CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814			r í	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 08/13/	ETED
	ROVIDER OR SUPPLIER			8307 C	ADDRESS, CITY, STATE, ZIP COD CASTLETON BLVD NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
W 0000							
Bldg. 00	#IN00438014.  Complaint #IN0043 deficiencies related W149 and W154.  Survey date: Augus Facility Number: 01 Provider Number: 1 AIMS Number: 201 These deficiencies a accordance with 46	10453 5G814 408320 also reflect state findings in	W	0000			
W 0149	483.420(d)(1) STAFF TREATME	ENT OF CLIENTS					
Bldg. 00	The facility must describe written policies and mistreatment, neg Based on record revisampled clients (Based on physicall client Barrow from accord (Emergency Room) abuse and to thorous client Based was taken to the facility's BDS (Compared to the facility's BDS).	develop and implement d procedures that prohibit elect or abuse of the client. Five and interview for 2 of 3 and C), the facility failed to by and procedures to prevent y abusing client C, to prevent apanying client C to the ER and witnessing the physical ghly investigate the reason to the ER with client C.	W	0149	CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abust the client. Direct Support Staff be retrained on abuse, neglect mistreatment and exploitation prevention, detection, and reporting.  PREVENTION: An Area Supervisor or Direct	se of f will st,	09/12/2024
	reports and investig	ations were reviewed on			Support Lead will be present,		

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

(X6) DATE

TITLE

Bob Morris QIDP Manager 08/28/2024

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.

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

PRINTED: 09/11/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G814	B. W	ING		08/13/	2024
				CTREET	ADDRESS SITE OF THE SOL		
NAME OF P	ROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
1/001 0/		INIDIANIA			ASTLETON BLVD		
VOCA CO	ORPORATION OF	INDIANA		INDIANAPOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	8/13/24 at 10:04 AM	M.			supervising active treatment d	urina	
					no less than five active treatme	•	
	-1. A BDS report dated indicated, " On the				sessions per week, on varied		
	afternoon of 7/2/24, while preparing to leave his				shifts to assist with and monito	or	
		rogram, [client C] attempted to			skills training, including but no		
		om his housemate [client D].			limited to assuring a training		
		nate [client D] (sic) became			environment free from abuse,		
	_	aff could intervene, [client D]			neglect and mistreatment. For	the	
	_	head with his lunch box. [Client			next 30 days, members of the		
		ration and avulsion (Separation			Operations Team (comprised	of	
	_	e) of his left earlobe. Staff			the Executive Director, Operat		
	-	C] to the [Name] Hospital			Managers, Program Managers		
		Department per nurse			Quality Assurance Manager, Q		
		R (Emergency Room) physician			Manager, QIDPs, Quality	χ.υ.	
		with assault and admitted him			Assurance Coordinators, Area		
	-	reatment of the injury. At 8:30			Supervisors, Assistant Nurse		
	_	he [Name] Police Department			Manager and Nurse Manager) will		
		are residential supervisor and			conduct twice weekly		
		ome to the hospital. Police			administrative monitoring durir	na	
	_	visor that while waiting on			varied shifts/times, to assure	9	
	-	dmission process for [client C],			interaction with multiple staff,		
	_	[FS (Former Staff)] #1 was			involved in a full range of activ	e	
		a slapping [client C], pulling			treatment scenarios, including		
		g him down by his neck. [FS			weekend observations. After 3		
		d charged with Battery			days, administrative monitoring		
	_	Person. ResCare suspended			will occur no less than weekly	9	
	_	ng investigation (sic) prior to			until all staff demonstrate		
		tive Director was notified			competence. After this period	of	
	immediately."				enhanced administrative	•.	
	,				monitoring and support, the		
	-"Plan to Resolve (1	Immediate and Long Term)."			Executive Director and Region	nal	
	(-				Director will determine the leve		
	-"[Client Cl has a o	ne-inch laceration with a 1/4			ongoing support needed at the		
		s left earlobe. He remains			facility. Current Operations Te		
		esCare nursing will remain in			members received training from		
	-	h the hospital to assure			the QIDP Manager on 12/14/2		
	continuity of care	-			assure a clear understanding		
		•			administrative monitoring as	٠.	
	-2. A BDS report d	ated 7/3/24 indicated, " On			defined below.		
