			PRINTED:	05/23/2024
NT OF HEALTH AND HU	MAN SERVICES		FORM API	PROVED
OR MEDICARE & MEDIC	CAID SERVICES		OMB NO. 0	938-039
ENT OF DEFICIENCIES	Y1) PROVIDER/CLIPPLIER/CLIA	(Y2) MIJI TIPLE CONSTRUCTION	(Y3) DATE SUBVE	v

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/08/2024	
	PROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	on BE PRIATE	(X5) COMPLETION DATE	
V 0000								
Bldg. 00	Provider Number: 10 AIMS Number: 20 These deficiencies accordance with 46 Quality Review of the	5G814 1408320 also reflect state findings in	WO	000				
V 0159 Bldg. 00	be integrated, cood a qualified intelled who-Based on record revisampled clients (#1 QIDP (Qualified In Professional) failed goals were modified achieved their goals #3's goals following achievement.  Findings include:  1. The facility's QII and #2's goals were they achieved their 2. The facility's QII and #2's goals were they achieved their 2. The facility's QII and #2's goals were they achieved their 2.	e treatment program must ordinated and monitored by stual disability professional view and interview for 3 of 3 s, #2, and #3), the facility's stellectual Disabilities to ensure clients #1 and #2's d and adjusted when they s, and failed to revise client g multiple months of lack of DP failed to ensure clients #1 modified and adjusted when goals. Please see W255.	W 0	159	CORRECTION: Each client's active treatment program must be integrated coordinated, and monitored qualified intellectual disability professional. Specifically, The QIDP will be retrained to monthly summaries to monoclients' progress effectively modify and adjust goals in response to clients' specificaccomplishments or needs new programs when they at their goals. The QIDP will be retrained active to modify the need to modify the	d, I by a ifty  ined te itor and to for chieve	03/10/2024	

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

(X6) DATE

TITLE

**Bob Morris** QIDP Mgr. 03/25/2024

Any defiencystatement 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: 05/23/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/08/2024
	PROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP COD CASTLETON BLVD NAPOLIS, IN 46256	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  R I SC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION COMPLETION
TAG	REGULATORY OF achievement. Pleas 9-3-3(a)	e see W257.	TAG	prioritized learning objective whenever a client is failing make progress.  The QIDP will also be that when the accuracy of data appears inaccurate, will retrain staff to facilitate accurate data collection.  All prioritized learning objectives will be modified on current progress.  PREVENTION:  The QIDP will be retrained regarding the need to assemble and updated as but no less than annually. The QIDP will turn in copi monthly and quarterly sure to the QIDP Manager for and follow-up to assure less objectives are modified as required. Additionally, menthe Operations Team (conformations of the Executive Director, Operations Managers, Programmers, Quality Assurance Coording Area Supervisors, and Numanager, QIDP Manager Quality Assurance Coording Area Supervisors, and Numanager) will conduct documentation reviews as but no less than monthly assure that:  The QIDP has modificationally assure that:  The QIDP has modificationally assure that:  All relevant assessments responsible parties.  QIDP Manager, QA Manager, Q	ives g to  the trained of goal the QIDP the QIDP the graph of the property of

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Event ID:

9H7B11

Facility ID: 010453

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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 02/08/2024			
	PROVIDER 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
W 0255	483.440(f)(1)(i)			Executive Director, Regional Director	
Bldg. 00	PROGRAM MONI The individual pro- at least by the qua- professional and r including, but not l which the client ha an objective or ob- individual program				
	sampled clients (#1 ensure clients #1 an and adjusted when the Findings include:  1. Client #1's record 10:10 AM.  Client #1's Data Control indicated client #1 is months of August 2 2023, November 20 January 2024: "1. [One takes medication verbal prompts, 80% months4. Given sliprompt, [client #1] activity of his choic consecutive months  Client #1's Data Control indicated client #1 is	liew and interview for 2 of 3 and #2), the facility failed to d #2's goals were modified hey achieved their goals.  I was reviewed on 2/6/24 at  Illection Sheets dated 2/6/24 and the following goals for the 023, September 2023, October 23, December 2023, and Client #1] will state the reason s, given skills training with 3 % of the time for 3 consecutive kill training and 1 verbal will participate in a leisure e, 50% of the time for 3.  Illection Sheet dated 2/6/24 was able to complete goal #1 or the months of August 2023, ctober 2023 November 2023, I January 2024. Client #1's ate documentation of a review	W 0255	CORRECTION:  The individual program plan meter be reviewed at, least by the qualified mental retardation, professional and revised as necessary, including, but not limited to situations in which the client has successfully complete an objective or objectives identified in the individual program. Through review of facility documentation, the governing body has determined that in addition to clients #1 and #2, the deficient practice may have affected all clients who reside in the facility. Specifically, the QID will be retrained regarding the need to modify and adjust goal response to clients' specific accomplishments or needs for new programs when they achieve their goals. The QIDP will also trained that when the accuracy goal data appears inaccurate, QIDP will retrain staff to facilitate accurate data collection. All prioritized learning objectives we	e e e d ram nis n DP s in eve be of the tte

