STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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 a Covid-19 focused infection control survey. Dates of Survey: 10/4/21, 10/5/21, 10/6/21 and 10/7/21. Facility Number: 001021 Provider Number: 15G507 AIMS Number: 100245130 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/20/21.	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), plus 5 additional clients (#4, #5, #6, #7 and #8). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8's home was clean, to ensure the facility had a policy regarding portable oxygen tank storage, to ensure the facility re-assessed clients #1 and #7 following changes/decline in their functional skills, to ensure the facility's nursing services met the health needs of clients #1, #3 and	W 0102	**W102: The governing body must ensure that specific governing body and management requirements are met.** **Corrective action:** · Nurse trained on completing nursing responsibilities per policy and procedure; including thorough documentation including all assessments, medical appointments, testing, immunizations, instructions given	11/06/2021

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
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	#7, to ensure staff administering medication dispensed clients #2, #6 and #7's medications at the time of administration and to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 practiced hand hygiene before medication administration and meals and to ensure staff wore face masks and screened visitors to the home. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Health Care services for 3 of 3 sampled clients (#1, #2 and #3), plus 4 additional clients (#4, #5, #6 and #7). Findings include: 1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8's home was clean, to ensure the facility had a policy regarding portable oxygen tank storage, to ensure the facility re-assessed clients #1 and #7 following changes/decline in their functional skills, to ensure the facility's nursing services met the health needs of clients #1, #3 and #7, to ensure staff administering medication dispensed clients #2, #6 and #7's medications at the time of administration and to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 practiced hand hygiene before medication administration and meals and to ensure staff wore face masks and screened visitors to the home. Please see W104. 2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Health Care services for 3 of 3 sampled clients (#1, #2 and #3), plus 4 additional clients (#4, #5, #6 and #7). Please see W318.		to staff, if you have spoken to the doctor etc. **(Attachment A).** · Nurse received a corrective action for failure to document thoroughly in the clients notes. · Nurse Manager or designee is at the facility 5 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment B)** · Nurse Manager contacted LinnCare, the oxygen supplier for the facility and had all empty oxygen cylinders picked up that were sitting in the living room area of the facility. · All other oxygen cylinders in the facility are in the proper storage container when not in use. · The facility had one oxygen in use sign on the main entry door but not the additional entries into the facility, signs have been placed on the end door as well as the 2 additional back doors. · Nurse Manager will complete medication administration observations 3 times weekly to ensure proper procedures are followed for medication administration for no less than three months. **(Attachment C)** · All staff in-serviced by the Nurse regarding adaptive equipment, medication administration, medical consults,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	9-3-1(a)		when to call the nurse, meal refusals, incontinence issues, dressing changes, following all client plans, liquids, creams, dressing changes and documentation. **(Attachment D)** · Med lead medication audit updated to include topical treatments and creams and when to notify the nurse that supplies are needed. **(Attachment E)** · Client #7 had OT evaluation and a fitted wheelchair was ordered. **(Attachment F)** · Client #3 had OT evaluation and a new fitted wheelchair was ordered. **(Attachment G)** · Client #1 had an appointment with psych on 10/27/21. **(Attachment H)** · Nurse Manager updated the positioning schedule for client #3. **(Attachment I)** · Rescare administrative observations to be completed three times a week including medication administrations observation for no less than three months. **(Attachment J)** · All staff trained on cleaning schedule for the home per shift. **(Attachment K & D)** · Staff received a corrective action for presetting the medications which resulted in termination. **(Attachment L)** · All staff trained on covid policies and procedures, visitor screening and mask policies.**(Attachment D)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
			· All staff trained on hygiene, hand washing prior to meals and medication administration.**(Attachment D)** · QIDP completed updated comprehensive functional assessments on clients #1 and #7**. (Attachment M)** · QIDP trained to ensure when a client has a change in mental or medical status new assessments must be completed immediately and update plans and goals accordingly**. (Attachment N)** · QIDP completed an addendum to client #1 behavior support plan and tracking form**. (Attachment O)** · Area Supervisor trained on continued oversight of home cleanliness, oxygen storage, client hygiene prior to medication administration and mealtime. **(Attachment P)** · Site Reviews are completed monthly to ensure home cleanliness, proper storage of medical supplies, etc. **(Attachment Q)**. **Monitoring of Corrective Action:** · All training sent to the Rescare trainer for filing in staff files. · All oversight observations will be sent to the Program Manager for monitoring and to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