	_	housemate [client C] was taken			· The role of the		
	, [andin D b] !		1		1110 1010 01 1110		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G814			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/13/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE COMPLETION		
IAU	to the [Name] Hosp Department and [cl. with staff. ResCare report that direct su [client C] and pulle presence. [FS #1] w investigation".  -A review of the BI indicated client C w for medical treatme at the hospital, FS # client C's hair. The Police Officers arre indicated client B w C and client B with client C.  -An IS (Investigative to 7/8/24 indicated client A]:"  -"I call him [FS #1]  -"I haven't seen him -"He's been really compared to the property of the property o	ital [Name] Emergency ient B] accompanied him along administrative staff received a pport staff [FS #1] slapped d [client C's] hair in [client B's] ras suspended pending  OS reports dated 7/3/24 ras injured and taken to the ER nt. The review indicated while f1 slapped, pushed and pulled review indicated the Hospital's sted FS #1. The review ras taken to the ER with client ressed staff physically abuse  re Summary) form dated 7/2/24 the following:  " " " " " " " " " " " " " " " " " "	TAU TAU	administrative monitor is not simply to observe & report.  When opportunities for training are observed, the manust step in and provide the training and document it.  If gaps in active treate are observed the monitor is expected to step in and mode appropriate provision of supton Assuring the health a safety of individuals receiving supports at the time of the observation is the top priority.  Review all relevant documentation, providing documented coaching and the as needed.  Administrative oversight will include assuring a training environment free from abusing neglect and mistreatment.  RESPONSIBLE PARTIES: Area Supervisor, Direct Support Staff, Operations Team, Regional Director	or nonitor e ment del the ports. and ag y. raining e, QIDP, aport		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       08/13/2024				ETED	
NAME OF P	ROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
VOCA CO	ORPORATION OF	INDIANA			APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	down but he doesn'	t really listen."					
	-"Then he (FS #1) g in the back."	got aggressive and kicked him					
	-"He wasn't mad bu because [client C] v	nt he was really irritated wouldn't listen."					
	-"I don't want to ge	t anybody fired though."					
	-"That's the only tir or frustrated."	ne I saw him (FS #1) get angry					
	-"But he's ok in the house."						
	-"He hasn't done that to anybody else in the house."						
	-"[Client H]:"						
	-"I know [FS #1], I	don't know."					
	-"I know how much	n I love everything."					
	-"I haven't seen him	n be mean or hit us."					
	-"I don't think so."						
	-"I haven't seen him think so."	n be mean to [client C], I don't					
	-"[Client F]:"						
	-"I know who that s	staff is (FS #1)."					
	-"I don't think I've s	seen him be aggressive."					
	-"I don't think I've s	seen him be physical to [client					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/13/2024	
	PROVIDER OR SUPPLIER			8307 CA	DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION heard him make any threats."	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	-"[Client D]:"	icard iiiii iiiake any tineats.					
	-"I don't know who that is (FS #1)."						
	-"I don't know any	new staff that's been working."					
	-"I haven't noticed aggressive."	any staff being physically					
	-"[Client E]:"						
	-"I know who that is (FS #1)."						
	-"I haven't seen hin	ı hit anybody."					
	-"I haven't seen hin	1 be mean to anybody."					
	-"I haven't seen hin	1 cursing."					
	-"[Client A]:"						
	-"I've never seen hi us."	m (FS #1) get aggressive with					
	-"He's been good to	o me."					
	-"I've never seen hi C]."	m get aggressive with [client					
	-"I've never seen hi	m make any threats."					
	-"[AS (Area Superv	visor)] #1:"					
	-"[Client C] was at with his lunch box.	the ER after [client D] hit him					
	-"The buckle or sor [client C's] ear."	nething caused a bad cut on					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 08/13/2024			
	PROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD IAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	-"That's why we too	ok him to the ER."			
	Hospital stated that	rom a police officer at [Name] he needed to speak with me in legal matters due to [client C's] visit."			
	_	C] became agitated or to the hospital as requested."			
	-"I met with the officers, and they said that they had the new [Address] staff, [FS #1] on camera slapping [client C], pulling his hair and shoving him down by his neck while in the behavioral health building and being treated. They're currently placing the staff member under arrest."				
