

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey.</p> <p>Dates of Survey: 3/29, 3/30, 3/31, 4/1, 4/6, and 4/9/21.</p> <p>Facility number: 000737 Provider number: 15G211 AIM number: 100243270</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 on 4/26/21.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) <b>GOVERNING BODY</b></p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 3 of 3 sampled clients (#1, #2, #3) plus 4 additional clients (#4, #5, #6, and #7), the governing body failed to exercise general operating direction over the facility to ensure broken blinds, missing baseboards and damaged walls in client #1's bedroom, a worn couch, and worn kitchen table chairs were replaced and/or repaired.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM and on 3/30/21 from 5:50 AM through 8:05 AM. During both observation periods there was a</p>	W 0104	<p>W104: Governing body must exercise general policy, budget, and operating direction over the facility. All of the blinds have been replaced, missing baseboards have been replaced, a work order has been initiated for the damage to the walls in Client #1's room. The worn couch has been taken out of the living room and is being replaced. The kitchen chairs are being replaced. The Area Supervisor and QIDP will complete weekly habilitation observations that will</p>	05/09/2021

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>	
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>couch located in the living room with 50% (percent) of the material peeling off, a 10 foot section of baseboard missing in client #1's room, a 10 foot by 3 foot section of missing paint/damaged wall in client #1's room, and 5 broken blinds in the living room and clients #2, #3, #5, and #6's rooms. The kitchen table chairs all were worn with the finish missing from them. This affected clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>The Med Coach (MC) was interviewed on 3/30/21 at 7:50 AM. The MC indicated the repairs in the home had been needed for at least a couple of months. The MC indicated client #1 destroys his property and runs his matchbox cars up and down the walls, which takes the paint off. The MC indicated she had replaced some of the blinds during 3rd shift.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP indicated repairs in the home have been needed for awhile. The QIDP stated she thought "the chairs had been cleaned and the cleaner had stripped off the finish of the chairs." The QIDP indicated the couch in the living room was client #7's and should be replaced.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated the blinds and the couch should be replaced. The PD indicated the walls and baseboard should be repaired and repainted. The PD indicated he was unaware of the chairs in the kitchen but if they were worn they should be refinished.</p> <p>9-3-1(a)</p>			<p>include an environmental checklist to ensure the environment is up to standard. If anything needs repaired; a work order will be submitted. A copy of the work order will be submitted to the Program Director to ensure the work is completed. A member of the management team (Program Directors, Program managers, Nursing managers, QA team) will review the site once per month and will include an environmental check during this review.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>00</b> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0157  Bldg. 00	<p><b>483.420(d)(4)</b> <b>STAFF TREATMENT OF CLIENTS</b> If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 additional client (#4), the facility failed to develop and implement effective corrective measures to address client #4's repeated falls.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following:</p> <p>1. A 11/25/20 BDDS report indicated " ...On 11/24/20 [client #4] fell in his bedroom hitting his head on the closet door. He received a 3 cm (centimeter) by 2 cm cut on the end of his left eyebrow. [Client #4] was not using his walker when he fell. When staff tried to help him up off the floor, he could not stand and he was shaking all over. Each time he tried to stand his knees would buckle. The agency nurse was contacted who recommended the staff call 911 and he be seen in the ER (Emergency Room). EMS (Emergency Medical Services) arrived and transported him to [name of hospital] ER. While in the ER he had a physical exam, labs and a CT (Computed Tomography) scan. All testing was normal. He was diagnosed with a fall, given IV (intravenous) fluids for dry mouth and chapped lips. He was released and is to follow up with his PCP (Primary Care Physician). Staff will complete neuros (head checks) every 2 hours for 24 hours and once a shift for the next 24 hours. He has a fall risk plan and a plan for medical non-compliance. His plans were followed by the staff. Notifications made."</p>	W 0157	<p>W157: If the alleged violation is verified, appropriate corrective action must be taken. QIDP and nurse were trained that when a consumer has repeated falls, IDT meetings should be held to discuss and document what changes to a client's plan (if any) will be made. Changes or new interventions need to be documented and staff will be trained on the changes. Program Director and QIDP will meet weekly (via phone or in person) and will include reviewing IRs to determine if an issue needs addressed by the IDT. QA will review IRs monthly and flag those with repeated falls to ensure that they are being addressed by the IDT.</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>A 11/25/20 Fall Assessment/Investigation (FAI) indicated "...No changes to risk plans at this time ...". The 11/25/20 FAI indicated client #4 did not need any further reassessment in regard to Physical Therapy and Occupational Therapy.