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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. BU	JILDING	00	COMPL	ETED
		15G814	B. Wl	ING		02/08/	2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	L			ASTLETON BLVD		
VOCA C	ORPORATION OF I	INDIANA			IAPOLIS, IN 46256		
	T				, T	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION  1 following 6 consecutive		TAG			DATE
	months of goal achi	•			be modified based on current		
	months of goar achievement.				progress.  PREVENTION:		
	Client #1's Data Co	llection Sheet dated 2/6/24			The QIDP will turn in copies o	f	
		was able to complete goal #4			monthly and quarterly summa		
	100% of the time for the months of August 2023,				to the QIDP Manager for revie		
		ember 2023, December 2023,			and follow-up to assure learning		
	and January 2024. The Data Collection Sheet				objectives are modified as		
	indicated client #1 was able to complete goal #4				required. Additionally, membe	rs of	
		the month of September 2023.			the Operations Team (compris		
		id not indicate documentation			of the Executive Director,		
	of a review of client #1's goal #4 following 6				Operations Managers, Progra	m	
	consecutive months of goal achievement.				Managers, Quality Assurance		
					Manager, QIDP Manager, QID	P,	
		l was reviewed on 2/7/24 at 9:30			Quality Assurance Coordinate	rs,	
	AM.				Area Supervisors, and Nurse		
					Manager) will conduct		
		llection Sheet dated 2/7/24			documentation reviews as nee		
		nad the following goals for the			but no less than monthly that	the	
	_	023, September 2023, October			QIDP has modified learning		
		23, December 2023, and			objectives as required.	DD	
		Client #2] will straighten and laily with 1 verbal prompt, 75%			RESPONSIBLE PARTIES: QI		
	_	per month, across 3			Area Supervisor, Direct Support Lead, Direct Support Staff,	או נ	
	* *	2. [Client #2] will identify 3			Operations Team, Regional		
		[aldol (antipsychotic) daily			Director		
		ot or less, 60% of the time of			200.01		
		ross 3 consecutive months. 3.					
		sh his bed linens weekly on his					
	-	lay with 1 verbal prompt 75%					
		month across 3 consecutive					
		#2] will independently choose a					
	physical activity to	complete of his choice with 2					
		ots from staff, three times per					
	· · · · · · · · · · · · · · · · · · ·	uccess rate over three					
		. 6. [Client #2] will help					
	* *	using safe cooking techniques					
		with staff assistance and 1					
		of the opportunities per month					
	across 3 consecutive	e months, 7, [Client #2] will			1		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G814	B. WI	NG		02/08/	2024
	PROVIDER OR SUPPLIER		-	8307 C	NDDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIG DV AN OF CORD FORMAN		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	···	DATE
	discuss with staff da	aily during active treatment					
		ways to use coping skills when					
		ssed independently 100% of					
		onth for 3 consecutive					
	_	#2] will wear his glasses daily n, at least once per day, with					
	_	1 1 or fewer verbal prompts					
		% opportunities per month for 3					
	months."	FL evenings bet mount tot 2					
	Client #2's Data Co	llection Sheet dated 2/7/24					
		was able to complete goal #1					
		or the months of September					
	2023, October 2023	3, November 2023 and January					
		e time for the month of					
		ient #2's record did not indicate					
		review of client #2's goal #1					
	I -	utive months of goal					
	achievement.						
	Client #2's Data Co	llection Sheet dated 2/7/24					
		was able to complete goal #2					
		or the months of September					
	2023, October 2023	3, November 2023 and December					
	i i	he time for the month of					
	1	nt #2's record did not indicate					
		review of client #2's goal #2					
	_	utive months of goal					
	achievement.						
	Client #2's Data Co	llection Sheet dated 2/7/24					
		was able to complete goal #3					
		or the months of September					
		ry 2024. Client #2's record did					
		entation of a review of client					
	_	ing 5 consecutive months of					
	goal achievement.						
	Client #21- D-t- C	Mostian Chart date 1 2/7/24					
		llection Sheet dated 2/7/24 was able to complete goal #5					