	-"[FS #1] was brand	d new."			
	-"It was only his fif	th day working."			
	-"I had not seen hin clients."	n act inappropriately with the			
	-"No other staff or o	clients had complained about thing to me."			
	-"[Staff #2]:"				
	-"I worked three shappened to [client	ifts with [FS #1] before what C] at he ER."			
		ust getting to know everyone, h the (sic), and helping them."			
	-"He was really chi	11."			
	-"He never even rai	sed his voice even (sic)."			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       08/13/2024				ETED	
	PROVIDER OR SUPPLIER		•	8307 CA	DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION If flags."	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	-"The guys liked hin	m."					
	-"He was nice to the	em."					
	-"No one reported to problems."	o me that there were any					
	-"I didn't hear anyth [client C] in the bac	ning about [FS #1] kicking k."					
	-"I definitely didn't see it happen."						
	-"Nothing like that."						
	-"He was really chil	ll with the guys".					
	-"Factual Findings	.".					
		ralled by the [Name] Police and R to speak to them, on the I."					
	Support Professiona	[AS #1] that DSP (Direct al) [FS #1] was observed on ient C], pulling his hair and by his neck."					
		rested [FS #1] and charged him at a Disabled Person."					
	-"DSP [FS #1] was	formally charged on 07/07/24."					
		eash bond on 07/07/24 and was dy with an initial hearing set g]."					
		to respond to text and voice or an interview by ResCare					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814	A. BUILDING B. WING	nstruction <u>00</u>	(X3) DATE SURVEY  _ COMPLETED  08/13/2024	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	8307 CA	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
investigators."  -"ResCare investigators made in-person, phone and written requests to view or obtain a copy of the video of the incident."  -"[Name of Hospital] Detective [Name] verified the content of the video and explained that a copy of the video could not be provided and that ResCare investigators could not be permitted to view the video due to the ongoing status of the investigation."  -"Indiana Adult Protective Services (APS) Detective [Name] contacted ResCare Investigators on 07/07/24 and also confirmed the content of the video".  -"Hospital records said that in addition to a 1 cm (centimeter) laceration with visible cartilage on his left ear, [client C] had a 4 cm yellow bruise on his right chest and multiple other bruises on his arms, left chest, back and left knee, in various stages of healing".  -"Conclusion:"  -"1. The evidence substantiates that DSP [FS #1] slapped [client C] on 7/2/24."  -"2. The evidence substantiates that DSP [FS #1] pulled [client C] down by his neck on 7/2/24."  -"3. The evidence substantiates that DSP [FS #1] pushed [client C] down by his neck on 7/2/24."  -"4. The evidence substantiates that DSP [FS #1] kicked [client C] in the back on an unspecified date."				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       08/13/2024		
	PROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD IAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	-"5. The evidence so actions constitute al	ubstantiates that DSP [FS #1's] puse."			
		ubstantiates that DSP [FS #1] Care Policies and Procedures."			
	indicated the facility physically abused c 7/2/24. The review substantiated FS #1 back on an unspecifindicate the investig was present at the F 7/2/24. The review investigation address witnessed the physical Client A was intervent Client A was asked stated, "Yes I do, he was asked if he had	seed whether client B had cal abuse of client C.  siewed on 8/13/24 at 7:04 AM. if he knew FS #1. Client A e was pretty chill." Client A seen FS #1 or any other staff A stated, "No. They're pretty			
	Client H was asked stated, "Yes he was everything." Client	iewed on 8/13/24 at 7:08 AM. if he knew FS #1. Client H nice. And I know I like H was asked if he had angry towards client C. Client			
	Client B was asked stated, "Yes he was he had seen FS #1 of Client B stated, "He Doctor's office. It so				
	Staff #1 was intervi	ewed on 8/13/24 at 8:20 AM.			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2024	
	PROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD JAPOLIS, IN 46256	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	LD BE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		if he had observed any staff towards client C. Staff #1			
		rained." Staff #1 was asked if			
	· /	act aggressively towards client			
		No he wouldn't do it before us.			
		ere about 2 weeks. He was			
	young."				
