STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey. Dates of Survey: January 11, 12, 13, 21 and 22, 2021. Facility Number: 000842 Provider Number: 15G324 AIM Number: 100243860 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/27/21.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8). The facility's governing body failed to exercise operating direction over the facility by failing to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic; to implement isolation protocol to separate Covid positive clients from Covid negative clients; to ensure evacuation drills were conducted quarterly for each shift of personnel; to pay for medication not covered by client #3's	W 0102	W102: The facility must ensure that specific governing body and management requirements are met. All staff have been retrained on the COVID policy with an emphasis on the procedures to follow if a client has tested positive for the virus. Staff have also been trained on proper storage of food. Client finances have been reconciled and are available in the home. Residential Manager has been trained that she will reconcile the finances weekly, Area Supervisor will review the finances	02/21/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	medical insurance and to ensure client #2 spent his money appropriately. Findings include: 1. For 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the governing body failed to exercise operating direction over the facility by failing to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic; to implement isolation protocol to separate Covid positive clients from Covid negative clients; to ensure evacuation drills were conducted quarterly for each shift of personnel; to pay for medication not covered by client #3's medical insurance and to ensure client #2 spent his money appropriately. Please see W104. 2. The governing body failed to meet the Condition of Participation: Physical Environment for 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8). The governing body failed to ensure quarterly evacuation drills were completed for each shift of personnel; to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic; to implement isolation protocol to separate Covid positive clients from Covid negative clients and to ensure raw chicken was stored properly. Please see W406. 9-3-1(a)		weekly and the QIDP will review finances bi-weekly. Residential Manager has been trained on the client finance policy including what ResCare is responsible for paying and appropriate expenditures for the clients. Clients 2 and 3 will be reimbursed for the pain medication and the flowers purchased for a previous employee's birthday. Area Supervisor and QIDP's reviews of finances will include reviewing to ensure appropriate purchases have been made. Financial ledgers will be submitted to the Program Director monthly. Program Director will review to ensure that the ledgers are completed and that no inappropriate purchases were made. Staff have been trained on conducting fire drills. Area Supervisor has a schedule of fire drills for the entire year that will meet the standard. Area Supervisor will review drills the week after they have been assigned to ensure that they have been conducted and documented accurately. A copy of the drills will be submitted to the Program Director monthly. Program Director will review and ensure that the drills have been completed according to standards. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will	

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			be in the home at least 3 times per week and will ensure COVID policies are followed, that food is stored properly, finances are reconciled and appropriate and fire drills are completed.	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic; to implement isolation protocol to separate Covid positive clients from Covid negative clients; to ensure evacuation drills were conducted quarterly for each shift of personnel; to pay for medication not covered by client #3's medical insurance and to ensure client #2 spent his money appropriately. Findings include: 1. For 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the governing body failed to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic, implement isolation protocol to separate Covid positive clients from Covid negative clients and ensure raw chicken was stored properly. Please see W455.	W 0104	W104: Governing body must exercise general policy, budget and operating direction over the facility. All staff have been retrained on the COVID policy with an emphasis on the procedures to follow if a client has tested positive for the virus. Staff have also been trained on proper storage of food. Client finances have been reconciled and are available in the home. Residential Manager has been trained that she will reconcile the finances weekly, Area Supervisor will review the finances weekly and the QIDP will review finances bi-weekly. Residential Manager has been trained on the client finance policy including what ResCare is responsible for paying and appropriate expenditures for the clients. Clients 2 and 3 will be reimbursed for the pain medication and the flowers purchased for a previous employee's birthday. Area Supervisor and QIDP's reviews of finances will include reviewing to	02/21/2021

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	15G324	A. BUILDING 00 B. WING	01/22/2021

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	2. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the governing body failed to conduct quarterly evacuation drills for each shift of personnel. Please see W440. 3. On 1/12/21 at 2:00 PM, the agency finances were reviewed. Client #3's finances included two receipts from the pharmacy dated 8/12/20 for $44.49 and 8/21/20 for $19.76. The receipt indicted client #3 purchased prescription medication. On 1/12/21 at 2:00 PM, the TL (Team Lead) was interviewed. The TL indicated client #3 purchased narcotic pain medication. The TL indicated client #3's medical insurance did not cover the medication. The TL stated, "I didn't realize he couldn't pay for that. That's on me". On 1/12/21 at 5:00 PM, the QIDP (Qualified Intellectual Disabilities Professional) and the AS (Area Supervisor) were interviewed and indicated client #3 should not have paid for his prescription medication. 4. On 1/12/21 at 2:00 PM, the agency finances were reviewed. Client #2's finances included a 11/17/20 receipt from a local flower shop in the amount of $85.60. On 1/12/21 at 2:00 PM, the TL was interviewed. The TL indicated client #2 purchased two dozen roses for former staff #7 for her birthday. The TL indicated she took him to the flower shop to purchase the roses. The TL indicated client #2 should not have purchased roses for staff. On 1/12/21 at 5:00 PM, the QIDP and the AS were interviewed and indicated client #2 should not purchase flowers for staff working at the group		ensure appropriate purchases have been made. Financial ledgers will be submitted to the Program Director monthly. Program Director will review to ensure that the ledgers are completed and that no inappropriate purchases were made. Staff have been trained on conducting fire drills. Area Supervisor has a schedule of fire drills for the entire year that will meet the standard. Area Supervisor will review drills the week after they have been assigned to ensure that they have been conducted and documented accurately. A copy of the drills will be submitted to the Program Director monthly. Program Director will review and ensure that the drills have been completed according to standards. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times per week and will ensure COVID policies are followed, that food is stored properly, finances are reconciled and appropriate and fire drills are completed.	

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	15G324	A. BUILDING 00 B. WING	01/22/2021

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	home and the TL should not have transported him to the flower shop. 9-3-1(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7 and #8) living in the group home, the facility failed to ensure the clients had the right to due process in regard to locking snack items in the medication room/office. Findings include: Observations were conducted at the group home on 1/11/21 from 5:45 AM to 8:30 AM and 3:45 PM to 6:15 PM. Throughout the observation periods the door to the medication room/office remained locked. The medication room/office contained the following food items: two opened 12 packs of soda, a large opened bag of cereal, a box of cereal, two storage containers filled with multiple types of snack bars, cookies, peanut butter, an opened box of coffee creamer, two opened containers of coffee, a box of hot chocolate, an 8 pack of gatorade, bags of chips and other snack items. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 1/12/21 at 11:00 AM, client #1's record was reviewed. The record did not indicate snacks	W 0125	W125: Facility must ensure the rights of all clients. All staff have been trained on client rights and having access to snacks. A chest has been purchased for the snacks and it is in a common area of the home accessible to all clients. Area Supervisor and QIDP will observe in the home at least 3 times weekly and will ensure that clients have access to snacks. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times per week and will ensure that clients have access to snacks.	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