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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	UILDING	00	COMPL	ETED
		15G814	B. W	ING		02/08/	2024
NAME OF P	PROVIDER OR SUPPLIER				ASTLETON BLVD		
VOCA CO	ORPORATION OF I	INDIANA		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	RIATE	
TAG		R LSC IDENTIFYING INFORMATION or the months of September	+	TAG	DEFICIENCE		DATE
		ry 2024. Client #2's record did					
	_	entation of a review of client					
	#2's goal #5 followi	ing 5 consecutive months of					
	goal achievement.  Client #2's Data Collection Sheet dated 2/7/24						
		was able to complete goal #6					
		or the months of September					
	_	ry 2024. Client #2's record did entation of a review of client					
		ing 5 consecutive months of					
	goal achievement.	ing 5 consecutive months of					
		llection Sheet dated 2/7/24					
		was able to complete goal #7					
		or the months of September ry 2024. Client #2's record did					
	_	entation of a review of client					
		ing 5 consecutive months of					
	goal achievement.						
	Client #2's Data Co	llection Sheet dated 2/7/24					
		was able to complete goal #9					
		or the months of September					
	_	ry 2024. Client #2's record did					
		entation of a review of client					
	_	ing 5 consecutive months of					
	goal achievement.						
	QIDPM (Qualified	Intellectual Disabilities					
		ger) #1 was interviewed on					
		QIDPM #1 was asked who was					
	responsible for the	•					
	*	client goals/objectives. QIDPM OP (Qualified Intellectual					
	· · ·	ional)." QIDPM #1 was asked					
		als were expected to be					
	_	#1 stated, "Monthly." QIDPM					
	#1 was asked what	factors would dictate					

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	T OF HEALTH AND HU R MEDICARE & MEDIO					FORM APPRO OMB NO. 093	
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	ľ	JILDING	ONSTRUCTION 00	(X3) DATE COMPI 02/08	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR 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
W 0257	goals. QIDPM #1 loss skills already towards a goal, or moving to a difference if a client has goal the client has achies success rate or hig occur. QIDPM #1 revised and/or more QIDPM #1 was as been made to client implemented when expected success rate or period tracked. QI 9-3-4(a)  483.440(f)(1)(iii) PROGRAM MON	ng to be made to a client's stated, "Having regressed or gained, failure to make progress meeting the goal criteria and ent goal." QIDPM #1 was asked to be tracked for 3 months and eved the goal at the expected her, what was expected to stated, "The goal should be diffied based on the client." ked if adjustments should have at #1 and #2's goals that were in both individuals achieved the ate for each goal for the time DPM #1 stated, "Yes."					
Bldg. 00	at least by the qu professional and including, but not which the client is	ogram plan must be reviewed palified mental retardation revised as necessary, ilimited to situations in a failing to progress toward wes after reasonable efforts.					
	sampled clients (# client #3's goals for of achievement.	eview and interview for 1 of 3 3), the facility failed to revise dllowing multiple months of lack	W	0257	CORRECTION: The individual program plan is be reviewed at least by the qualified mental retardation professional and revised as	nust	03/10/2024
	Findings include:  Client #3's record  AM.	was reviewed on 2/7/24 at 10:35			necessary, including, but not limited to situations in which t client is failing to progress to identified objectives after		

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Client #3's Data Collection Sheet dated 2/7/24

indicated client #3 had the following goals for the

months of August 2023, September 2023, October

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reasonable efforts have been

documentation, the governing

body has determined that in

made. Through review of facility

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

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/08/2024
PROVIDER OR SUPPLIEF		8307 C	ADDRESS, CITY, STATE, ZIP COD CASTLETON BLVD NAPOLIS, IN 46256	•
SUMMARY (EACH DEFICIEN REGULATORY OF  2023, November 20 January 2024: "1. O prompts, [client #3] book to assist in conneeds daily 50% of months. 2. Given haverbal prompt, [client #3] while checking out shopping trips 60% months6 Given shoverbal prompts, [client #3] while checking out shopping trips 60% months6 Given shoverbal prompts, [client #3] while checking out shopping trips 60% months6 Given shoverbal prompts, [client #3] verbal prompts, [client #3] appropriate physica of the time for 3 condicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 2023, December 200 Client #3's Data Conindicated client #3's goal # months of not accord Client #3's Data Conindicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2 Sheet indicated client #3 in 100% of the time for 2023 and October 2	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 23, December 2023, and Given skill training and 3 verbal will use the communication municating his wants and the time for 3 consecutive and over hand assistance and 1 ant #3] will wash his body parts the time for three consecutive kills training and 1 verbal will hand the cashier the money at the register during weekly for three consecutive cill training, 2 choices and 3 ant #3] will participate in an 1 activity of choice daily 75% ansecutive months."  Illection Sheet dated 2/7/24 arefused to attempt goal #1 for the months of September 2023. Client #3's Data Collection ant #3 did not accomplish goal the for the months of November 23 and January 2024. Client #3's ate documentation of a review 1 following 5 consecutive	8307 C	CASTLETON BLVD	Final Experience of the completion of the completion of the complete of the co
months of not accor	2 following 5 consecutive mplishing the goal.  llection Sheet dated 2/7/24			