	, , ,	Intellectual Disabilities			
	1	ger) #1 was interviewed on			
		. QIDPM #1 was asked if the			
		d an allegation of physical			
	1	client A. QIDPM #1 stated,			
		views with a Hospital Police			
		PS Detective that staff was			
	_	al video slapping and pushing			
		#1 was asked if the facility			
		was present in the ER with QIDPM #1 stated, "Yes."			
		ed if the investigation			
	-	nt B was present at the ER with			
	1	I stated, "No and yes it should			
		ndicated the facility's policy on			
		buse, neglect and mistreatment			
		nted as written. QIDPM #1			
		ions of abuse, neglect and			
	_	d be thoroughly investigated.			
	The Facility's policy	y and procedures were			
		4 at 3:42 PM. The facility's			
		ploitation policy revised on			
	_	Policy: Adept staff actively			
	advocate for the rig				
	_	egations or occurrences of			
		exploitation shall be reported			
	_	uthorities through the			
		sory channels and will be			
		ated under the policies of			
		nd local, state and federal			
		nal/physical neglect: failure to			

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2024	
	ROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD IAPOLIS, IN 46256	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		a LSC IDENTIFYING INFORMATION or services necessary for the	TAG	DEFICIENCY)	DATE
		physical harm. Failure to			
	provide the support	necessary to an individual's			
		ocial well being. Failure to			
		requirements such as food,			
	shelter, clothing and	-			
		se include but are not limited to			
		g: corporal punishment i.e. vity, prone restraints,			
		, hitting, pinching, the			
		or noxious stimuli, the use of			
		nfliction of physical pain,			
	seclusion in an area	which exit is prohibited, an			
	example of seclusio				
		edroom and not allowing them			
		ractice or overcorrection,			
		ening, verbal abuse including			
		g, name-calling, belittling, dual's self-respect or dignity,"			
	"Program interventi	on neglect:Failure to			
	_	t plan, inappropriate			
		vention with out (sic) a			
	qualified person not	tification/review".			
	This federal tag rela	ates to complaint #IN00438014.			
	9-3-2(a)				
W 0154	483.420(d)(3) STAFF TREATME	ENT OF CLIENTS			
Bldg. 00		ave evidence that all			
J	_	are thoroughly investigated.			
	•	record review and interview	W 0154	CORRECTION:	09/12/2024
	_	ns of abuse, neglect and		The facility must have evident	ce
		ved, the facility failed to		that all alleged violations are	
		ate the reason client B was		thoroughly investigated.	
	taken to the ER with	h client C.		Specifically: All facility	. d b.,
	Findings include:			investigations will be complete trained investigators. <i>The faci</i>	- I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	
		15G814	B. W	B. WING 08/13/2024			
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L.	8307 CASTLETON BLVD				
VOCA CO	ORPORATION OF I	INDIANA	INDIANAPOLIS, IN 46256				
	Г		1		I	1	(Y5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1/10	REGULATORY OR	CESC IDENTIFIED IN ORWINITON	+	1710	must have evidence that all		DATE
	The facility's RDS (	Bureau of Disability Services)			alleged violations are thorough	hlv	
		ations were reviewed on			investigated. Specifically:	,	
	8/13/24 at 10:04 AN				oongatou. opeomouny.		
					All facility investigations will be	<sub>e</sub>	
	-1. A BDS report da	ated indicated, " On the			completed by trained		
	_	, while preparing to leave his			investigators. When incidents		
		rogram, [client C] attempted to			requiring investigation occur, t	he	
		om his housemate [client D].			QA Manager or designee will		
	[Client C's] housem	ate [client D] (sic) became			assign the investigation to a		
	upset and before sta	ff could intervene, [client D]			specific investigator. The QIDI	P	
	hit [client C] in the	head with his lunch box. [Client			Manager will conduct follow-up	p	
	_	ation and avulsion (Separation			with the investigator to assure		
	· ·	) of his left earlobe. Staff			completion within required		
		C] to the [Name] Hospital			timeframes, and that each		
		Department per nurse			allegation is investigated		
		R (Emergency Room) physician			thoroughly. Copies of all		
		with assault and admitted him			investigations will be maintain	ed	
	_	reatment of the injury. At 8:30			by the Quality Assurance		
		he [Name] Police Department			Department to be available for		
		are residential supervisor and			review, as required.		
