					
	home for 2 to 3 v	weeks due to bed bugs in					
	her bedroom. A	dministrative staff #3					
	indicated the bed	l bugs were brought into					
	the group home	from some items the					
	client's mother h	ad gave the client.					
	Administrative s	taff #3 indicated the					
	group home had	been treated for the bed					
	bugs and client A	A and C's mattresses and					
		e replaced as they were					
		n the room with the bed					
	_	rative staff #3 indicated					
		esses/box springs had					
		th plastic to prevent the					
	_	eturning. Administrative					
		d clients C, D, E and F's					
	mattresses had n						
		taff #3 indicated the pest					
		had completed a third					
		ast week. When asked					
	when bed bugs v	· ·					
		aff #3 stated "about a					
	month ago." The	e administrative staff					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE (COMPL 10/18/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					NOLLTON RD		
	ORPORATION OF				APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
		d been found/seen on a					
		oom. Administrative					
	staff #3 indicated	d facility staff had not					
		any bed bugs recently.					
	Administrative s	taff #3 indicated facility					
	staff should repo	rt any bed bugs so the					
	facility could inf	form the pest control					
		would come back out.					
		e facility was checking					
	_	ight, administrative staff					
		dministrative staff #3					
		ility staff had used PPE					
	_	igs were first found in the					
	_	the spread of the bed					
	bugs.						
	Interview with a	dministrative staff #2 and					
		t 9:30 AM indicated the					
		d been completed.					
	Administrative s	taff #2 indicated facility					
	staff should have	e reported seeing a bed					
	bug this week.	Administrative staff #2					
		'operational decision" to					
	J - 1	attress covers for clients					
		nistrative staff #2					
		not have any input into					
		lministrative staff #2					
		ility's policy for bed bug					
		ot specifically include any					
	^	rective measures the					
	1	nplement/take to prevent					
	_	bugs to other parts of					
	be professionally	, and/or others except to					
	be professionally	ucateu.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G447 10/18/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4114 KNOLLTON RD VOCA CORPORATION OF INDIANA INDIANAPOLIS, IN46208 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 9-3-1(a) W0149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. CORRECTION: The facility must Based on observation, interview and W0149 11/20/2011 develop and implement written record review for 1 of 3 sampled clients policies and procedures that (A) and for 1 additional client (D), the prohibit mistreatment, abuse or facility failed to implement its policy and neglect of the client. Specifically, procedures in regard to reporting all a report was submitted to Divisionof Disability and allegations of abuse, injuries of unknown Rehabilitation Services regarding origin immediately to the administrator. client A's injury of unknown The facility failed to implement its policy origin, after the reporting error was and procedures to conduct through discovered during a review of documentation and facility staff investigation in regard to incident of were retrained regarding unknown origin. reporting requirements. Specifically for Client Findings include: D.supervisory staff was also retrained regarding the need to draw conclusions in investigations The facility's policy and procedures were based solely on the evidence reviewed on 10/13/11 at 11:51 AM. The gathered during the investigation. facility's 9/14/07 policy entitled Abuse, Additionally, staff A was suspended on 10/18/11 when, Neglect, Exploitation indicated "Adept through investigation, additional employees actively advocate for the rights allegations indicated suspected and safety of all individuals. All abuse. These allegations have allegations or occurrences of abuse, been substantiated and Staff A's employment will be terminated. neglect and exploitation shall be reported PREVENTION: Operations Team to the appropriate authorities through the members will review all facility appropriate supervisory channels and will documentation on an ongoing be thoroughly investigated under the basis to assure all incidents are reported as required and the policies of Adept, Rescare, local, state and Operations Team will review all federal guidelines." The 9/14/07 policy facility investigations to assure indicated "...3. Any employee who conclusions match the gathered

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

Event ID:

LW5N11

Facility ID:

000961

If continuation sheet

Page 9 of 24

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MU A. BUII B. WING	DING	00	(X3) DATE S COMPLI 10/18/20	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN46208					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	abuse, neglect or immediately notif (PD) Director of of Quality Assurate investigation Director and the also be notified policy indicated neglect and incidunknown origin of the staff immediately unknown origin regarding client A. 2. The facility fathorough investign D's injury of unknown origin of the control of the	ridual is the victim of exploitation will of the Program Director Operations and Director ance who will then begin process. The Executive Regional Director will" The facility's 9/14/07 allegations of abuse, lents of injuries of would be investigated. Aniled to ensure facility of the administrator A. Please see W153. Aniled to conduct a gation involving client mown origin and in gation of abuse involving see W154.			evidence. Additionally the Executive Director and Huma Resources Director will cond Peer Review of all investigatic conducted by the Operations Team to assure conclusions match the gathered evidence that all relevant evidence is collected. Responsible Parti QDDPD, Support Associates Operations Team, Executive Director, HR Director	uct a ons and es:		
W0153	mistreatment, neg injuries of unknow immediately to the	ensure that all allegations of lect or abuse, as well as n source, are reported administrator or to other ance with State law through dures.						