			ensure completion. · Site Reviews will be completed monthly by Rescare management and entered into the database. · Covid policy training is completed at monthly house meetings. · Nurse Manager will send medication administration observations to the Program Manager for tracking and review. · QIDP will ensure all updated plans and assessments are completed annually and as needed based on client needs. · QIDP will meet with the IDT and submitted the IDT notes to the Program Manager. **Completion Date: 11/6/21**	
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), plus 5 additional clients (#4, #5, #6, #7 and #8), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8's home was clean, to ensure the facility had a policy regarding portable oxygen tank storage, to ensure the facility re-assessed clients	W 0104	**W104: The governing body will exercise general policy, budget, and operating direction over facility.** **Corrective action:** · Nurse trained on completing nursing responsibilities per policy and procedure;	11/06/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	#1 and #7 following changes/decline in their functional skills, to ensure the facility's nursing services met the health needs of clients #1, #3 and #7, to ensure staff administering medication dispensed clients #2, #6 and #7's medications at the time of administration and to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 practiced hand hygiene before medication administration and meals and to ensure staff wore face masks and screened visitors to the home. Findings include: 1. Observations were conducted at the group home on 10/4/21 from 4:20 PM through 6:50 PM. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were present in the home throughout the observation period. The home's living room had potato chips and crumbs in a 3 foot radius in front of the tv. Clients #1, #2, #3, #4, #5, #6, #7 and #8 and staff #1, staff #2 and staff #3 moved throughout the area from 4:20 PM through 5:15 PM. Staff #3 was interviewed on 10/4/21 at 6:36 PM. Staff #3 indicated the home should be clean. Staff #3 indicated the home had a chore/cleaning schedule staff should follow to routinely sweep the floors. Staff #5 was interviewed on 10/5/21 at 11:30 AM. Staff #5 indicated the home should be clean. Staff #5 indicated the home had a chore list/chart with assigned routine cleaning duties for staff. RM (Resident Manager) was interviewed on 10/5/21 at 12:47 PM. RM indicated the home should be clean. RM indicated staff had a chore chart with assigned cleaning duties. PM (Program Manager) was interviewed on		including thorough documentation including all assessments, medical appointments, testing, immunizations, instructions given to staff, if you have spoken to the doctor etc. **(Attachment A).** · Nurse received a corrective action for failure to document thoroughly in the clients notes. · Nurse Manager or designee is at the facility 5 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment B)** · Nurse Manager contacted LinnCare, the oxygen supplier for the facility and had all empty oxygen cylinders picked up that were sitting in the living room area of the facility. · All other oxygen cylinders in the facility are in the proper storage container when not in use. · The facility had one oxygen in use sign on the main entry door but not the additional entries into the facility, signs have been placed on the end door as well as the 2 additional back doors. · Nurse Manager will complete medication administration observations 3 times weekly to ensure proper procedures are followed for medication administration for no less than three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	10/6/21 at 12:04 PM. PM stated, "All shifts and staff should participate in keeping the home clean. There's a chore list for who's responsible for what." PM indicated the home's living room should be cleaned and free of food debris. 2. Observations were conducted at the group home on 10/4/21 from 4:20 PM through 6:50 PM and on 10/5/21 from 10:30 AM through 1:20 PM. Clients #1, #2 and #7 were on continuous oxygen therapy and client #5 was on PRN (as needed) oxygen therapy. The home had 9 oxygen cylinders stored in the home's living room and an additional supply of oxygen cylinders located in a closet in the living room area. The cylinders were not secured. There were no placards (signs) posted in the home or on the home's exterior entryways. Staff #3 was interviewed on 10/4/21 at 6:36 PM. Staff #3 indicated clients #1, #2 and #7 utilized continuous oxygen therapy and client #5 was on PRN oxygen therapy. Staff #3 indicated the stored oxygen tanks/cylinders in the home's living room and closet in the living room. Staff #5 was interviewed on 10/5/21 at 11:30 AM. Staff #5 indicated clients #1, #2 and #7 utilized continuous oxygen therapy and client #5 was on PRN oxygen therapy. Staff #5 indicated the home stored oxygen tanks/cylinders in the living room and in a closet in the living room. Staff #5 indicated the cylinders in the living room were empty and the cylinders in the closet were full. Staff #5 indicated the home had a grate system to secure the cylinders. PM, Manager and NM (Nurse Manager) were interviewed on 10/6/21 at 12:04 PM. NM stated, "I want to say the extra containers are stored in the med room. I'm not sure how that home is set up."		