	_	ome to the hospital. Police			In addition to weekly face to fa		
	_	visor that while waiting on dmission process for [client C],			training and follow-up with the		
		[FS (Former Staff)] #1 was			Quality Assurance Manager, t investigators will receive ongo		
		slapping [client C], pulling			mentorship from the QIDP	''''y	
		g him down by his neck. [FS			Manager, including but not lim	<sub>iited</sub>	
		d charged with Battery			to interview techniques, gathe		
	_	Person. ResCare suspended			and analysis of documentary	9	
		ng investigation (sic) prior to			evidence. The emphasis of thi	s l	
		tive Director was notified			mentorship/training will be		
	immediately."				development of appropriate so	cope	
	_				and conclusions, as well as tir	-	
	-"Plan to Resolve (I	mmediate and Long Term)."			management skills to facilitate		
					timely completion if investigati		
	-"[Client C] has a or	ne-inch laceration with a 1/4			and specifically that all clients		
	inch avulsion on his	s left earlobe. He remains			affected by the allegations are	,	
	hospitalized and Re	sCare nursing will remain in			included in the inviestigation.	The	
		h the hospital to assure			training focus will also include		
	continuity of care	".			assuring all qualifying incident	s	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		15G814	B. W	B. WING 08/13/2024			2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ASTLETON BLVD		
VOCA CORPORATION OF INDIANA					IAPOLIS, IN 46256		
	Т				, T	ı	OV.5
(X4) ID	SUMMARY 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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
	2 A DDC nament de	ated 7/3/24 indicated, " On			are investigated, and that all		
	•				pertinent aspects of the incide		
		housemate [client C] was taken			are included in the scope of the		
		oital [Name] Emergency			investigations. The QIDP Man	-	
	_	ient B] accompanied him along			will provide weekly follow-up to		
		administrative staff received a			QA Manager regarding progre	ess	
		pport staff [FS #1] slapped			and additional training needs.		
		d [client C's] hair in [client B's]			The feeling OIDD/		
		as suspended pending			The facility QIDP has been tra	ined	
	investigation".				as an investigator and will be		
		7.7			assisting with completion of		
		OS reports dated 7/3/24			required investigations. When		
		vas injured and taken to the ER			investigator assigned to the fa	cility	
		nt. The review indicated while			is not available, The QIDP		
	_	<sup>‡</sup> 1 slapped, pushed and pulled			Manager or designee assigne	d by	
		review indicated the Hospital's			the QA Manager will assume		
		sted FS #1. The review			responsibility for completion o	f	
		vas taken to the ER with client			required investigations.		
		essed staff physically abuse			PREVENTION:		
	client C.				The QIDP Manager will maint	ain a	
					tracking spreadsheet for incide	ents	
		ve Summary) form dated 7/2/24			requiring investigation, follow-	up	
	to 7/8/24 indicated	the following:			and corrective/protective mea	sures	
					will be maintained and distribu		
	-"Summary of Inter	views".			daily to facility supervisors and	d l	
					designated members of the		
	-"[Client A]:"				Operations Team, (comprised		
					Operations Managers, Progra		
	-"I call him [FS #1]	."			Managers, Quality Assurance		
					Manager, QIDP Manager, QID	Ps,	
	-"I haven't seen him	be mean or anything to me."			Quality Assurance Coordinate	rs,	
					Area Supervisors, and Nurse		
	-"He's been really c	hill working with us."			Manager). The Quality Assura	ince	
					Manager will meet with his/he	r QA	
	-"I think he's (FS #1	l) a nice guy, that's what I			Department investigators as		
	think."				needed but no less than week	ly to	
					review the progress made on	all	
	-"He's really good,	he respects me."			investigations, review incident	s	
					and assign responsibility for n		
	-"He (FS #1) doesn't have any issues with us."				incidents/issues requiring		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BUILDING <u>00</u> COMP.		(X3) DATE SURVEY COMPLETED 08/13/2024		
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
VOCA C	ORPORATION OF	INDIANA		CASTLETON BLVD NAPOLIS, IN 46256		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
				investigation. QA team memb	pers	
	-	e if he gets frustrated with		will be required to attend and	-	
		es he asks him (client C) to sit		an in-service documentation		
	down but he doesn't	t really listen."		these meetings stating that the	-	
	"The are her (EC #1) o	got aggressive and kicked him		are aware of which investigat		
	in the back."	got aggressive and kicked min		with which they are required to		
	in the back.			conduct, as well as the specificomponents of the investigation		
	-"He wasn't mad hu	t he was really irritated		which they are responsible, w		
	because [client C] v			the five-business day time fra		
	ceedase [enem e] ,	voulair t listelli		the live-business day time he	inic.	