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	should be locked in the medication room/office. On 1/12/21 at 12:30 PM, client #2's record was reviewed. The record did not indicate snacks should be locked in the medication room/office. On 1/12/21 at 3:00 PM, client #3's record was reviewed. The record did not indicate snacks should be locked in the medication room/office. On 1/12/21 at 4:00 PM, a focused review of client #4's record was conducted. The record did not indicate snacks should be locked in the medication room/office. On 1/12/21 at 4:05 PM, a focused review of client #5's record was conducted. The record did not indicate snacks should be locked in the medication room/office. On 1/12/21 at 4:10 PM, a focused review of client #6's record was conducted. The record did not indicate snacks should be locked in the medication room/office. On 1/12/21 at 4:15 PM, a focused review of client #7's record was conducted. The record did not indicate snacks should be locked in the medication room/office. On 1/12/21 at 4:20 PM, a focused review of client #8's record was conducted. The record did not indicate snacks should be locked in the medication room/office. On 1/11/21 at 6:40 AM, the TL (Team Lead) was interviewed. The TL stated, "Snacks aren't supposed to be in there. Staff get lazy and don't put stuff where it belongs".			

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	On 1/11/21 at 4:35 PM, staff #5 was interviewed. Staff #5 stated the snacks were locked in the office, "Probably because of [client #3]. They've been in there the three years that I've been here". Staff #5 indicated the snacks shouldn't be locked. On 1/11/21 at 4:38 PM, client #2 was interviewed. Client #2 stated, "I have to ask when I want a snack". Client #2 indicated he did not have a key to access the locked snacks. On 1/12/21 at 5:00 PM, the QIDP (Qualified Intellectual Disabilities Professional) and the AS (Area Supervisor) were interviewed. The QIDP stated, "Part of the issue is they don't have a lot of storage. I suggested to move the crock pots to make room for snacks in the kitchen. I just suggested this on Monday morning". The QIDP indicated snacks should not be locked in the office and the clients did not have access to the snacks without asking staff to unlock the room. The QIDP stated, "Those will get moved". 9-3-2(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure a system was being utilized to maintain an accurate accounting of clients #1, #2 and #3's funds managed by the facility. Findings include: On 1/12/21 at 2:00 PM, financial records from	W 0140	W140 The facility must establish and maintain a system that assures a full and complete accounting of client's personal funds. Client finances have been reconciled and are available in the home. Residential Manager has been trained that there must be a receipt for every purchase	02/21/2021

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	15G324	A. BUILDING 00 B. WING	01/22/2021

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	September 2020 through January 2021 for clients #1, #2 and #3 were reviewed. 1. Client #1's financial record did not indicate documentation of a current and accurate balance/accounting of client #1's funds. Client #1's finances did not include receipts for money spent or receipts for pocket money provided to her personal use. Client #1's finances contained a check dated 11/3/20 for $99.00 which had not been cashed or deposited. 2. Client #2's financial record did not indicate documentation of a current and accurate balance/accounting of client #2's funds. Client #2's finances did not include receipts for money spent or receipts for pocket money provided to him for his personal use. Client #2's finances contained a check dated 11/3/20 for $99.00 which had not been cashed or deposited. Client #2's finances included a receipt dated 11/17/20 from a local flower shop in the amount of $85.60. 3. Client #3's financial record did not indicate documentation of a current and accurate balance/accounting of client #3's funds. Client #3's finances did not include receipts for money he spent. Client #3's finances included two receipts from the pharmacy dated 8/12/20 for $44.49 and 8/21/20 for $19.76. The receipt indicted client #3 purchased prescription medication. On 1/12/21 at 2:00 PM, the TL (Team Lead) was interviewed. The TL indicated client #3 purchased narcotic pain medication with his funds. The TL indicated client #3's medical insurance did not cover the medication. The TL stated, "I didn't realize he couldn't pay for that. That's on me". The TL indicated client #2 purchased two dozen roses for former staff #7 for		including pocket money and that checks are to be cashed the same week that they are received. Client 1 and 2's checks for$99.00 have been cashed. Residential Manager has been trained that she will reconcile the finances weekly, Area Supervisor will review the finances weekly and the QIDP will review finances bi-weekly to ensure they have been completed and receipts are available for every expense. Residential Manager has been trained on the client finance policy including what ResCare is responsible for paying and appropriate expenditures for the clients. Clients 2 and 3 will be reimbursed for the pain medication and the flowers purchased for a previous employee's birthday. Area Supervisor and QIDP's reviews of finances will include reviewing to ensure appropriate purchases have been made. Financial ledgers will be submitted to the Program Director monthly. Program Director will review to ensure that the ledgers are completed and that no inappropriate purchases were made. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times per week will ensure finances are completed.	

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	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	her birthday. The TL indicated she took him to the flower shop to purchase the roses. The TL indicated client #2 should not purchase roses for staff. The TL indicated she had been filling in for the Med (medical) coach who had been on medical leave since July 2020. The TL stated, "I've been trying to catch up". The TL indicated the finances should be completed monthly and they should be sent to the regional office monthly. The TL stated, "I apologize they aren't completed like they should be. I'm very behind". On 1/12/21 at 5:00 PM, the QIDP (Qualified Intellectual Disabilities Professional) and the AS were interviewed and indicated client #3 should not have paid for his prescription medication and client #2 should not purchase flowers for staff working at the group home. The AS indicated checks should be cashed as soon as they are received. The AS indicated the lobby was closed at the bank and the agency van was too tall for them to use the drive up. The QIDP and the AS indicated the group home should have a complete and accurate accounting of clients' funds. 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure monthly reports for clients #1, #2 and #3 contained detailed information about medical appointments, goal data and behaviors.	W 0159	W159: Each client's active treatment program must be integrated, coordinated and monitored by a QIDP. The QIDP has been trained that the monthly reviews need to include more details about appointments, goal and objective	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	Findings include: On 1/12/21 at 11:00 AM, client #1's record was reviewed. Client #1's monthly reports from January 2020 through November 2020 were reviewed. The review indicated the reports from January 2020 through October 2020 were vague and only included the following information: dates of medical appointments with physician names, the goals and objectives were reviewed and tracked, behaviors were reviewed and tracked and outings attended. The monthly reports did not include information about what happened during the medical appointments, what goals were reviewed and updated and a review of the monthly behavior data. On 1/12/21 at 12:30 PM, client #2's record was reviewed. Client #2's monthly reports from January 2020 through November 2020 were reviewed. The review indicated the reports from January 2020 through October 2020 were vague and only included the following information: dates of medical appointments with physician names, the goals and objectives were reviewed and tracked, behaviors were reviewed and tracked and outings attended. The monthly reports did not include information about what happened during the medical appointments, what goals were reviewed and updated and a review of the monthly behavior data. On 1/12/21 at 3:00 PM, client #3's record was reviewed. Client #3's monthly reports from January 2020 through November 2020 were reviewed. The review indicated the reports from January 2020 through October 2020 were vague and only included the following information: dates of medical appointments with physician names, the goals and objectives were reviewed		progression/regression and behaviors. Program Director and QIDP will meet weekly (either in person or via phone) to review and discuss the consumers, plans, staffing, goal implementation, changes with any consumers, monthly reviews and any other issue/concern that arises. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times per week and will include reviewing the monthlies to ensure they contain details.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