</p> <p>2. A 11/22/20 Incident Report indicated client #4 had a fall at 4:10 AM. The 11/22/20 IR indicated the fall was discovered and not observed. The IR indicated "[Client #4] was straightening the bathroom rug after laying it down and fell backwards on his butt and hit his head behind right ear on the leg of his walker per [client #4]. He stated he lost his balance. Staff checked (client #4) for injury. None seen at this time."</p> <p>A 11/23/20 FAI indicated "...No changes to risk plan at this time ...". The 11/23/20 FAI indicated client #4 did not need any further reassessment in regard to Physical Therapy and Occupational Therapy.</p> <p>3. A 9/3/20 BDDS report indicated "On 09/2/20 [client #4] was using the bathroom and turned from his walker to wash his hands and fell/tripped over his feet, striking his left side of his face on the floor. He had a red line on his eyebrow 1.8 cm by 1 cm and an area of redness under his left eye 1.9 cm by .5 cm. Agency nurse notified ...First aid was administered by staff. Skin assessments will be completed on the areas. Tylenol (for pain) 325 mg (milligrams) times 2 tablets every 4 hours as needed for pain, neuros will be conducted every hour for 4 hours, then every 2 hours for 20 hours, lastly once a shift for 24 hours. [Client #4] has a fall risk plan and it was being followed. Notifications made."</p> <p>A 9/3/20 FAI form indicated "...No changes to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>risk plan at this time ...". The 9/3/20 FAI indicated client #4 did not need any further reassessment in regard to Physical Therapy and Occupational Therapy.</p> <p>4. A 7/19/20 BDDS report indicated on 7/18/20 "...[Client #4] was standing up to put on boxer shorts when he fell, resulting in a laceration to his left elbow and an abrasion to his head- Staff contacted 911 and [client #4] was transported to the ER where he received 3 staples for the laceration on his elbow. The agency nurse was notified. [Client #4] was discharged and instructed to take Tylenol as needed. Follow - up with PCP as needed. Neuro- checks are in place every 2 hours for 24 hours and then once a shift for 24 hours. Skin assessments were implemented. [Client #4] has a fall risk plan in place ... ResCare will continue to monitor the consumer's health and wellness and follow plan of care. All protocols were followed. Notifications made."</p> <p>A 7/19/20 FAI indicated " ...No changes to risk plan at this time ...". The 7/19/20 FAI indicated client #4 did not need any further reassessment in regard to Physical Therapy and Occupational Therapy.</p> <p>5. A 3/5/20 BDDS report indicated "On 3/4/20 [Client #4] was getting out of the shower and fell striking his nose and mouth. He was transported to the ER by staff. Agency nurse notified ...He was given a CBC (complete blood count) with Differential, CT scan of the head, face and cervical spine. He was diagnosed with a closed fracture of nasal septum. Staff are to complete neuros every 2 hours for the 1st 24 hours and once a shift for 72 hours. He was released and is to follow up with his PCP on 3/12/20 at 9:15 am. He may follow up with an ENT (ear, nose and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)
	<p>throat) if he wants a nasal bones (sic) reset. He does have a fall risk plan and it was being followed. Since it was a fracture, ResCare will conduct an internal review of the fall. Notifications made."</p> <p>Client #4's record was reviewed on 3/31/2021 at 12:37 PM. Client #4's 8/2020 Monthly Summary indicated "...[Client #4] had a physical therapy session on 8.11.20 where the therapist indicated [client #4] might need 1:1 (one on one) assistance when ambulating ...".</p> <p>Client #4's 1/2021 Medical Non-compliance Risk Plan indicated "Interventions:</p> <ul style="list-style-type: none"> <li>" Staff will praise [client #4] for efforts in cooperation and compliance of using adaptive equipment and complying with medical procedures, treatments and risk reduction techniques as ordered/implemented by his physicians'/ care team.</li> <li>" Staff will educate [client #4] regarding the health and safety consequences of refusals.</li> <li>" Staff will encourage [client #4] to verbalize his feelings.</li> <li>" Staff will know how and when to call the nurse ...".</li> </ul> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP indicated the plan was not effective if client #4 was having repeated falls. The NM stated she added the medical non-compliance to his plan around 6/2020 and "staff can only prompt so much, the only thing that would save him from falling is having 1:1 staff right by him."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0186  Bldg. 00	<p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD stated the facility "should have had more team meetings to determine if there were different interventions, we could have done to help prevent his falls, or maybe he should have continued with physical therapy."</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) <b>DIRECT CARE STAFF</b> The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2, #3) plus 4 additional clients (#4, #5, #6, and #7), the facility failed to ensure there were sufficient staff to meet the needs of clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM. From 2:38 PM until 3:20 PM, staff #3 was the only staff present in the home. Staff #3 indicated she had been in the home by herself since 2:00 PM with clients #1, #2, #3, #5, and #6. Staff #3 indicated she was waiting for RM (Residential Manager) #2 to come home with clients #4 and #7 from workshop. Throughout the observation period while staff #3 was in the home by herself,</p>	W 0186	<p>186: The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. (NOTE: The person identified as the RM in the survey was actually the Area Supervisor. There currently is not a person in the RM role). The Area Supervisor will submit a schedule for the home to the Program Director who will review and ensure at least 2 staff are scheduled during waking hours.