	-"I don't want to get anybody fired though."			The Quality Assurance Team		
				review each investigation to		
	or frustrated."	ne I saw him (FS #1) get angry		that they are thorough –meeting		
	or trustrated."			regulatory and operational		
	-"But he's ok in the	1 !!		standards, and will not design		
	- But he's ok in the	nouse.		an investigation, as complete does not meet these criteria.	a, II IL	
	"Ua haan!t dana the	at to anybody else in the		Failure to complete thorough		
	house."	at to anybody cise in the		investigations within the allow	/ahle	
	nouse.			five business day timeframe i		
	-"[Client H]:"			result in progressive corrective	-	
	[enem 11].			action to all applicable team		
	-"I know [FS #1], I	don't know."		members.		
	[], -			RESPONSIBLE PARTIES: Q	IDP.	
	-"I know how much	I love everything."		Area Supervisor, Direct Supp Staff, Operations Team, Regi	ort	
	-"I haven't seen him be mean or hit us."			Director		
	-"I don't think so."					
	-"I haven't seen him think so."	n be mean to [client C], I don't				
	-"[Client F]:"					
	-"I know who that s	staff is (FS #1)."				
	-"I don't think I've s	een him be aggressive."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G814		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE COMPL 08/13/	LETED	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	-"I don't think I've s C]."	seen him be physical to [client				
		neard him make any threats."				
	-"[Client D]:" -"I don't know who	that is (FS #1)."				
	-"I don't know any	new staff that's been working."				
	-"I haven't noticed any staff being physically aggressive."					
	-"[Client E]:"					
	-"I know who that i	s (FS #1)."				
	-"I haven't seen him	n hit anybody."				
	-"I haven't seen him	n be mean to anybody."				
	-"I haven't seen him	n cursing."				
	-"[Client A]:"					
	-"I've never seen him (FS #1) get aggressive with us."					
	-"He's been good to	me."				
	-"I've never seen hi C]."	m get aggressive with [client				
	-"I've never seen hi	m make any threats."				
	-"[AS (Area Superv	visor)] #1:"				
	-"[Client C] was at with his lunch box."	the ER after [client D] hit him				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BU	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       08/13/2024			LETED	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		Ĭ	8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256	-		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	"I met with the off had the new [Addr slapping [client C] him down by his ne health building and currently placing the ""IFS #1] was brant ""I was only his fire." I had not seen his clients."  "No other staff or him or reported any ""[Staff #2]:"  -"I worked three she happened to [client collections."	mething caused a bad cut on  ok him to the ER."  from a police officer at [Name] the needed to speak with me in legal matters due to [client C's] s visit."  C[] became agitated or nt to the hospital as requested."  ficers, and they said that they ess] staff, [FS #1] on camera pulling his hair and shoving eck while in the behavioral being treated. They're ne staff member under arrest."  dd new."  fith day working."  m act inappropriately with the  clients had complained about ything to me."  infts with [FS #1] before what t C] at he ER."  just getting to know everyone,			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	
	-"He was really chi	th the (sic), and helping them."					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  15G814		(X2) MULTIPLE CO A. BUILDING B. WING	nstruction 00	(X3) DATE SURVEY COMPLETED 08/13/2024
	PROVIDER OR SUPPLIER	8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5)  COMPLETION  OPRIATE  DATE
	-"He never even raised his voice even (sic)."			
	-"There were no red flags."			
	-"The guys liked him."			
	-"He was nice to them."			
	-"No one reported to me that there were any problems."			
	-"I didn't hear anything about [FS #1] kicking [client C] in the back."			
	-"I definitely didn't see it happen."			
	-"Nothing like that."			
	-"He was really chill with the guys".			
	-"Factual Findings".			
	-"AS [AS #1] was called by the [Name] Police and asked tot eh (sic) ER to speak to them, on the evening of 07/02/24."			