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VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	and tracked, behaviors were reviewed and tracked and outings attended. The monthly reports did not include information about what happened during the medical appointments, what goals were reviewed and updated and a review of the monthly behavior data. On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP were interviewed. The QIDP indicated she was responsible for completing monthly reports for the clients. The QIDP indicated the reports should be detailed and contain medical information and they should not say the same thing every month. The QIDP indicated the monthly reports should be detailed enough to where someone could read them and know exactly what happened throughout the month. The QIDP stated, "They are super full of stuff now. November is better. Yes, they should be detailed. I'm working on that since you cited it at [name of group home]". 9-3-3(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review and interview for 1 non-sampled client (#5), the facility failed to ensure staff demonstrated competence with administering client #5's BAP (bran, applesauce, prune juice) as scheduled on the MAR (medication administration record). Findings include: On 1/11/21 at 4:35 PM, an observation of client #5's medication administration was conducted.	W 0192	W192: For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Staff will be retrained on passing medications per physician's orders including offering BAP to all clients. Staff will also be trained to notify the nurse if a client is refusing something that has been ordered	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	Staff #5 did not administer client #5's BAP as scheduled on the MAR. On 1/12/21 at 4:05 PM, a focused review of client #5's record was conducted. Client #5's 12/7/20 PO (physician's orders) indicated client #5 had an order for "BAP- give one serving twice daily (7AM and 5PM) for constipation, give at med (medication) pass". On 1/11/21 at 4:35 PM, staff #5 was interviewed. Staff #5 stated, "He is supposed to get BAP, but he refuses. [Client #8] refuses it too. I don't even offer it anymore. We just give them applesauce". On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The QIDP stated, "I have never had either one of them refuse it". The QIDP indicated the BAP should still be offered and if refusals are happening it should be communicated with someone. The AS and the QIDP indicated staff needed to be retrained. On 1/13/21 at 11:03 AM, the LPN (Licensed Practical Nurse) was interviewed. The LPN stated, "Even if someone would refuse they still have to have it offered to them. That will be a training. I will have to go in and see how she (staff #5) charted that". The LPN indicated staff working at the group home have been trained to administer medication and treatments as ordered by the physician. The LPN indicated staff needed to be retrained. 9-3-3(a)		by the physician. Area supervisor will be in the home at least 5 times per week and will include observing medication passes to ensure that staff are passing the meds according to physician's orders. Nurse and QIDP will observe 2 medication passes (each) weekly. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times per week for oversight and observation.	
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

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	formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview, for 1 of 3 sampled clients (#2) and 1 additional client (#5), the facility failed to use formal and informal opportunities to educate clients #2 and #5 regarding their medications when opportunities existed. Findings include: 1. An observation of client #2's medication administration was conducted on 1/11/21 at 4:15 PM. Staff #5 administered client #2's medication and did not explain to client #2 what she was going to do, how to take the medication, the name of the medication, the reason for the medication use and the side effects. On 1/12/21 at 12:30 PM, client #2's record was reviewed. Client #2's 11/25/20 Lifestyle Plan indicated client #2 had an objective to say the name of two targeted meds (medications). 2. An observation of client #5's medication administration was conducted on 1/11/21 at 4:35 PM. Staff #5 administered client #5's medication and did not explain to client #5 what she was going to do, how to take the medication, the name of the medication, the reason for the medication use and the side effects. On 1/12/21 at 4:05 PM, a focused review of client #5's record was conducted. Client #5's 6/24/20 Lifestyle Plan indicated client #5 had an objective	W 0249	W249: client must be offered a continuous active treatment program. All staff have been retrained on the medication protocol and that they are to be training with the client at every medication pass, indicating what medication the client is taking and the reason for taking it as well as any specific objective the client has for medication. Area supervisor will be in the home at least 5 times per week and will include observing medication passes to ensure that staff are utilizing all med passes to train on medications. Nurse and QIDP will observe 2 medication passes (each) weekly. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times per week for oversight and observation.	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

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	to independently say a side effect of his targeted medication. On 1/11/21 at 4:35 PM, staff #5 was interviewed. Staff #5 stated, "They all have med goals that they work on, but we don't review meds with them every time". Staff #5 indicated it was important for the clients to know what medication they take, what the medications are for and the side effects of the medications. On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. When asked if medication training should be completed with the clients, the QIDP stated, "Yes, all the time." On 1/13/21 at 11:03 AM, the LPN (Licensed Practical Nurse) was interviewed by phone. When asked if medication training should be completed with the clients, the LPN stated, "Yes, you are supposed to ask or tell them what them what they are taking". 9-3-4(a)			
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 2 of 3 sampled clients (#2 and #3), the facility failed to ensure client #2 had an annual PSA screening (prostate levels) and client #3 attended appointments with the podiatrist (foot specialist) as recommended. Findings include: 1. On 1/12/21 at 12:30 PM, client #2's record was	W 0322	W322: The facility must provide or obtain preventive and general medical care. Client 1's PSA was completed on 1/22/21, Client 3's Podiatry appointment is 2/9/21. Nurse has been trained that appointments must be scheduled as requested per physician and/or state guidelines. Nurse has initiated an appointment tracking	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

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VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	reviewed. Client #2's record indicated he was over the age of 50. Client #2's record did not include a PSA screening. On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The QIDP indicated PSA screenings should be completed annually for men over the age of 50. On 1/13/21 at 11:03 AM, the LPN (Licensed Practical Nurse) was interviewed by phone. When asked how often PSA screenings should be completed, the LPN stated, "After a certain age every year and as ordered by their doctor. It's 50 and over. I would think the doctor would order it. I will call and see if it has been done". 2. On 1/12/21 at 3:00 PM, client #3's record was reviewed. Client #3 had an appointment with his Podiatrist on 12/20/19 and the recommendation was for him to return for a follow up appointment in 3 months. There was no documentation of the follow-up appointment being completed. On 1/12/21 at 5:00 PM, the AS and the QIDP were interviewed. The QIDP stated, "I think it was supposed to be yesterday and it was canceled because of Covid". On 1/13/21 at 11:03 AM, the LPN was interviewed by phone. The LPN stated, "We will probably just have to make an appointment for that. It wasn't carried through". The LPN indicated follow up appointments should be scheduled and attended as recommended by the physician. 9-3-6(a)		sheet for each consumer in the home to ensure that appointments are scheduled and completed as scheduled. Nurse will initially review the tracking sheet weekly to ensure appointments are completed and the documentation is in place and follow-up completed. Staff will be trained that if they “run” an appointment and a follow up appointment is scheduled (or needs scheduled) they are to contact the nurse to let her know and she will add the appointment to the tracking sheet. Nurse manager will be in the home 4 times a month to review appointment tracking sheets to ensure appointments are completed and documentation in place.	