</p> <p>Management staff will sign in and out when working as direct care in order for their hours to be reflected as staff present in the home. Area Supervisor and QIDP</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE  810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>client #1 got up multiple times and got close to clients #3 and #5. He would hit client #3's chair where he was sitting and scare him and shake client #5's walker. Staff #3 stated client #1 was "having a bad day."</p> <p>Staff #4 was interviewed on 3/30/21 at 7:40 AM and stated "you can't work by yourself here because of [client #1] and his behaviors. His behaviors are out of control." Staff #4 stated staff have had to work by themselves "multiple times."</p> <p>The facility's time cards from 1/1/21 through 3/29/21 were reviewed on 4/1/21 at 3:00 PM. January's 2021 schedule indicated 4 days in the month had single staffing during 1st or 2nd shift for 2 hours or more. January 2021's schedule indicated 6 days in the month had single staffing during 1st or 2nd shift for 6 hours or more. February 2021's schedule indicated 12 days in the month had single staffing during 1st or 2nd shift for 3 hours or more. March 2021's schedule indicated 14 days in the month had single staffing during 1st or 2nd shift for 4 hours or more.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP stated it would be difficult to "get anything done" if client #1 is in the home and having behaviors.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD stated during awake hours there should be at least 2 staff in the home, and "sometimes circumstances occur, and it is not recommended to have less than 2 in the home."</p> <p>9-3-3(a)</p>		will each complete a habilitation observation weekly to include staffing ratios. A member of the management team (Program Directors, Program managers, Nursing managers, QA team) will review the site once per month and will include staff ratios during their review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE  810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0192  Bldg. 00	<p>483.430(e)(2) <b>STAFF TRAINING PROGRAM</b></p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review, and interview for 1 additional client (#7), the facility failed to ensure staff were trained and competent in administering client #7's medications to ensure he chewed a chewable medication.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/30/21 from 5:50 AM through 8:05 AM. At 6:55 AM, Residential Manager (RM) #1 had client #7 come to the medication room. RM #1 gave client #7 1 tablet of Aspirin (for heart health) 81 mg. (milligram) chewable tablet. Client #7 swallowed the pill whole with water and did not chew it. RM #1 stated client #7 does not chew the Aspirin 81 mg. chewable tablet "as far as I know." Client #7's Aspirin 81 mg. chewable tablet bubble pack indicated client #7 was to "chew 1 tablet every morning."</p> <p>Client #7's 3/2021 Quick MAR (Medication Administration Record) was reviewed on 3/30/21 at 7:00 AM and indicated client #7 was to take 1 tablet Aspirin 81 mg. every morning.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The NM indicated she was not aware client #7 was put back on a chewable form of the Aspirin and thought he was still on a non-chewable pill. The NM indicated if the bubble pack indicated he was to chew the tablet then staff should have had him chew the Aspirin tablet.</p>	W 0192	<p>W192: For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Staff have been retrained that they are to administer the medication as directed by the physician and the MAR. If it is a chewable, the staff are to have the client chew the medication, not swallow it whole. AS and QIDP will each observe a medication pass weekly to ensure that medications are passed per physician's orders.</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0193  Bldg. 00	<p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated if the Aspirin was a chewable tablet then staff should ensure he is chewing the tablet.</p> <p>9-3-3(a)</p> <p><b>483.430(e)(3)</b> <b>STAFF TRAINING PROGRAM</b> Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p> <p>Based on observation, record review, and interview for 1 of 3 sampled clients (#1) plus 1 additional client (#4), the facility failed to ensure staff were trained and competent in managing clients #1 and #4's behaviors.</p> <p>Findings include:</p> <p>1. Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM. At 2:50 PM, client #1 got up and started hitting the chairs in the living room. Staff #3 told client #1 to go to his room and keep his hands off of people. Client #1 did not go to his room. At 3:10 PM, client #1 got up from his chair and went to sit by client #6 on the couch. Staff #3 told client #1 to get up and keep his hands to himself. Staff #3 asked client #6 to get up from the couch and move to a different spot so he wouldn't get hit by client #1. Client #6 got up and went and sat at the kitchen table. At 3:32 PM, client #1 got up from his chair and went over to where client #5 was sitting on the couch and started hitting the couch. Residential Manager (RM) #2 prompted client #1 to go sit down. At 3:35 PM, client #1 got up from his seat and</p>	W 0193	<p>W193: Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. All staff have been retrained on Client #1's BSP focusing on the intervention techniques that are to be utilized. Client 4 has moved to supported living, however staff will also be trained that they are not to tell clients that they are going to write their behavior