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	LETED
		15G814	B. W	ING		02/08/	/2024
		<b>.</b>		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ASTLETON BLVD		
VOCAC		INDIANA		1	APOLIS, IN 46256		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	indicated client #3	refused to attempt goal #4					
	100% of the time fo	or the months of September					
	2023 and October 2	2023. Client #3's Data Collection					
	Sheet indicated clie	ent #3 did not accomplish goal					
	#4 100% of the tim	e for the months of November					
		23 and January 2024. Client #3's					
		eate documentation of a review					
		4 following 5 consecutive					
	months of not accor	mplishing the goal.					
		ellection Sheet dated 2/7/24					
		refused to attempt goal #6					
		or the months of September					
		2023. Client #3's Data Collection					
		ent #3 did not accomplish goal					
		e for the months of November					
		23 and January 2024. Client #3's					
		eate documentation of a review					
		6 following 5 consecutive					
	months of not accor	mplishing the goal.					
	OIDDM (O. 1'C. 1	T ( 11 ( 112) 1222					
		Intellectual Disabilities					
	`	ger) #1 was interviewed on					
		QIDPM #1 was asked who was					
	responsible for the	-					
	_	client goals/objectives. QIDPM DP (Qualified Intellectual					
		ional)." QIDPM #1 was asked					
		als were expected to be #1 stated, "Monthly." QIDPM					
		factors would dictate					
		g to be made to a client's					
		tated, "Having regressed or					
		gained, failure to make progress					
		neeting the goal criteria and					
		nt goal." QIDPM #1 was asked					
	-	to be tracked for 3 months and					
		to achieve the goal					
		ne tracking period, what was					
	expected to occur.	QIDPM #1 stated, "The goal					1

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED.
		15G814	B. W	ING		02/08/	/2024
NAME OF B	DOWNER OF CURRINE			STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				ASTLETON BLVD		
VOCA CO	ORPORATION OF I	INDIANA		INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
		nd/or modified based on the was asked if client #3's					
	`	cated multiple goals where he					
		goal or refused to attempt to					
		ve months, what was expected					
	-	to his goals. QIDPM #1 stated,					
		been revised or modified to					
	address the refusals						
	9-3-4(a)						
W 0352	492 460(f)(2)						
VV 0332	483.460(f)(2)	'E DENTAL DIAGNOSTIC					
Bldg. 00	SERVICE	E DENTAL DIAGNOSTIC					
Diag. 00		ental diagnostic services					
		xamination and diagnosis					
	performed at least						
		view and interview for 1 of 3	l <sub>w</sub>	)352	CORRECTION:		03/10/2024
		), the facility failed to ensure	'' '	,552	Comprehensive dental diagno	stic	03/10/2021
		ent completed dental			services include periodic		
	examination.	•			examination and diagnosis		
	Findings include:				performed at least annually. Specifically, the facility has		
	C1:4 #2!1	vas reviewed on 2/7/24 at 10:35			scheduled a dental examination		
	AM.	as reviewed on 2///24 at 10:53			for client #3. An audit of facility medical charts indicated this	ý	
	AWI.				deficient practice did not affect	·t	
	Client #3's record in	ndicated a completed dental			additional clients who reside a		
		7/26/21. Client #3's record did			facility.	it tilo	
	·	entation of a current dental			PREVENTION:		
	examination.				· The Facility nurse will		
					complete monthly audits of all		
	DON (Director of N	Jursing) #1 was interviewed on			charts and turn in the audits to		
	· ·	DON #1 was asked how often			Nurse Manager for review.		
	clients were expecte	ed to have dental examinations			· The Nurse Manager will		
	completed. DON #1	stated, "Annually." DON #1			review issues revealed in aud	its	
	was asked if the fac	ility had documentation of a			with the Executive Director an	d	
	current dental exam	ination for client #3. DON #1			Department heads weekly for		
	stated, "No, we can	not locate the documentation.			follow-up.		
	I will get with the d	entist and if an appointment is			· The Executive Director a	nd	

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

PRINTED: 05/23/2024 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/08/2024		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
		redule one immediately."			will follow-up with the Nurse Manager as needed to addre issues raised through audits, incident reports or other cond brought to management atter Members of the Operations T (comprised of the Executive Director, Operations Manage Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Are Supervisors, and Nurse Mana and nursing staff will incorpor medical chart reviews into the formal audit process, which w occur no less than monthly to assure that medical follow-ald including but not limited to de examinations take place as required.  RESPONSIBLE PARTIES: Q Area Supervisor, Direct Supp Lead, Health Services Team, Direct Support Staff, Operation Team, Regional Director	erns ntion. feam rs,  a ager) rate eir vill ong ntal		

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