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	15G324	A. BUILDING 00 B. WING	01/22/2021

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W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3 had an annual vision screening. Findings include: On 1/12/21 at 3:00 PM, client #3's record was reviewed. The record indicated client #3's last vision exam was on 4/25/18 and the doctor recommended a follow up appointment in two years. The record did not include documentation of a current vision exam. On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The QIDP indicated vision exams should be completed every 2 years or as recommended. On 1/13/21 at 11:03 AM, the LPN (Licensed Practical Nurse) was interviewed by phone. The LPN indicated vision exams should be completed every two years. 9-3-6(a)	W 0323	W323: Facility must provide or obtain annual physical examinations of each client that includes an evaluation of vision and hearing. Client 3's vision appointment is 2/8/21. Nurse has been trained that appointments must be scheduled as requested per physician and/or state guidelines. Nurse has initiated an appointment tracking sheet for each consumer in the home to ensure that appointments are scheduled and completed as scheduled. Nurse will initially review the tracking sheet weekly to ensure appointments are completed and the documentation is in place and follow-up completed. Staff will be trained that if they "run" an appointment and a follow up appointment is scheduled (or needs scheduled) they are to contact the nurse to let her know and she will add the appointment to the tracking sheet. Nurse manager will be in the home 4 times a month to review appointment tracking sheets to ensure appointments are completed and documentation in place.	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the facility's nursing services failed to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic; implement isolation protocol to separate Covid positive clients from Covid negative clients; client #2 had an annual PSA screening (prostate levels) and client #3 attended appointments with the podiatrist (foot specialist); client #3 had an annual vision screening and client #3 was provided with timely dental services. Findings include: 1. For 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the facility's nursing services failed to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic, implement isolation protocol to separate Covid positive clients from Covid negative clients and ensure raw chicken was stored properly. Please see W455. 2. For 2 of 3 sampled clients (#2 and #3), the facility's nursing services failed to ensure client #2 had an annual PSA screening (prostate levels) and client #3 attended appointments with the podiatrist (foot specialist) as recommended. Please see W322. 3. For 1 of 3 sampled clients (#3), the facility's	W 0331	W331: The facility must provide clients with nursing services in accordance with their needs. Nurse has been trained on her role of ensuring agency guidelines are implemented and followed when clients test positive for COVID. Client 1's PSA was completed on 1/22/21, Client 3's Podiatry appointment is 2/9/21 . Client 3's vision appointment is 2/8/21 Nurse has been trained that appointments must be scheduled as requested per physician and/or state guidelines. Nurse has initiated an appointment tracking sheet for each consumer in the home to ensure that appointments are scheduled and completed as scheduled. Nurse will initially review the tracking sheet weekly to ensure appointments are completed and the documentation is in place and follow-up completed. Staff will be trained that if they "run" an appointment and a follow up appointment is scheduled (or needs scheduled) they are to contact the nurse to let her know and she will add the appointment to the tracking sheet. Nurse manager will be in the home 4 times a month to review appointment tracking sheets to ensure appointments are completed and documentation in	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	nursing services failed to ensure client #3 had an annual vision screening. Please see W323. 4. For 1 of 3 sampled clients (#3), the facility's nursing services failed to ensure client #3 was provided with timely dental services. Please see W348. On 1/13/21 at 11:03 AM, the LPN (Licensed Practical Nurse) was interviewed by phone. When asked who was responsible for ensuring the Covid-19 policy/procedure was followed, the LPN stated, "Well, it would probably be me. I will take the blame for it. I'm not here hardly ever. The med (medical) coach is responsible for ensuring that is done". When asked who was responsible for ensuring clients received timely medical care, the LPN stated, "Overall, I am. The med (medical) coach is on medical leave and has been since July 2020. [Team Lead] is covering for her. She's (TL) done a really good job considering everything she has to do". 9-3-6(a)		place.	
W 0348 Bldg. 00	483.460(e)(1) DENTAL SERVICES The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3 was provided with timely dental services. Findings include:	W 0348	W348. Dental services: Client 3's dental appointment was 2/2/21. Nurse has been trained that appointments must be scheduled as requested per physician and/or state guidelines. Nurse has	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

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	On 1/12/21 at 3:00 PM, client #3's record was reviewed. The record indicated client #3 had a dental appointment on 11/21/19 and a follow up appointment was scheduled for 5/22/20. The record did not include documentation of client #3 attending the scheduled follow-up appointment. On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The AS stated, "The dentist canceled (due to Covid). They usually send a card in the mail and I haven't received a card". On 1/13/21 at 11:03 AM, the LPN (Licensed Practical Nurse) was interviewed by phone. The LPN indicated dental exams should be completed once a year, every six months or whenever the dentist recommends. 9-3-6(a)		initiated an appointment tracking sheet for each consumer in the home to ensure that appointments are scheduled and completed as scheduled. Nurse will initially review the tracking sheet weekly to ensure appointments are completed and the documentation is in place and follow-up completed. Staff will be trained that if they “run” an appointment and a follow up appointment is scheduled (or needs scheduled) they are to contact the nurse to let her know and she will add the appointment to the tracking sheet. Nurse manager will be in the home 4 times a month to review appointment tracking sheets to ensure appointments are completed and documentation in place.	
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the facility failed to secure the medication keys at the group home. Findings include: An observation was conducted at the group home on 1/11/21 from 3:45 PM to 6:15 PM. At 5:05 PM, staff #5 placed the lanyard with the med (medication) room keys on the kitchen counter. At 5:25 PM, staff #5 picked up the lanyard with the med room keys, unlocked the med room door	W 0383	W383: Only authorized persons may have access to the keys to the drug storage area. Staff have been trained that their keys are to be secured. Area Supervisor and QIDP will observe in the home at least 3 times weekly and will ensure that keys are secured. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