down, they are to simply document behaviors without commenting to the client. QIDP and AS will each complete a habilitation observation weekly to include observing DCPs implementing behavior plans as written. A member of the management team (Program Directors, Program managers, Nursing managers, QA team) will review the site once per month and will include observing</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>started shaking his hand toward client #3, while he sat in a recliner. Client #1 hit the recliner client #3 was seated in and startled him. At 3:48 PM, client #1 got up from his seat and walked over to client #5's walker and started shaking it while client #5 sat in the couch beside it. Client #1 continued to yell and cuss at everyone for about 20 more minutes. At 5:05 PM, client #1 started walking close to client #3 and staff #3 told client #1 to go to his room. Client #1 did not go to his room.</p> <p>Client #1's record was reviewed on 3/31/21 at 2:05 PM. Client #1's 2/3/21 Behavior Support Plan (BSP) indicated client #1 had behaviors of physical and verbal aggression. Client #1's 2/3/21 BSP indicated for physical aggression "...Reactive Strategies</p> <p>In the event that [client #1] demonstrates physical aggression, implement the indicated interventions in response to his aggression. Note that all members of the interdisciplinary team are expected to maintain a positive training environment at all times. In other words, 'arranging the environment' is a given unless otherwise specified in a specific intervention strategy. Lastly, remember ...interventions are not training, but are a way to get [client #1] back to his regular programming.</p> <p>A. Redirect: To another activity such as going for a walk, go outside to swing or cleaning his room.</p> <p>B. Accompany: Accompany him to another area of the house.</p> <p>C. Return to programming."</p> <p>Client #1's 2/3/21 BSP indicated for verbal aggression "...In the event that [client #1] demonstrates verbal aggression, implement the indicated interventions in response to his verbal</p>		behavior interventions by staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>	
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>aggression. Note that all members of the interdisciplinary team are expected to maintain a positive training environment at all times. In other words, 'arranging the environment' is a given unless otherwise specified in a specific intervention strategy. Lastly, remember ...interventions are not training, but are a way to get [client #1] back to his regular programming.</p> <p>A. Redirect: Redirect [client #1] by calmly explaining to him that this type of language is offensive to others. Also, if [client #1] can be engaged in a constructive activity, then he may deescalate this behavior..</p> <p>B. Planned Ignore: Ignore [client #1] up to 30 seconds by walking away from him and going to another area, only if it is safe to do so for others. DO NOT LEAVE THE ROOM IF THERE ARE OTHERS IN THE ROOM HE MAY BECOME AGGRESSIVE TOWARDS. Once [client #1] realizes that you are not giving him attention, he will normally cease verbally aggressive behaviors.</p> <p>C. Return to programming."</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP indicated staff should redirect client #1 to a preferred activity or to clean his room. The QIDP stated it is not in client #1's plan to tell him to go to his room, "that will not work for him."</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated staff should follow client #1's BSP which indicates to prompt him to another activity. The PD indicated staff should not tell him he has to go to his room.</p> <p>2. Observations were completed in the group</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE  810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>home on 3/29/21 from 2:38 PM through 5:50 PM. At 3:20 PM, client #4 arrived home from the workshop. Client #4 said he wanted some coffee to drink and a snack. Staff #3 had him clean out his lunch box and put his coffee in the refrigerator and told him he could have it at dinner. At 3:53 PM, client #4 drank water out of his metered cup. At 3:58 PM, client #4 told staff he would really like to have coffee when he got home from work. At 4:45 PM, client #4 indicated he would like a snack. RM (Residential Manager) #2 told client #4 they were going to eat soon. At 5:16 PM, client #4 got up from the couch and told RM #1 he was hungry. RM #1 told client #4 she was going to write in his book about him and how he kept asking for food and drinks.</p> <p>Client #4's record was reviewed on 3/31/2021 at 12:37 PM. Client #4's 1/25/21 Individual Support Plan and Behavior Support Plan did not indicate he had a plan with an intervention which indicated staff should tell him they are going to write down in his book about him and his behaviors.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP indicated client #4 does not have an intervention in his plan where staff should tell him they are going to write in his book about him. The QIDP stated staff should not be telling client #4 they are going to write in his book about him, they should "just simply track it in his book."</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated staff should not be telling client #4 they are going to write in his book about him.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0247  Bldg. 00	<p>9-3-3(a)</p> <p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation and interview for 1 additional client (#4), the facility failed to ensure client #4 was able to eat snacks and have drinks when he wanted to throughout the course of the day.