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	(X2) MULTIPLE CONSTRUCTION O0			(X3) DATE SURVEY COMPLETED	
		15G447	A. BUILD	ING		10/18/2	
			B. WING	CTDEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8			IOLLTON RD		
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	CORRECTION:		DATE
		ew and record review for	W01	153	The facility mustensure that a	all	11/20/2011
		s of abuse, neglect and/or			allegations of mistreatment,		
		own origin reviewed, the			neglect or abuse, as well		
	-	immediately report an			asinjuries of unknown source	e are	
	injury of unknov	•			reported immediately to the administrator or toother offici	als in	
	administrator for	client A.			accordance with state law	นเร แ	
					through established procedu	res.	
	Findings include	:			Specifically,a report was made	de to	
					the Division of Disability and	dul#	
		l was reviewed on			Rehabilitation Services and A Protective Services regarding		
		40 p.m. A "Program Plan			client A's injury of unknown of	_	
	Progress Note" d				afterthe reporting error was		
	· · · · · · · · · · · · · · · · · · ·	iter discovered a bruise			discovered during a review o		
		veen knee and ankle.			documentation and facilitysta were retrained regarding	att	
		e size of a half silver			reporting requirements.		
	dollar. Purplish	blue"			1 0 1		
					PREVENTION:		
		oortable incident reports			The facility will send copies of internal incident reports to the		
		n 10/13/2011 at 11:20			administrator via electronic fa		
	-	y's reportable incident			upon completion, to assure		
	•	1 to 10/11 indicated there			theoperations team has the a	ability	
		tation to indicate an			to report incidents to state agencies asrequired in a time	alv	
		vn origin for client A had			manner. Members of the	y	
	been immediatel	y reported to			operations team will		
	administrator.				compareinternal incident rep		
					to the agency's incident track log to assureincidents are	king	
	_	iew on 10/14/2011 at			reported as required.		
		QDDP (Qualified			1		
	-	Disabilities Professional)			Responsible Parties:		
		s not aware of client A's			QDDPD, Support Associates Operations Team	,	
	injury of unknov	2			орегацонь теані		
		e indicated the injury					
		n immediately reported to					
	the administrator	r					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/18/2011
	ROVIDER OR SUPPLIER		4114 K	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD NAPOLIS, IN46208	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W0154	9:30 a.m., Admir indicated he was documented on a 10/05/2011 on 10 Administrative st staff should have of unknown origin when found on 19 9-3-2(a) The facility must halleged violations a Based on intervice 2 of 8 allegations injuries injuries or reviewed, the fact thorough investigation determine how the investigation determine how the injuries of unknow to an allegation of involving client of the facility's preports and/or involving the investigation of involving client of the facility's preports and/or involving the facility is preported the facility in the facility in the facility is preported the facility in the facility in the facility is preported the facility in the facility in the facility in the facility is preported the facility in the facility in the facility is preported the facility in the facility in the facility is preported the facility in the facility in the facility is preported the facility in the facility in the facility is preported the facility in the facility in the facility is preported the facility in the facility in the facility is preported the facility in the facility in the facility is preported the facility in the facility in the facility is preported the facility in the	notified of the bruise progress note, dated 0/13/2011. raff #2 indicated facility reported client A's injury in to the administrator 0/5/11. ave evidence that all are thoroughly investigated. we and record review for of abuse, neglect and/or of unknown origin ility failed to conduct a gation in regard to an origin for client D as did not actually ne client received the win origin, and in regard of staff to client abuse G.	W0154	CORRECTION: The facility in have evidence that all allege violations are thoroughly investigated. Specifically for Client D, supervisory staff was retrained regarding the need draw conclusions in investigated based solely on the evidence gathered during the investigation additionally, staff A was suspended on 10/18/11 whee through investigation, additionally allegations indicated suspect abuse. These allegations has been substantiated and Staff employment will be terminate PREVENTION: The Operation Team will review all facility investigations to assure conclusions match the gather evidence. Additionally the Executive Director and Humanical contents are substantially the executive Director and Humanical contents are supported by the substantial contents are supported by the substantial contents are supported by the supported by	as as ato ations e ation. n, onal ted ve f A's ed. ons