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	and left the key in the lock on the door knob. The keys remained there throughout the remainder of the observation. Clients #1, #2, #3, #4, #5, #6, #7 and #8 accessed all areas throughout the home including where the keys were hanging. On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The AS stated, the med room keys should be "on the staff." The AS and the QIDP indicated the keys to the med room should not be on the counter or left hanging in the door. On 1/13/21 at 11:03 AM, the LPN (Licensed Practical Nurse) was interviewed by phone. The LPN stated, the med room keys "should be kept on the person that is working". The LPN indicated the keys to the med room should not be on the counter or left hanging in the door. 9-3-6(a)		per week and will include ensuring staff are securing their keys.	
W 0406 Bldg. 00	483.470 PHYSICAL ENVIRONMENT The facility must ensure that specific physical environment requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Physical Environment for 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8). The facility failed to ensure quarterly evacuation drills were completed for each shift of personnel; to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic; to implement isolation protocol to separate Covid positive clients from Covid negative clients and to ensure raw chicken was	W 0406	W406: Facility must ensure that specific physical environment requirements are met. All staff have been retrained on the COVID policy with an emphasis on the procedures to follow if a client has tested positive for the virus. Staff have also been trained on proper storage of food. Staff have been trained on conducting fire drills. Area Supervisor has a schedule of fire drills for the entire year that will meet the standard. Area	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	stored properly. Findings include: 1. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Please see W440. 2. For 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the facility failed to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic, implement isolation protocol to separate Covid positive clients from Covid negative clients and ensure raw chicken was stored properly. Please see W455. 9-3-7(a)		Supervisor will review drills the week after they have been assigned to ensure that they have been conducted and documented accurately. A copy of the drills will be submitted to the Program Director monthly. Program Director will review and ensure that the drills have been completed according to standards. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times per week and will ensure COVID policies are followed, that food is stored properly and fire drills are completed.	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: The facility's evacuation drills were reviewed on 1/11/21 at 2:00 PM. The review did not indicate documentation of an evacuation drill being conducted during the first quarter (January 2020, February 2020 and March 2020) on the overnight shift (10:00 PM to 6:00 AM) and during the third quarter (July 2020, August 2020 and September	W 0440	W440: The facility must hold evacuation drills at least quarterly for each shift of personnel. Staff have been trained on conducting fire drills. Area Supervisor has a schedule of fire drills for the entire year that will meet the standard. Area Supervisor will review drills the week after they have been assigned to ensure that they have been conducted and documented accurately. A copy of the drills will be submitted to the Program Director monthly. Program Director will review and ensure that	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