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM. At 3:20 PM, client #4 arrived home from the workshop. Client #4 said he wanted some coffee to drink and a snack. Staff #3 did not say anything to client #4 but had him clean out his lunch box and put his coffee in the refrigerator and told him he could have the coffee at dinner. At 3:53 PM, client #4 drank water out of his metered cup. At 3:58 PM, client #4 told staff he would really like to have coffee when he got home from work. At 4:45 PM, client #4 indicated he would like a snack. RM (Residential Manager) #2 told client #4 they were going to eat soon. Client #4 told RM #2 his sugar might go down if he doesn't eat something. RM #2 told client #4 he "would figure it out." At 5:16 PM, client #4 got up from the couch and told RM #1 he was hungry. At 5:24 PM, client #4 told staff #3 he was thirsty and wanted something to drink. Staff #3 told client #4 he had to wait until dinner because he had already had extra drinks.</p> <p>Client #4 was interviewed on 3/30/21 at 12:15</p>	W 0247	<p>W247: The individual program plan must include opportunities for client choice and self-management. Staff have been trained that unless there is a medical or dietary restriction, clients who indicate that they would like a snack should be provided the snack/drink. QIDP and RM will each complete a habilitation observation weekly to include ensuring that clients who request snacks/drinks are provided with the snack/drink.</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE  810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0249  Bldg. 00	<p>PM. Client #4 indicated he would have liked to have a snack when he got home from workshop. Client #4 indicated he had not had a snack from the time he ate lunch until the time he ate dinner and he was hungry.</p> <p>Client #4's record was reviewed on 3/31/2021 at 12:37 PM. Client #4's record did not indicate he had a calorie or fluid restriction.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP indicated there was no reason staff should not have let client #4 have a snack when he got home from work or more to drink when he requested it. The NM indicated client #4 was not on a calorie or fluid restriction.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated client #4 should be able to choose when and how much he has to drink. The PD indicated if client #4 wanted a snack after he got home from work he should have been able to have one.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) <b>PROGRAM IMPLEMENTATION</b> As soon as the interdisciplinary team has 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.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2, and</p>	W 0249	W249: Each client must receive a continuous active treatment	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>#3), the facility failed to ensure clients #1, #2, and #3 received training on their program objectives.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM. At 2:38 PM, clients #1, #2, #3, #5, and #6 were in the living room. Throughout the observation period client #2 would pace around the house, entering his room, lying in bed, and coming back out to the living room. Clients #1 and #3 sat in recliners throughout the entire observation period. Client #1 would get up periodically to hit a couch or yell at the other clients in the home. Clients #5 and #6 sat on the couch and watched television. At 3:20 PM, clients #4 and #7 came home from workshop and took showers. At 3:58 PM, staff #3 wiped down the kitchen table and Residential Manager (RM) #2 took the trash out to the garage. At 4:45 PM, client #4 helped open cans of vegetables. RM #2 poured the vegetables in the pan and added water. RM #2 pureed clients #1, #3, #4, #5, #6, and #7's food for them in the blender. RM #2 put chicken salad, bread, and green beans on client #2's plate and put it at his place setting at the table. Staff #3 brought client #7's clothes out of the restroom and placed them in the washer. At 5:05 PM, staff #3 placed napkins and silverware at each client's place setting. RM #2 poured the pureed green beans and chicken salad in separate bowls and took them to the kitchen table. At 5:24 PM, staff #3 poured drinks for each client. At 5:35 PM, RM #2 took plates out and put them on the table at each client's spot. Staff #3 put applesauce at each client's place setting. At 5:47 PM, clients #1, #2, #3, #4, #5, #6, and #7 went to the kitchen table to eat dinner. Clients #1, #2, and #3, were not</p>		<p>program. All staff have been trained that they are to encourage/prompt clients to do as much for themselves as possible. Staff have been retrained that they are not to do "for" clients but to do "with" clients. Staff have been retrained that they are to conduct formal and informal training for each client daily. Area Supervisor has been trained that he is a role model for staff and when he does not ask clients to assist with daily activities it gives the DCPs "permission" to not encourage clients to do as much as possible for themselves. QIDP and Area Supervisor will each complete a habilitation observation weekly to include ensuring that clients are involved with active treatment. A member of the management team (Program Directors, Program managers, Nursing managers, QA team) will review the site once per month and will include ensuring that staff are encouraging clients to participate in active treatment throughout the day.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>prompted to pick a leisure activity or work on goals throughout the observation period.</p> <p>1. Client #1's record was reviewed on 3/31/21 at 2:05 PM. Client #1's 1/25/21 Individual Support Plan (ISP) indicated client #1 had formal training objectives for: dining skills, oral hygiene skills, personal hygiene skills, toileting, domestic skills, fire safety skills, and privacy.