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G447		LDING	NSTRUCTION 00	СО	ATE SURVEY MPLETED 8/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4114 KNOLLTON RD INDIANAPOLIS, IN46208					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
IAU	Indiana Division Rehabilitative Se 07/18/2011 at 7:: "While assistin morning shower, diameter (SIC) w middle and black Supervisory staff were notified per coordinator has i the origin of the An Indiana Divis Rehabilitative Se Up Report, dated "The bruise on D's] abdomen he complications. T team determined actually saw [clie she most likely re result of bumping transferred in or wheelchair. Thre the interdisciplin [client D] rushes from her wheelcl results in injury. self-injurious bel [client D's] Beha A "STAFF INTE UNKNOWN OR	of Disability and ervices report, dated, 50 a.m., indicated, g [client D] with her staff noted a 4 in (inch) which was red in the around the edges. If and the nurse on call protocolThe Program initiated an investigation injury" sion of Disability and ervices Incident Follow 108/01/2011 indicated, the left side of [client aled without Chrough investigation, the that although no one ent D] sustain the injury, ecceived the bruise as a g into something as she		IAU	Resources Director will Peer Review of all inves conducted by the Opera Team to assure conclus match the gathered evic that all relevant evidenc collected. Responsible QDDPD, Support Assoc Operations Team	conduct a stigations stions stions dence and e is Parties:		