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	2020) on the day shift (6:00 AM to 2:00 PM). This affected clients #1, #2, #3, #4, #5, #6, #7,and #8. On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The AS stated, drills should be completed "At least one per quarter per shift". The QIDP stated, "I looked through everything and I couldn't find them. I really tried". 9-3-7(a)		the drills have been completed according to standards. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times per week and will ensure that drills are completed.	
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the facility failed to ensure agency guidelines were implemented to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic, implement isolation protocol to separate Covid positive clients from Covid negative clients and ensure raw chicken was stored properly. Findings include: 1. An observation was conducted at the group home on 1/11/21 from 5:45 AM to 8:30 AM. Upon entry to the group home at 5:45 AM, the storm door was propped open and the signs posted about the Covid-19 protocols, including face masks being required were not visible. Client #5 answered the door and let the surveyor in. Client #5 was not wearing a face mask. There was a table in the entryway with medical face masks, a	W 0455	W455: Must be an active program for the prevention, control and investigation of infection and communicable diseases. All staff have been retrained on infection control, including the following: prompting clients to wash hands, ensuring paper towels are available for hand drying, wearing their masks appropriately, completing their COVID screening when coming on shift, ensuring all visitors are screened, prompting clients to cover their mouth when coughing and the COVID policy with an emphasis on the procedures to follow if a client has tested positive for the virus. Staff have also been trained on proper storage of food. Area Supervisor and QIDP will observe in the home at least 3 times weekly to ensure	02/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	thermometer, hand sanitizer, symptom screening logs, alcohol swabs and a book which contained the Covid-19 policies and protocols. Staff #1 was the only staff working and she was not wearing a face mask. Staff #1 stated, "I haven't put it (face mask) on yet because [client #5] just got up". The surveyor was not screened for signs/symptoms of Covid-19 upon entry to the group home. Clients #1, #2, #3, #4, #6, #7 and #8 were sleeping. Staff #5 indicated 6 of the 8 clients (#1, #2, #4, #6, #7 and #8) were currently positive for Covid-19 and they tested positive on Wednesday or Thursday last week. Staff #1 indicated client #3 refused the test and client #5 tested negative. At 6:00 AM, client #5 coughed multiple times and was not prompted to wash his hands. At 6:15 AM, client #5 wandered throughout the group home without wearing a face mask. Staff #1 was not wearing a face mask. The two main bathrooms did not have paper towels or anything to dry your hands with. At 6:25 AM, client #5 was still the only client awake. Client #5 and staff #1 were not wearing face masks. At 6:25 AM, the TL (Team Lead) and staff #3 arrived for work. The TL was wearing a face mask and her nose was not covered. Staff #3 walked through the group home to the office without wearing a face mask. Neither of them completed the Covid-19 screening form and they did not take their temperatures. Client #6 came out of her room and she was wearing a face mask. The TL asked client #6 to get a potato masher and bring it to her in the medication room. Client #6 got the potato masher out of the kitchen drawer and did not wash her hands. At 6:30 AM, staff #1 clocked out and left the group home. At 6:35 AM, staff #3 came out of the office wearing a KN95 face mask. Staff #3 prompted client #5 to put his face mask on and client #5 complied. At 6:40 AM, client #5 coughed into his hand and was		COVID policies are followed, staff are ensuring hand washing is completed by clients and food is stored properly. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator, Nursing Director) will be in the home at least 3 times per week and will ensure COVID policies are followed, staff are prompting clients to wash hands when necessary and that food is stored properly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	not prompted to wash his hands. The TL's nose was not covered by her face mask. At 6:50 AM, the TL administered client #6's medication and the TL did not prompt client #6 to wash her hands prior to taking her medication. At 7:10 AM, there was a pile of gowns, protective goggles and KN95 face masks in the office. Client #4 came out of her bedroom and stated, "I have Covid. I hate it. We all have it." Client #4 had a face mask on, but her nose was not covered. Client #5 and client #6 were both watching television in the living room and their noses were not covered by their face masks. The surveyor looked in the tray of symptom screening forms and there was only one completed form from August, 2020. At 7:20 AM, client #6 was in the kitchen talking with staff #3. Client #4 came out of the medication room with her nose and mouth not covered by her face mask. At 7:25 AM, the QIDP (Qualified Intellectual Disabilities Professional) arrived at the group home. The QIDP wore a cloth face mask and completed the symptoms screening form as soon as she walked into the group home. Client #6 carried butter, jelly and juice to the dining room table and she was not prompted to wash her hands. Client #4's nose was not covered by her face mask. Client #5 carried milk to the dining room table and he was not prompted to wash his hands. At 7:30 AM, client #4's nose was not covered by her face mask. Client #3 came out of his bedroom and he was not wearing a face mask. The QIDP prompted client #3 to put a face mask on and he refused. At 7:35 AM, clients #2, #3, #5, #6 and #8 sat at the kitchen table without face masks on waiting for breakfast. Client #8 coughed several times and was not prompted to cover his mouth. The QIDP prompted him to use hand sanitizer after he coughed. Clients #1, #4 and #7 were prompted to come to the table for breakfast			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and they declined. At 7:45 AM, staff #3 served everyone eggs and toast. The clients passed the milk around the table and poured it into their cereal bowls. The butter was passed around the table and the clients used the same knife to butter their toast. At 7:50 AM, client #4 watched television in the living room and her nose was not covered by her face mask. At 8:10 AM, staff #3 wiped down the door knobs throughout the group home. Clients #3, #4 and #8 were in the dining room visiting with the QIDP and they were not wearing face masks. At 8:15 AM, client #8 carried his dishes to the kitchen, coughed multiple times and he was not prompted to cover his mouth or wash his hands. Client #6 loaded the dirty dishes into the dishwasher. At 8:20 AM, client #3 watched television in the living room and her nose was not covered with her face mask. At 8:25 AM, client #2 wiped down the dining room table without wearing a face mask. Client #4 swept the dining room floor and her nose was not covered by her face mask. The TL wore a fabric face mask and her nose was not covered throughout the observation. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. An observation was conducted at the group home on 1/11/21 from 3:45 PM to 6:15 PM. Upon entry to the group home at 3:45 PM, the storm door was propped open and the signs posted about the Covid-19 protocols, including face masks being required were not visible. Client #5 answered the door and he wasn't wearing a face mask. Staff #5 was the only staff working and she was washing the dishes. Staff #5 wore a fabric face mask and her nose was not covered by the face mask. The surveyor was not screened upon entry to the group home. Client #5 assisted staff #5 with washing the dishes. Client #4 was on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	telephone in the living room and her nose and mouth were not covered by her face mask. Clients #2, #3 and #6 were watching television in the living room and client #7 was lying on the couch with her eyes closed. Client #3 was not wearing a mask and client #7's nose was not covered with her face mask. Clients #1 and #5 were in their bedrooms. At 4:00 PM, client #7 went to the kitchen to help unload the dishwasher and she was not prompted to wash her hands prior to handling the clean dishes. On the table in the entry way there was a stack of gowns, a pair of goggles and KN95 face masks. The screening logs were reviewed and the only screening log in the tray was from August 2020. Staff #5's nose was not covered by her face mask. At 4:15 PM, staff #5 administered client #2's medication. Client #2 was not prompted to wash his hands. At 4:35 PM, staff #5 administered client #5's medication. Client #5 was not prompted to wash his hands. At 4:40 PM, client #2 sneezed three times and he was not prompted to wash his hands. At 4:45 PM, clients #1, #4 and #7 went to their bedrooms to lay down until dinner. At 4:45 PM, client #8 came to the medication room and he wasn't wearing a face mask. After his medication was administered, he went back to his bedroom. At 5:00 PM, client #7 came back to the kitchen. Client #7 touched the outside of her face mask with her hands repeatedly and wasn't prompted to wash her hands. Staff #5's nose was not covered with her face mask. Client #6 came into the kitchen to help cook dinner. She used her hands to adjust her face mask then retrieved eggs from the refrigerator, cracked the eggs open then dumped them into a bowl. Client #6 did not wash her hands prior to handling the food. At 5:05 PM,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	client #2 stated, "We're supposed to be quarantined to our rooms". Staff #5 stated, "They have to quarantine for 2 weeks since they tested positive for Covid-19". At 5:15 PM, staff #5's nose and mouth were not covered with her face mask. Staff #5 brought a container of yogurt to client #3 and stood beside him while he ate the yogurt. Client #3 dropped yogurt onto his hand then he licked his hand. Client #3 did not wash his hands before he ate the yogurt. At 5:25 PM, staff #5's mouth and nose were not covered by her face mask. At 5:30 PM, client #5 came into the kitchen to help prepare dinner. Client #5 did not wash his hands and he opened three cans of corn and poured them into a pan. At 5:50 PM, staff #5's nose and mouth were not covered by her face mask. Clients #4, #6 and #7 were not wearing face masks. Clients #5 and #7 carried the prepared food to the table. They did not wash their hands. At 6:05 PM, clients #1, #2, #3, #4, #5, #6 #7 and #8 were prompted to go to the dining room table for dinner and they were not prompted to wash their hands. All of the clients except for client #3 participated in family style dining and used the same serving utensils without washing their hands. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 1/12/21 at 3:00 PM training records were reviewed and indicated staff working at the group home were trained on the Infection Control Policy on 3/17/20. On 12/21/20, the QIDP, TL and staff #3 signed an Inservice Sign-In Sheet indicating they received training on the Covid Flow sheet to Identify and Assess 2019 Novel Coronavirus. On 12/28/20, the QIDP, TL and staff #3 signed an Inservice Sign-In Sheet indicating they received training on Isolation Precautions and PPE (personal protective equipment).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	On 1/13/21 at 4:00 PM, LimsNet (software program) Covid-19 Test results dated 1/6/21 were reviewed and indicated clients #1, #2, #4, #6, #7 and #8 were tested for Covid-19 on 1/5/21 and the results were positive on 1/6/21. On 1/12/21 at 2:30 PM the Covid-19 staff screening forms were reviewed for December 2020 and January 2021 and indicated the following: Staff #3 completed a form on 1/11/21 (after the surveyor asked if she completed a screening when she arrived for her shift). Staff #6 completed logs on 12/5/20, 12/12/20, 12/13/20, 12/19/20, 1/2/21, 1/9/21 and 1/10/21. No other staff screening forms were completed. There was a minimal amount of forms completed by the QIDP and the LPN. The AS and the PM did not complete any screenings. On 1/13/21 at 12:00 PM, the 12/30/20 Isolation Procedure: Residential Client Tests Positive for Covid-19 was reviewed and indicated, "This procedure has been developed to provide guidance for when an individual in one of our Residential homes tests positive for COVID-19. 1. The individual is placed in a private room with the door closed (if possible). A mask is placed on the individual.... 11. Implement full visitor restriction to the home by posting this sign. 12. Staff who enter the room must wear an N95 mask, gloves, gown and eye protection. 13. Begin Isolation Precautions: a. Note: NN95 (sic) masks are to be worn by all persons providing care and services. b. Individuals in the home are always separated from others by a minimum of 6 feet. c. Individual with COVID-19 infection should be assigned their own bathroom. NO ONE ELSE should use this bathroom. Disinfect the bathroom after each use. d. DO NOT share household items. e. Encourage the individual with COVID-19 infection to remain			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	in their room, wear a mask if coughing, and to wash their hands frequently. f. Staff in close contact should wear PPE (N95 mask, gown, gloves, eye protection). g. PPE is disposed of inside the individual's room. h. Common surfaces should be cleaned twice daily. i. Refer to the process flow for symptom management process. 14. The individual is not to attend work, school or community events. 15. Other individuals in the home will be educated and reminded to practice social distancing. 16. Determine whether other individuals in the home have been in close contact with the infected person (if so, implement quarantine procedures). Additional Considerations: Where compliance with isolation procedures is unlikely: Due to individual abilities, isolation procedures may not be well tolerated, creating a potential safety issue for staff or individuals living in the home. In these cases, contact your Regional Quality Director for direction: ·Hold an IDT (interdisciplinary team) meeting to discuss and resolve issues. ·Consider moving the individual to another home. ·Consider moving the other residents to another home. ·Contact the state/case manager to discuss alternative living situation for the individual. ·Consider using a nearby home with a vacancy to relocate the other individuals or the individual with the virus...." On 1/12/21 at 3:00 PM, the undated article "Guidance for Group Homes for Individuals with Disabilities" was reviewed from the website www.cdc.gov. The article indicated: "...Screen and advise residents, staff, and essential volunteers. GH (group home)administrators may want to consider screening residents, workers, and essential volunteers for signs and symptoms of COVID-19. Screening includes actively taking each person's			