</p> <p>2. Client #2's record was reviewed on 4/1/21 at 10:46 AM. Client #1's 3/15/21 ISP indicated he had formal training objectives for: communication skills, bathing skills, dining skills, oral hygiene skills, toileting skills, domestic skills, medication administration skills, and privacy skills.</p> <p>3. Client #3's record was reviewed on 3/31/21 at 10:47 AM. Client #3's 6/15/20 ISP indicated he had formal training objectives for: dining skills, dressing skills, oral hygiene skills, personal hygiene skills, toileting skills, laundry skills, and medication administration skills.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP indicated staff should be prompting clients during formal and informal opportunities to work on their goals and the clients should not be sitting around watching television all day.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated staff should be prompting clients to work on goals or pick a leisure activity throughout the day during formal and informal opportunities.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0268  Bldg. 00	<p><b>483.450(a)(1)(i)</b> <b>CONDUCT TOWARD CLIENT</b> These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview for 3 of 3 sampled clients (#1, #2, and #3) plus 3 additional clients (#4, #6, and #7), the facility failed to remove clients #1, #2, #3, #4, #6, and #7's facial hair and encourage client #1 to change his clothes that were soiled with food and liquid in regards to their dignity.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM. Throughout the entire observation period clients #1, #2, #3, #4, #6, and #7, faces were unshaven and appeared to be a couple day's worth of hair growth. Client #1 walked around with various stains on his shirt. At 2:50 PM, staff #3 pointed to client #1's shirt and stated "you can tell he's been having a good day." Staff #3 indicated client #1 had been having behaviors all day. Staff #3 did not prompt client #1 to change his shirt.</p> <p>Observations were completed on 3/30/21 from 5:50 AM through 8:05 AM. At 7:18 AM, the Med Coach (MC) was sitting at the kitchen table with client #6 and was shaving his face. The MC stated client #6 had "probably not been shaved in a week." Client #4 asked the MC if he could shave his face before work and the MC told him "you know we shave after shower tonight."</p> <p>Client #4 was interviewed on 3/30/21 at 12:15 PM. Client #4 stated he shaves at night "but sometimes staff forget to help me shave."</p>	W 0268	<p>W268: These policies and procedures must promote the growth development and independence of the client. Staff have been retrained that they are to assist clients with hygiene(shaving) at least every other day and more often if the client needs or requests it. Staff have been retrained that when clients have spilled on or stained their clothing during the day, they are to request the client to change the clothing and/or assist them in changing their clothes. QIDP and Area Supervisor will each complete a habilitation observation weekly to include ensuring that clients are shaved regularly and in clean clothing. A member of the management team (Program Directors, Program managers, Nursing managers, QA team) will review the site once per month and will include ensuring that clients are shaved and in clean clothing.</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0288  Bldg. 00	<p>Client #7 was interviewed on 3/30/21 at 12:45 PM. Client #7 indicated staff sometimes forget to help him shave.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP stated she believed the clients were shaven every other day "but if they want to shave sooner they should be able to." The QIDP indicated staff should have had client #1 change his shirt or prompt him to go change his shirt.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated clients should be shaven on a regular basis and should not have days worth of growth on their faces. The PD indicated staff should have had client #1 change his shirt or prompted him to change.</p> <p>9-3-5(a)</p> <p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. Based on observation, record review, and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1 was not restricted from his clothing.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM and on 3/30/21 from 5:50 AM through 8:05 AM. During both observation periods client #1's clothes were in the garage in totes.</p>	W 0288	<p>W288: Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. The QIDP has been retrained that any restrictive intervention must be included in the client's plan and a goal must be developed to reduce the restriction. The IDT will meet and discuss his needs surrounding his clothing. A plan will be developed and included in</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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)
W 0382 Bldg. 00	<p>The Med Coach (MC) was interviewed on 3/30/21 at 7:45 AM. The MC stated client #1 did not have any clothes in his room, because "we had been instructed to put them in the garage so he would not destroy them." The MC indicated she was not sure when she was told to put client #1's clothes in the garage.</p> <p>Client #1's record was reviewed on 3/31/21 at 2:05 PM. Client #1's 1/25/21 Individual Support Plan (ISP) and Behavior Support Plan (BSP) did not indicate a behavior of destroying his clothes. Client #1's 1/25/21 ISP and BSP did not indicate there was an intervention for client #1 destroying his clothes.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP indicated she had told the staff in the group home they could put client #1's clothes in the garage. The QIDP indicated client #1 should not have his clothes in the garage and the facility should not implement their own restrictions without a plan.