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)	MULTIPLE CO			(X3) DATE COMPL	
AND PLAN	OF CORRECTION	15G447		UILDING	00		10/18/2	
		100441	B. W	ING			10/10/2	011
NAME OF I	ROVIDER OR SUPPLIER	R			DDRESS, CITY, STA	ATE, ZIP CODE		
VOCA C	ORPORATION OF I	INDIANA			NOLLTON RD APOLIS, IN4620	18		
			 		OLIO, IIV -1 020			ave
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX		LAN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCE	ED TO THE APPROPRIATICIENCY)	E	DATE
		"falling, walking or						
		objects in or outside of						
	the home," and							
	· ·	ehavior within the past 24						
	hours."	onavior within the past 24						
	nours.							
	Δ "STΔEF INITE	ERVIEW - INJURY OF						
		RIGIN" form, dated						
		me recorded, indicated						
	· ·	client D "falling, walking						
		any objects in or outside						
		nd did not indicate						
	· ·							
		ehavior within the past 24						
	hours."							
	A "STAFF INTE	ERVIEW - INJURY OF						
		RIGIN" form, dated						
		00 p.m., indicated staff						
		t D "falling, walking or						
		objects in or outside of						
	the home," and d							
		ehavior within the past 24						
	hours."	chartor within the past 24						
	nours.							
	Δ "STAFF CON	ISUMER INJURY OF						
		RIGIN CONFIDENTIAL						
		TEMENT FORM" dated						
		0 p.m., indicated the						
		ed did not see client D						
		OR HIT ANY OBJECTS						
		E THE HOME," and did LF IN INJURIOUS						
		VITHIN THE PAST 48						
	HOURS."							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	LW5N	11 Facility I	D: 000961	If continuation sh	neet Par	ge 14 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		15G447	B. WIN	G		10/18/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF I	INDIANA			NOLLTON RD APOLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A "STAFF CON	SUMER INJURY OF					
		RIGIN CONFIDENTIAL					
		ΓΕΜΕΝΤ FORM" dated					
	7/19/2011, no tin	ne recorded, indicated the					
	client interviewe	d did not see client D					
		R HIT ANY OBJECTS					
		E THE HOME," and did					
		LF IN INJURIOUS					
	BEHAVIORS WITHIN THE PAST 48						
	HOURS."						
	A "CONSUMER	NTERVIEW -					
		KNOWN ORIGIN					
	CONFIDENTIA						
		ORM" dated 7/23/2011					
	at 2:15 p.m., indi	icated the client					
	interviewed did 1	not see client D "falling,					
	walking or runni	ng into any objects in or					
		me," and did not indicate					
		him/herself within the					
	past 24 hours."						
	A "CONSIIMED	R INTERVIEW INJURY					
	OF UNKNOWN						
	CONFIDENTIA						
		ORM" dated 7/23/2011					
	at 2:20 p.m. indi						
	_	not see client D "falling,					
	walking or runni	ng into any objects in or					
		me," and did not indicate					
		him/herself within the					
	past 24 hours."						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		15G447	B. WIN	G		10/18/20)11
NAME OF F	PROVIDER OR SUPPLIER	3	-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					IOLLTON RD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN46208		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	dated "Final Report"					
	ı `	immary) indicated,					
		SUBSTANTIATES					
		MER (client D) DID					
		Y TO HIMSELF (SIC)					
	OR OTHERS A	S A RESULT OF HER					
	BEHAVIOR"	-					
		I not specifically indicate					
	what kind of self	f-injurious behavior client					
	D demonstrated	to cause the injuries as					
	facility staff indi	icated client D did not					
	demonstrate any	self-injurious behavior.					
	During an interv	iew on 10/14/2011 at					
	10:00 a.m., Adm	ninistrative staff #2 stated,					
	he could, "only s	speculate" the injury was					
	due to self-injuri	ious behavior because					
	client D "engage	ed in self injurious					
	behaviors." Adr	ninistrative staff #2					
	indicated he did	not consider self					
	transferring fron	n the wheel chair to be					
	self injurious bel	havior. He stated "poor					
	-	sed on the incident report.					
	2. The facility's	reportable incident					
	1	vestigations were					
	•	13/11 at 11:20 AM. The					
		reportable incident					
	<u>-</u>	"A co-worker reported to					
	•	ordinator that staff [staff					
		I hitting [client G].					
	_	not injured but told the PC					
	that she had been						
	mai she nad beel	n roughed up.					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CO	NSTRUCTION 00		(X3) DATE COMPL	
		15G447		BUILDING			10/18/2	
		1	В. У	WING	DDDESS CITY OF	ATE ZIR CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STA NOLLTON RD	ATE, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN4620	08		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S P	LAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FUI		PREFIX	(EACH CORRECTIV CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	ON)	TAG	DEF	ICIENCY)		DATE
	1	21/11 Investigation						
	1	ated facility staff and						
	clients were inte	erviewed. The 9/21/11						
	investigation ind	dicated client G was						
	interviewed 2 di	ifferent times. Client G's						
	9/15/11 witness	statement indicated clien	t					
	G indicated clier	nt D had attempted to hit						
	her and they wer	re arguing back and forth						
	Client G's 9/15/1	11 witness statements						
	indicated client	G did not substantiate						
	staff A hit her. (Client G's witness						
	statement indica	ated the client stated						
	clients D and E l	hit her when client E was						
		by staff. Client G's witnes						
		ated she could not name						
		orked with her that						
		stated a name of a staff						
	_	not have that name in her						
	group home.	not have that hame in her						
	group nome.							
	The facility's 9/2	21/11 investigation						
	indicated the sta	iff person who reported						
		dent "she observed [staf	f l					
	_	the medication room and						
	_	veral times while						
		direct her" The 9/21/1	1					
		dicated client G was						
	_	oral incident with client I)					
		ged client G hit client D.						
	1	on indicated staff C						
		ervene and client G						
	scratched the sta							
		dicated "[Staff C]said						
	_	rent into the medication						
DODL CLC						TO (1 1 1 1		
FORM CMS-2	567(02-99) Previous Versi	ions Obsolete Event 1	D: LW5N	V11 Facility I	^{ID:} 000961	If continuation sh	eet Pa	ge 17 of 24