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	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

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	temperature using a no-touch thermometer, and asking whether or not the person is experiencing symptoms such as shortness of breath or has a cough...." On 1/12/21 at 3:05 PM, the article "Coronavirus Disease 2019 (COVID-19): Protect Yourself" was reviewed from the website www.cdc.gov. The article indicated: "...Everyone should: Wash your hands often: Wash your hands often with soap and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing. If soap and water are not readily available, use a hand sanitizer that contains at least 60% (percent) alcohol. Cover all surfaces of your hands and rub them together until they feel dry. Avoid touching your eyes, nose, and mouth with unwashed hands. Avoid close contact: Avoid close contact with people who are sick, even if inside your home. If possible, maintain 6 feet between the person who is sick and other household members. Put distance between yourself and other people outside of your home. Remember that some people without symptoms may be able to spread virus. Stay at least 6 feet from other people. Do not gather in groups. Stay out of crowded places and avoid mass gatherings. Keeping distance from others is especially important for people who are at higher risk of getting very sick. Cover your mouth and nose with a cloth face cover when around others: You could spread COVID-19 to others even if you do not feel sick. Everyone should wear a cloth face cover when they have to go out in public, for example if they have to go to the grocery store or to pick up other necessities.... The cloth face cover is meant to protect other people in case you are infected.... Continue to keep about 6 feet distance between yourself and others. The cloth face cover is not a substitute			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for social distancing. Cover coughs and sneezes: If you are in a private setting and do not have on your cloth face covering, remember to always cover your mouth and nose with a tissue when you cough or sneeze or use the inside of your elbow. Throw used tissues in the trash. Immediately wash your hands with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol. Clean and disinfect: Clean and disinfect frequently touched surfaces daily. This includes tables, door knobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets and sinks. If surfaces are dirty, clean them. Use detergent or soap and water prior to disinfection. Then, use a household disinfectant. Monitor your health: Be alert for symptoms. Watch for fever, cough, shortness of breath, or other symptoms of COVID-19. Especially important if you are running essential errands, going into the office or workplace, and in setting where it may be difficult to keep a physical distance of 6 feet. Take your temperature if symptoms develop.... Follow CDC (Center for Disease Control) guidance if symptoms develop." On 1/11/21 at 5:45 AM, staff #1 was interviewed. Staff #1 indicated the clients were tested for Covid-19 on Wednesday (1/6/21) or Thursday (1/7/21) last week. Staff #1 indicated the clients had not been isolated to their rooms. Staff #1 stated the only directive she was given after the positive test results were received was to "wear PPE and that's all". Staff #1 stated, "I haven't put it (face mask) on yet because [client #5] just got up". Staff #1 indicated she should wear a face mask while working at the group home. Staff #1 stated, "I know there's a policy, but I don't know anything about it". Staff #1 indicated she had not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	been formally trained on the Covid-19 policies/procedures. Staff #1 stated, "They just hang stuff up on the door and have us read it". Staff #1 stated they "have plenty of PPE". Staff #1 stated she had symptoms of Covid-19 in December and she was "forced to work with symptoms" while awaiting test results and the results came back positive. On 1/11/21 at 6:40 AM, the TL was interviewed. The TL indicated client #6 went to visit her family over Christmas and New Year's and ended up getting sick when she returned to the group home. The TL indicated they thought it was the flu but she wasn't getting better so they took everyone to get tested for Covid-19 and 6 of the 8 clients tested positive, client #3 refused to be tested and client #5 was negative. On 1/11/21 at 8:00 AM and 8:15 AM, staff #3 was interviewed. Staff #3 indicated she had been trained on the Covid-19 protocol/procedures and what to do if clients test positive for Covid-19. Staff #3 stated the clients "should quarantine in their rooms as much as possible". Staff #3 indicated the Covid-19 screening checklist should be completed at the beginning on the shift. Staff #3 stated, "I didn't do it this morning because I was running late. I'll do it now". Staff #3 indicated visitors should have their temperatures taken and they should complete the screening upon entry. Staff #3 stated, "Staff should ask as soon as they arrive at the home before they enter the home". Staff #3 stated, "When I first found out they had it (Covid-19) I had full PPE on. Now I just make sure I wear my mask and gloves". Staff #3 indicated the group home had plenty of PPE. On 1/11/21 at 8:35 AM, the TL was interviewed. The TL stated, "Staff screening logs should be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G324	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	4516 W WALDEN DR MUNCIE, IN 47304