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated he thought client #1 had in his plan for his clothes to be kept in the garage. The PD indicated if it was not in a plan, staff should not be implementing it and client #1 should have his clothes in his room.</p> <p>9-3-5(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p>			his ISP. Program Director and QIDP will meet weekly (via phone or in person) and part of the discussion will be ensuring that restrictions are put into plans.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0420 Bldg. 00	<p>Based on observation and interview for 3 of 3 sampled clients (#1, #2, #3) plus 4 additional clients (#4, #5, #6, and #7), the facility failed to ensure medications were locked when not being administered.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM. Throughout the entire observation period 2 bags of medications labeled with other group home names sat on the counter in the kitchen. Staff #3 indicated they were medications for the other 2 group homes and she was waiting for staff to pick them up. This affected clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The NM indicated the medications should have been kept in the medication room until the other group homes came to pick them up.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated the medications should be locked in the medication room when not being administered. The PD indicated if they were for another group home they should be kept in a locked cabinet or room until they are picked up.</p> <p>9-3-6(a)</p> <p><b>483.470(b)(4)(iv)</b> <b>CLIENT BEDROOMS</b> The facility must provide each client with functional furniture, appropriate to the clients needs.</p>	W 0382	<p>W382: The facility must keep all drugs and biologicals locked. All staff have been trained that when medications are received for another group home, the medications must be stored in the medication room. QIDP and Area Supervisor will each complete a habilitation observation weekly to include ensuring that all medications in the home are stored in the locked medication room.</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/09/2021
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Based on observation and interview for 1 of 3 sampled clients (#1), the facility failed to provide a dresser or a nightstand in client #1's bedroom.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM and on 3/30/21 from 5:50 AM through 8:05 AM. During both observation periods client #1's room only had a bed, a tote, and various small items in the tote and on the ground.</p> <p>Residential Manager (RM) #2 was interviewed on 3/29/21 at 3:35 PM. RM #2 stated he thinks "there is only a bed in his room because he destroys things, but I'm still learning the guys in the house."</p> <p>The Med Coach (MC) was interviewed on 3/30/21 at 7:45 AM. The MC indicated client #1 only had a bed and tote in his room because he will destroy anything else.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP indicated client #1 does not have furniture in his room besides a bed and a tote of various items. The QIDP indicated client #1 should have a dresser and nightstand in his room.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated client #1 should have a dresser and a nightstand in his room.</p> <p>9-3-7(a)</p>	W 0420	<p>W420: The facility must provide each client with functional furniture, appropriate for the client's needs. Area Supervisor and QIDP were trained that client #1 should have a nightstand and dresser in his room. A nightstand and dresser will be provided for client #1. QIDP and RM will each complete a habilitation observation weekly to include ensuring that clients have functional furniture, appropriate to the client's needs. A member of the management team (Program Directors, Program managers, Nursing managers, QA team) will review the site once per month and will include ensuring that clients have functional furniture.</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0455  Bldg. 00	<p><b>483.470(l)(1)</b> <b>INFECTIOUS CONTROL</b></p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, record review, and interview for 3 of 3 sampled clients (#1, #2, #3) plus 4 additional clients (#4, #5, #6, and #7), the facility failed to screen visitors and staff at the group home upon entry, ensure staff wore their masks appropriately in the group home, and ensure clients washed their hands after coughing/sneezing to assist with preventing the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM. Upon arrival to the group home, the surveyor's temperature was not taken. Staff #3 did not ask screening questions regarding COVID-19. This affected clients #1, #2, #3, #4, #5, #6, and #7. At 3:01 PM, client #5 sneezed and staff #3 told him "bless you." Staff #3 did not prompt client #5 to wash his hands or sanitize them. At 4:08 PM, RM #2 and clients #4 and #7 came home from workshop. RM #2 and clients #4 and #7 did not take their temperature upon entry into the group home. At 4:45 PM, RM #2 and client #4 started opening cans of vegetables and putting them into a pot. RM #2 and client #4 did not wash their hands prior to starting to prepare dinner. At 4:58 PM, client #6 was coughing. RM #2 and staff #3 did not prompt him to cover his mouth or wash his hands.</p> <p>Observations were completed in the group home on 3/30/21 from 5:50 AM through 8:05 AM.</p>	W 0455	<p>W455: There must be an active program for the prevention, control and investigation of infection and communicable diseases. All staff have been retrained on the COVID 19 policies and protocols including screening visitors, staff, and clients upon entry to the home as well as staff wearing their masks appropriately. They have been trained to ensure they prompt clients to wash their hands after coughing/sneezing and to prompt clients to cover their mouths when coughing. Staff have been retrained that they are to wash their hands and to have clients wash their hands prior to handling or preparing any food. QIDP and Area Supervisor will each complete a habilitation observation weekly to include ensuring that clients are prompted when appropriate to wash hands and to cover their mouths when sneezing/coughing.