PRINTED: 11/23/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE COMPL	
AND TEAN	or condition	15G447		LDING		10/18/2	
		100117	B. WIN		DDDDGG CITY CTATE TIP CODE	10/10/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF I	INDIANA			APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	nd aid for herself, [staff					
	A] (Support Asso	_					
		e out of the medication					
		d [client G] from behind					
		an open hand several					
		ng 'I told you to stop.'					
		aff B]was in the living					
		" The facility's 9/21/11					
		icated staff A and B					
		did not hit client B. The					
	· ·	ation indicated staff A					
indicated she had placed her hand on							
		n and asked the client to					
		ent D's items. The					
	investigation ind						
	"described her	action as gentle and not					
	restraining" T	the facility's investigation					
	indicated staff C	indicated staff A had					
	placed her hand	on client G's forearm, and					
	did not indicate s	staff A had hit client G.					
	The facility's inv	estigation also indicated					
	staff A and B inc	licated client G did not					
	hit client D.						
	The facility's 4/2	1/11 "Conclusions:"					
		vestigation indicated "1.					
	The evidence do	es not substantiate that					
	[staff A]hit [cli	ent G] (consumer/alleged					
	victim) on the ev	rening of Wednesday,					
	9/14/11. 2. The	evidence does not					
	substantiate that	[staff A's] actions					
	resulted in [clien	t G] experiencing injury					
	or mental anguis	h. 3. Based on					
	demonstrative an	nd testimonial evidence,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		15G447	B. WIN			10/18/2	011
NAME OF I	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA			NOLLTON RD APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		artially obscured view of		IAG			DATE
		lent and most likely					
	_	what she believed she					
	observed."						
	The facility's 4/2	21/11 investigation did not					
	specifically indic	cate staff C stated her					
	_	ally obscured." The					
	1	investigation did not					
indicate the facility re-interviewed staff in							
regard to their conflicting statements to ensure the alleged abuse did not occur.							
	ensure the allege	ed abuse did not occur.					
	Confidential inte	erview M stated staff A					
	"slapped" client	G in the back of the head					
		Confidential interview M					
		head moved "forward"					
		was slapped in the back of					
		dential interview M					
		G had a stroke a couple of ould get confused.					
	, care ago and w	our got confused.					
		dministrative staff #3 on					
		PM indicated she did not					
		afficts between staff at the					
		dministrative staff #3					
		got a waiver" and was ortive living group home.					
	inoved to a supp	orave fiving group nome.					
	Interview with a	dministrative staff #2 on					
		AM indicated the facility					
		ate staff A hit client G					
	_	ff C indicated it happened.					
	Administrative s	staff #2 indicated client G					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G447	B. WING		10/18/2011
	PROVIDER OR SUPPLIER		4114 KI	ADDRESS, CITY, STATE, ZIP CODE NOLLTON RD IAPOLIS, IN46208	
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID	I	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
W0157	substantiate the a staff #2 indicated witnessed the inca abuse occurred. This federal tag is #IN00096931. 9-3-2(a) If the alleged viola corrective action in Based on 1 of 9 a neglect and/or in reviewed, the factorrective measure incident of staff to there were conflicted involving client of the facility's repland/or investigat 10/13/11 at 11:20 9/14/11 reportable indicated "A co-Program Coordinates was observed hit	allegations of abuse, juries of unknown origin ility failed to put in place res to address/monitor an to client abuse where cting statements. G. cortable incident reports ions were reviewed on D. A.M. The facility's le incident report worker reported to the nator that staff [staff A] ting [client G]. [Client ed but told the PC that	W0157	CORRECTION: If the alleg violation is verified, approparation must be taken. Specified to additional substantial allegations, Staff A is curre suspended and termination employment has been appropriately entire to the facility will deaplan to implement protect measures including but not limited to an increased supervisory presence, cour and retraining and weekly follow-up with potentially a clients. Members of the Operations Team will follow with facility supervisory state oversee the implementation protective measures are in Responsible Parties: QDDF Support Associates, Opera Team	riate iffically, ated intly of roved. licting velop ive iseling ffected r-up if to place. PD,