	-"The officers told [AS #1] that DSP (Direct Support Professional) [FS #1] was observed on camera slapping [client C], pulling his hair and pushing him down by his neck."			
	-"Hospital Police arrested [FS #1] and charged him with Battery Against a Disabled Person."			
	-"DSP [FS #1] was formally charged on 07/07/24."			
	-"[FS #1] posted a cash bond on 07/07/24 and was released from custody with an initial hearing set for [Date of Hearing]."			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION  00	COM	te survey pleted 3/2024	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			8307 C	ADDRESS, CITY, STATE, ZIP COE ASTLETON BLVD APOLIS, IN 46256	<u>-</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	message requests for investigators."  -"ResCare investigators."	to respond to text and voice or an interview by ResCare ators made in-person, phone is to view or obtain a copy of				
	the video of the incident."  -"[Name of Hospital] Detective [Name] verified the content of the video and explained that a copy of the video could not be provided and that ResCare investigators could not be permitted to view the video due to the ongoing status of the investigation."  -"Indiana Adult Protective Services (APS) Detective [Name] contacted ResCare Investigators on 07/07/24 and also confirmed the content of the video".  -"Hospital records said that in addition to a 1 cm (centimeter) laceration with visible cartilage on his left ear, [client C] had a 4 cm yellow bruise on his right chest and multiple other bruises on his arms, left chest, back and left knee, in various stages of healing".  -"Conclusion:"					
	slapped [client C] o	ubstantiates that DSP [FS #1]				
	pushed [client C] do	ubstantiates that DSP [FS #1] own by his neck on 7/2/24."  ubstantiates that DSP [FS #1]				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814			JILDING	nstruction <u>00</u>	(X3) DATE COMPL <b>08/13</b> /	ETED
NAME OF F	PROVIDER OR SUPPLIER	3		DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA	INDIAN	APOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR 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	
	kicked [client C] in date."	the back on an unspecified				
	-"5. The evidence s actions constitute a	ubstantiates that DSP [FS #1's] buse."				
		ubstantiates that DSP [FS #1] sCare Policies and Procedures."				
	-A review of the IS dated 7/2/24 to 7/8/24 indicated the facility substantiated FS #1 had physically abused client C at the Hospital on 7/2/24. The review indicated the facility substantiated FS #1 had kicked client C in his back on an unspecified date. The review did not					
	indicate the investig was present at the F 7/2/24. The review investigation address	gation addressed why client B Hospital ER with client C on				
	Client A was asked stated, "Yes I do, ho was asked if he had	riewed on 8/13/24 at 7:04 AM. if he knew FS #1. Client A e was pretty chill." Client A l seen FS #1 or any other staff A stated, "No. They're pretty good care of me."				
	Client H was asked stated, "Yes he was everything." Client	riewed on 8/13/24 at 7:08 AM. if he knew FS #1. Client H nice. And I know I like H was asked if he had angry towards client C. Client				
	Client B was asked stated, "Yes he was he had seen FS #1 of	iewed on 8/13/24 at 7:42 AM. if he knew FS #1. Client B good." Client B was asked if or any other staff hit client C. e (FS #1) hit him, at the				

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

PRINTED: 09/11/2024 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	A. BUILDING B. WING	B. WING 08/13/		ETED
NAME OF PROVIDER OR SUPPLIER			8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	Doctor's office. It see	cared me."				
	Staff #1 was asked acting aggressively stated, "No we are to he had seen FS #1 at C. Staff #1 stated," He had only been he young."  QIDPM (Qualified Professional Manage #13/24 at 1:15 PM facility confirmed with client C on 7/2 QIDPM #1 was asked addressed why client C. QIDPM #1 have." QIDPM #1 is abuse, neglect and to thoroughly investig	dewed on 8/13/24 at 8:20 AM. if he had observed any staff towards client C. Staff #1 trained." Staff #1 was asked if act aggressively towards client No he wouldn't do it before us. ere about 2 weeks. He was  Intellectual Disabilities ger) #1 was interviewed on . QIDPM #1 was asked if the elient B was present in the ER to 2/24. QIDPM #1 stated, "Yes." and if the investigation at B was present at the ER with I stated, "No and yes it should indicated all allegations of mistreatment should be ated.  ates to complaint #IN00438014.				

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