</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE  810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>From 6:00 AM through 8:05 AM, staff #4 wore her mask below her nose when completing daily living skills with clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The NM indicated staff should be checking visitor's temperatures and asking screening questions for COVID-19 when they enter the group home. The NM indicated staff and clients upon entry into the group home should be checking their temperatures and washing their hands. The NM indicated clients and staff should wash their hands before preparing food. The NM indicated clients should be prompted to wash their hands after sneezing/coughing.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD staff and visitors should check their temperatures and fill out a screening assessment when entering the group home. The PD indicated clients should be washing their hands before preparing dinner and after they sneeze/cough.</p> <p>On 3/31/21 at 10:00 AM, the article "Coronavirus Disease 2019 (COVID-19): Protect Yourself" was reviewed from the website <a href="http://www.cdc.gov">www.cdc.gov</a>. The article indicated: "</p> <p>...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,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021	
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE  810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>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 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</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15G211</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/09/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>VOCA CORPORATION OF INDIANA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>810 CARLYLE ST COLUMBIA CITY, IN 46725</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0488  Bldg. 00	<p>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."</p> <p>9-3-7(a)</p> <p>483.480(d)(4) <b>DINING AREAS AND SERVICE</b> The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 3 of 3 sampled clients (#1, #2, #3) plus 4 additional clients (#4, #5, #6, and #7), the facility failed to teach and encourage clients to help prepare their meals, set the table, and participate in family style dining.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/21 from 2:38 PM through 5:50 PM. At 4:45 PM, Residential Manager (RM) #2 had client #4 help open the cans of mixed vegetables for dinner. At 4:55 PM, RM #2 stirred the vegetables on the stove. At 5:05 PM, staff #3 put napkins and cups on the kitchen table. RM #2 drained the vegetables and put them in a bowl. At 5:24 PM, RM #2 put chicken salad in a divided plate, tore up a slice of bread and put it on top of the chicken salad, and put a scoop of green beans in the divided plate for client #2. Staff #3 poured milk, water, and juice in each client's cup at the</p>	W 0488	<p>W488: The facility must assure that each client eats in a manner consistent with his or her developmental level. Staff have been retrained that they are not to do "for" clients but to do "with" clients. Staff have been retrained that they are to conduct formal and informal training for each client daily. Area Supervisor has been trained that he is a role model for staff and when he does not ask clients to assist with daily activities it gives the DCPs "permission" to not encourage clients to do as much as possible for themselves. Staff have specifically been trained that they are to have the clients participate in meal preparation, setting the table and participating in family style dining. QIDP and Area</p>	05/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G211	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 810 CARLYLE ST COLUMBIA CITY, IN 46725		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>kitchen table. At 5:26 PM, RM #2 added chicken salad, chicken broth, and bread into the blender and blended it. Staff #3 took bowls out of the cabinet and put them at each client's spot at the kitchen table. At 5:35 PM, RM #2 took plates out of the cabinet and put them at each client's place at the kitchen table. Staff #3 placed a cup of applesauce at each client's spot at the table. At 5:36 PM, RM #2 put green beans in the blender and blended them and then took the chicken salad and green beans to the table. RM #2 and staff #3 did not prompt clients #1, #2, #3, #4, #5, #6, and #7 to help prepare the dinner, set the table, and participate in family style dining.</p> <p>The Qualified Intellectual Professional (QIDP) and the Nursing Manager (NM) were interviewed on 4/6/21 at 11:01 AM. The QIDP indicated clients should be prompted to help prepare the meal, set the table, and have the opportunity to participate in family style dining.</p> <p>The Program Director was interviewed on 4/6/21 at 12:23 PM. The PD indicated staff should be prompting clients to help set the table, help prepare the dinner, and have the opportunity to participate in family style dining.</p> <p>9-3-8(a)</p>		<p>Supervisor will each complete a habilitation observation weekly to include ensuring that clients are involved with all aspects of mealtime. A member of the management team (Program Directors, Program managers, Nursing managers, QA team) will review the site once per month and will include ensuring that staff are encouraging clients to participate in all aspects of mealtime.</p>	