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER		(X2) MUL	TIPLE CO	NSTRUCTION		(X3) DATE COMPL	
AND PLAN	OF CORRECTION	15G447		A. BUILD	ING	00		10/18/2	
		130441		B. WING				10/10/2	011
NAME OF F	PROVIDER OR SUPPLIER	₹				DDRESS, CITY, STA	TE, ZIP CODE		
V/OC	ORPORATION OF I	ΙΝΠΙΔΝΙΔ				IOLLTON RD APOLIS, IN4620	18		
						- OLIO, IIV4020			
(X4) ID PREFIX		TATEMENT OF DEFICIENCING ICY MUST BE PERCEDED BY		рі	ID REFIX		LAN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORM			TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT	E	DATE
1710		21/11 Investigation	111011)		1710				DITTE
		ted facility staff and							
	1	rviewed. The facility	'c						
		ation Summary indica							
	_	clients were interview							
	l *	estigation indicated cl							
		ed 2 different times.	10111						
		1 witness statement							
		G indicated client D h	ad						
		her and they were arg							
		Client G's 9/15/11	umg						
		nts indicated client G	did						
		staff A hit her. Client							
		nt indicated the client	. 0 5						
		and E hit her when cli	ent						
		oned by staff. Client							
		nt indicated she could							
		ho worked with her th							
		tated a name of a staff							
	_	not have that name in							
	group home.	not have that hame in	iici						
	group nome.								
	The facility's inv	vestigation indicated the	ne						
		reported the alleged							
	_	observed [staff A] com	ne						
		ation room and hit [cl							
		while attempting to	10111						
	_	The 9/21/11 investiga	tion						
	indicated client (VI.011						
		ent with another clien	f						
		n indicated staff C							
		ervene and client G							
	scratched the sta								
		licated "[Staff C]sai	d						
EODM CMC 2				/ENI4.4	Easilie. P	D: 000004	If continued:	vaat D	04 -£04
FURIN CINIS-2	567(02-99) Previous Version	ons Obsolete Ev	vent ID: LW	/5N11	Facility II	D: 000961	If continuation sh	icei Pai	ge 21 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2)	(X2) MULTIPLE CONSTRUCTION				SURVEY ETED	
AND PLAN	OF CORRECTION	15G447	A. B	UILDING	00		10/18/2	
		130447	B. W	ING			10/10/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STA	ATE, ZIP CODE		
VOCAC	ORPORATION OF I	INIDIANIA			NOLLTON RD APOLIS, IN4620	00		
					APOLIS, IN4020	U6		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENC	VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	E	COMPLETION DATE
TAG				IAG	DLI	TELENC I)		DATE
		ent into the medication						
	1	nd aid for herself, [staff						
	A] (Support Asso	•						
		e out of the medication						
		d [client G] from behind						
		an open hand several						
	1	ng 'I told you to stop.'						
	' ' '	aff B]was in the living						
	room at the time.	" The facility's 9/21/11						
	investigation ind	licated staff A and B						
	indicated staff A	did not hit client B. The						
	facility's investig	gation indicated staff A						
	indicated she had	d placed her hand on						
	client G's forearr	m and asked the client to						
	stop throwing cli	ient D's items. The						
	investigation ind							
		action as gentle and not						
		The facility's investigation						
		indicated staff A had						
		on client G's forearm, and						
	1 ^	staff A had hit client G.						
	ard not marcate s	starr it had hit chefit G.						
	The facility's 4/2	21/11 "Conclusions:"						
	1	vestigation indicated "1.						
		es not substantiate that						
		ient G] (consumer/alleged						
	' ' '	vening of Wednesday,						
	· /	e evidence does not						
		[staff A's] actions						
		=						
	_	nt G] experiencing injury						
	or mental anguis							
		nd testimonial evidence,						
		artially obscured view of						
	the alleged incide	ent and most likely						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	LW5N	11 Facility I	D: 000961	If continuation sh	eet Pa	ge 22 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G447	B. WIN			10/18/2	011
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
VOCA C	ORPORATION OF	INDIANA			NOLLTON RD APOLIS, IN46208		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		vhat she believed she					
	observed."						
	The facility's 4/21/11 investigation did not						
	include any addi	tional corrective					
	measures on hov	w the facility would					
	monitor staff A	and/or staff at the group					
	home, as their w	ras conflicting evidence					
	given during the	investigation, to ensure					
	clients would no	t be abused.					
		erview M stated staff A					
		G in the back of the head					
		Confidential interview M					
		head moved "forward"					
		was slapped in the back of					
		dential interview M					
		G had a stroke a couple of					
	years ago and w	ould get confused.					
	Interview with a	dministrative staff #3 on					
	10/13/11 at 1:05	PM indicated she did not					
	know of any cor	iflicts between staff at the					
	• •	dministrative staff #3					
		got a waiver" and was					
	moved to a supp	ortive living group home.					
	Interview with a	dministrative staff #2 on					
		AM indicated the facility					
		ate staff A hit client G					
		of C indicated it happened.					
		staff #2 indicated client G					
		3 times and did not					
		abuse. Administrative					
							<u> </u>

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G447			(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/18/2011
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	R		NOLLTON RD	
VOCA C	ORPORATION OF	INDIANA	INDIAN	APOLIS, IN46208	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
0		d the other staff who	1110		DATE
		cident did not indicate the			
	abuse occurred.				
		1			
	#IN00096931.	relates to complaint			
	#11100070731.				
	9-3-2(a)				