**(Attachment C)** · All staff in-serviced by the Nurse regarding adaptive equipment, medication administration, medical consults, when to call the nurse, meal refusals, incontinence issues, dressing changes, following all client plans, liquids, creams, dressing changes and documentation. **(Attachment D)** · Med lead medication audit updated to include topical treatments and creams and when to notify the nurse that supplies are needed. **(Attachment E)** · Client #7 had OT evaluation and a fitted wheelchair was ordered. **(Attachment F)** · Client #3 had OT evaluation and a new fitted wheelchair was ordered. **(Attachment G)** · Client #1 had an appointment with psych on 10/27/21. **(Attachment H)** · Rescare administrative observations to be completed three times a week including medication administrations observation for no less than three months. **(Attachment J)** · All staff trained on cleaning schedule for the home per shift. **(Attachment K & D)** · Staff received a corrective action for presetting the medications which resulted in termination. **(Attachment L)** · All staff trained on covid policies and procedures, visitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	NM stated, "I think we do have a protocol but I would have to look it up." PM stated, "I don't know what the policy says. We recently got cited at another location." PM indicated she was not sure if there was a policy but would follow up and provide a copy if the agency had one. No additional documentation regarding the oxygen storage policy was provided. 3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility re-assessed clients #1 and #7 following changes/decline in their functional skills. Please see W259. 4. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility's nursing services met the health needs of clients #1, #3 and #7. Please see W331. 5. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure staff administering medication dispensed clients #2, #6 and #7's medications at the time of administration. Please see W367. 6. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients #1, #2 #3, #4, #5, #6, #7 and #8 practiced hand hygiene before medication administration and meals and to ensure staff wore face masks and screened visitors to the home. Please see W455. 9-3-1(a)		screening and mask policies.**(Attachment D)** · All staff trained on hygiene, hand washing prior to meals and medication administration.**(Attachment D)** · QIDP trained to ensure when a client has a change in mental or medical status new assessments must be completed immediately and update plans and goals accordingly**. (Attachment N)** · QIDP completed updated comprehensive functional assessments on clients #1 and #7**. (Attachment M)** · QIDP updated client #1 goals**. (Attachment R)** · QIDP updated client #7 goals**. (Attachment S)** · QIDP completed an addendum to client #1 behavior support plan and behavior tracking**(Attachment O)** · Area Supervisor trained on continued oversight of home cleanliness, oxygen storage, client hygiene prior to medication administration and mealtime. **(Attachment P)** · Site Reviews are completed monthly to ensure home cleanliness, proper storage of medical supplies, etc. **(Attachment Q)**. **Monitoring of Corrective**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
			Action: · All training sent to the Rescare trainer for filing in staff files. · All oversight observations will be sent to the Program Manager for monitoring and to ensure completion. · Site Reviews will be completed monthly by Rescare management and entered into the database. · Covid policy training is completed at monthly house meetings. · Nurse Manager will send medication administration observations to the Program Manager for tracking and review. · QIDP will ensure all updated plans and assessments are completed annually and as needed based on client needs. · QIDP will meet with the IDT and submit the IDT notes to the Program Manager. **Completion Date: 11/6/21**	
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	reviewed by the interdisciplinary team for relevancy and updated as needed. Based on observation, record review and interview for 1 of 3 sampled clients (#1), plus 1 additional client (#7), the facility failed to re-assess clients #1 and #7 following changes/decline in their functional skills. Findings include: 1. Observations were conducted at the group home on 10/4/21 from 4:20 PM through 6:50 PM. At 5:35 PM, client #1 was in his bedroom and seated on the side of his bed. Client #1 was nude with only a pair of socks on his body. Client #1's oxygen tubing was wrapped around his legs. Client #1's bed and floor were wet. There was a puddle of urine on the floor and client #1's feet. Staff #1 entered the bedroom and began verbally directing client #1 to put on clothing so he could walk to the home's shower and clean himself up. Client #1 was unable to follow staff #1's directions to stand up, put on his shorts, put on his shirt, reposition his oxygen tubing from his body and go to the shower. Client #1 was confused and made inarticulate statements. Staff #1's verbal cues were not sufficient in assisting client #1. Staff #1 began physically prompting and assisting client #1. Staff #1 requested staff #3 to come to client #1's bedroom to assist. Staff #1 and staff #3 physically assisted client #1 with dressing and going to the shower. At 6:21 PM, the home began the evening family style meal. Client #1 was still in the shower and had not completed cleaning up after being incontinent at 5:35 PM. Staff #1 stated, "[Client #1's] still in the shower. He's just been sitting in there. I'm going to go check on him and get him out for dinner." Staff #1 was interviewed on 10/4/21 at 5:35 PM.	