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	completed at the start of every shift. They should be by the front door". The surveyor asked if the logs could be somewhere else if they weren't by the front door and the TL stated, "That would mean the staff aren't screening like they should and I need to get on them to do it". The TL indicated she did not complete the screening when she arrived at the group home this morning. On 1/11/21 at 3:45 PM, staff #5 was interviewed. Staff #5 indicated she was diagnosed with Covid-19 in December. Staff #5 stated, "They hang a paper up for training. I've never had in person training. It's always just a paper. I don't know anything about the isolation policy. I've never been trained". Staff #5 indicated everyone should wash their hands often and wear face masks to assist with preventing the spread of Covid-19. On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The AS and the QIDP indicated face masks should be worn at all times. The nose and mouth should be covered and they should only be removed to eat or drink. The QIDP indicated client #6 was the first client with symptoms of Covid. She was quarantined to her room and only came out to go to the bathroom. Everything (meds, eating, etc.) was done in her room. Nothing extra was being done by staff. The QIDP stated, "It didn't dawn on me to have staff wear extra PPE (gowns, face shields and gloves). Weekend staff did have full PPE on". The QIDP indicated vitals were done on everyone every two hours while they were awake. The QIDP indicated all of the clients (client #3 refused) were tested at the same time on 1/5/21. The results came back on Thursday 1/7/21 late afternoon and everyone was			

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	15G324	A. BUILDING 00 B. WING	01/22/2021

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	positive except for client #5. The QIDP stated, "[LPN/Licensed Practical Nurse] was the one that was mainly involved with this. You need to ask her". The QIDP stated the LPN told her "It's their home and they don't have to isolate. After you left yesterday morning they were encouraged to stay in their rooms". The QIDP indicated staff should wear face masks, gowns, face shield/goggles and gloves. The QIDP stated hand washing should occur, "Everytime you work with a consumer, before meds (medications), before touching food, before eating, after coughing and before touching dishes". The QIDP stated staff and visitor screenings should happen, "every time they come on for a shift for staff and visitors before they walk in the door. We definitely need to do some retraining on that". The QIDP indicated staff had been trained on Covid-19 procedures. The QIDP stated, "They obviously need retrained". The QIDP indicated the bathrooms should have paper towels. The QIDP and the AS indicated the Covid-19 isolation procedure was not being implemented. On 1/13/21 at 11:03 AM, the LPN was interviewed by phone. The LPN stated staff and clients should wear face masks "at all times" and "they should be up over the mouth and nose". The LPN stated, "When they get a positive test they should always have their mask on and should isolate as much as possible to their rooms. It's hard for some of our clients to understand. That's what we have talked about. They should for sure have a mask on at all times. Staff should prompt them to stay in their rooms but because this is their home they still have a right to come out. I've told them they are to be in their rooms. I've been down there and they've been in the living room". The LPN stated the following things should be done when there is a positive Covid case at the			

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	15G324	A. BUILDING 00 B. WING	01/22/2021

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	group home: Staff should "wear gowns, masks, gloves if needed, wash hands really well, not really certain about the goggles all the time. You might want to wear them if coughing all the time". The LPN stated hand washing should occur, "It should occur about every 3-5 minutes. After you touch cabinets, door handles, touch face, scratch your head, prior to eating, med pass, putting away dishes, assisting with any care and after coughing". The LPN stated, "I would say that we are quarantined and there should be no visitors at all. If we have Covid, visitors should not be allowed inside the door. They should be told there are no visitors at this time. As soon as you come in you should have your temp (temperature) taken and the screening checklist should be done. They should meet the visitor at the door. They all know to do the screening even before we had positive cases". The LPN indicated staff have been trained on the Covid-19 procedures. The LPN stated, "They should have all been trained on Covid. I have a training to send to you but not everyone has signed it. We just did a recent Covid training. I'll send it to you. Again they all didn't sign it. It's hard to get everyone to sign. They are just like that. The staff sometimes has (sic) their own minds". When asked who was responsible for ensuring the Covid-19 policy/procedure was followed, the LPN stated, "Well, it would probably be me. I will take the blame for it. I'm not here hardly ever. The med (medical) coach is responsible for ensuring that is done. [TL] is filling in as the med coach". When asked what she informed staff to do after the positive results were received, the LPN stated, "Just whoever I talked to on the phone. I asked [TL] to make sure we were getting temps every two hours and to monitor for signs and symptoms. I asked [TL] to call the doctor to see if there were any protocols to follow but I don't			

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	think that got done". The LPN indicated paper towels should be available in the bathrooms for staff and clients to dry their hands. The LPN indicated the agency had a Covid-19 isolation procedure and it was not being implemented. On 1/13/21 at 12:50 PM the PM (Program Manager) was interviewed. The PM stated, "We have trained and trained and trained on this (Covid). The employees know what they should do and they just don't do it. The clients should be isolated to their rooms and if they refuse they should be prompted to go to their rooms. They should be washing hands and everyone should be wearing masks. Staff should complete screenings logs every shift and masks should be worn at all times". The PM indicated the Covid policy/procedure should be followed. The PM stated, "All of the clients but one understand Covid and are capable of following the policy with redirection from staff". 2. An observation was conducted at the group home on 1/11/21 from 3:45 PM to 6:15 PM. At 3:45 PM, four family size packages of raw chicken were on the island in the kitchen. Staff #5 indicated they were having meatloaf for dinner. When asked what the chicken was for, staff #5 stated, "I just need to go put it in the freezer in the garage. I just haven't had time. I can't leave the clients unsupervised in the house". The chicken was still on the counter at 6:15 PM when the observation was over. On 1/12/21 at 5:00 PM, the AS and the QIDP were interviewed. The QIDP asked the AS what time the groceries were purchased and the AS stated, "You don't even want to know when that was purchased. We'll make sure it gets thrown away". The QIDP stated, "That's a bad thing".			

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	On 1/13/21 at 11:03 AM, the LPN was interviewed by phone. When asked if if was safe for raw chicken to be on the counter for over 2.5 hours the LPN stated, "Well that would be contaminated. I don't think it should ever be left on the counter". 9-3-7(a)			
W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the facility failed to provide napkins and a full set of silverware during meals. Findings include: Observations were conducted at the group home on 1/11/21 from 5:45 AM to 8:30 AM and from 3:45 PM to 6:15 PM. At 7:35 AM, clients #2, #3, #4, #5, #6 and #8 ate eggs, oatmeal/cereal and toast for breakfast. The clients were not provided napkins. At 6:05 PM, clients #1, #2, #3, #4, #5, #6, #7 and #8 ate meatloaf, mashed potatoes, corn and fruit for dinner. Each place setting had a fork and did not have a spoon, knife or a napkin. At 6:10 PM, client #3 licked food off of his fingers. On 1/12/21 at 5:00 PM, the AS (Area Supervisor) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The AS and the QIDP indicated clients should have napkins and a full set of silverware during meals. 9-3-8(a)	W 0475	W475: Food must be served with appropriate utensils. Staff have been trained that utensils appropriate for the meal and napkins must be on the table. Area Supervisor and QIDP will observe in the home at least 3 times weekly to ensure that utensils and napkins are offered to the clients. A member of the management team (Nurse manager, Program Director, Quality Manager, Quality Coordinator) will observe in the home at least 3 times weekly and will ensure that utensils and napkins are offered.	02/21/2021

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