W 0259	**W259:** Program Monitoring and Change **Corrective Action:** · QIDP completed updated comprehensive functional assessments on clients #1 and #7**. (Attachment M)** · QIDP trained to ensure when a client has a change in mental or medical status new assessments must be completed immediately and update plans and goals accordingly**. (Attachment N)** · QIDP completed an addendum to client #1 behavior plans **and tracking. (Attachment O)** · QIDP completed an addendum to client #7 plans**.** · QIDP updated goals for client #1**. (Attachment R)** · QIDP updated goals for client #7. (**Attachment S**) · All staff trained on updated goals. **(Attachment D)** · Client #7 had OT evaluation and a fitted wheelchair was ordered. **(Attachment F)** · Client #3 had OT evaluation and a new fitted wheelchair was ordered. **(Attachment G)** · Dining plan updated for client #7. **(Attachment T)**	11/06/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	Staff #1 indicated he had worked at the home with client #1 since June 2021. Staff #1 stated, "[Client #1] has changed since I've known him and worked with him." Staff #1 indicated client #1 was not incontinent. Staff #1 indicated client #1 had been independent with dressing himself and showering. Staff #2 was interviewed on 10/4/21 at 5:40 PM. Staff #2 indicated client #1's mental status had changed. Staff #2 indicated client #1 had become confused when attempting tasks, incontinent and required multiple verbal cues and physical assistance to complete tasks. Staff #2 indicated client #1 had routine cycles of schizophrenia and confusion. Staff #2 indicated client #1's current behavior was more intense and was longer in duration. Staff #3 was interviewed on 10/4/21 at 4:45 PM. Staff #3 indicated clients #1 and #7 had Covid-19 in September 2021 and were not fully recovered. Staff #3 stated client #1 was "still sluggish and hasn't fully recovered his energy." Observations were conducted at the group home on 10/5/21 from 10:30 AM through 1:20 PM. At 11:20 AM, client #1 sat at the dining room table to eat his lunch. Client #1 sat at the table and did not eat his meal. Client #1 looked around the room and spoke inarticulate words. Staff encouraged client #1 to eat his meal. Client #1 responded to staff's prompting but then resumed looking around while not eating. Staff #5 was interviewed on 10/5/21 at 11:30 AM. Staff #5 indicated client #1's functional abilities to complete tasks had changed. Staff #5 indicated client #5 had been independent with toileting, bathing, dressing himself and eating. Staff #5 indicated client #5 was now incontinent and		**Monitoring of Corrective Action:** · QIDP will update assessments based on client need and inform the IDT team of any changes in goals and plans and send all to the Program Manager for review. · All staff will be trained by the QIDP and Area Supervisor on any new or updated plans. · The QIDP will review all goal completion monthly when completing consumer monthly summaries. **Completion Date: 11/6/21**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	needed additional verbal and physical assistance to complete bathing, dressing and eating tasks. Staff #5 stated, "At breakfast this morning he just sat there staring at his food. He made comments about God. He finally ate after prompting." Client #1's record was reviewed on 10/6/21 at 9:50 AM. Client #1's ISP (Individual Support Plan) dated 4/29/21 indicated the following: -"[Client #1] ambulates independently. At times, [client #1] chooses to walk with a cain (sic), but he is not ordered to do so by a doctor." -"[Client #1] takes pride in being very independent-minded and he likes to make his own decisions regarding the future even though he needs a great deal of guidance to do so." -"[Client #1] is largely independent with performing basic self-care tasks." -"[Client #1] is diagnosed with Schizophrenia and may display anxiousness, staying up late drinking excessive amounts of coffee. Will ask and talk about things that are not related to the task at hand. May express excessive worrying, feelings of uneasiness, difficulty staying on task...." Client #1's CFA dated 4/29/21 indicated the following: -"B. Toilet use: Never has toilet accidents." -"Item 6: (Yes) Lowers pants at the toilet without help; Sits on toilet seat without help; Uses toilet tissue; Flushes toilet after use; Puts on clothes without help; Wash hands without help." -"F. Dressing and undressing: Dresses self by putting all clothes on with verbal promoting and by fastening." -"Item 8 Bathing: Washes and dries self with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	help." Client #1's record did not indicate re-assessment of client #1's functional needs since the 4/29/21 functional assessment. 2. Observations were conducted at the group home on 10/5/21 from 10:30 AM through 1:50 PM. Client #7 was present in the home throughout the observation period. Client #7 utilized a manual wheelchair with an adjustable reclining back for his mobility. Client #7 was not able to self-propel the wheelchair. Client #7 was not able to re-position his body in the wheelchair to sit in an upright position. Client #7's positioning in the wheelchair was not upright. Client #7 was in a reclined position while the wheelchair backrest was in a 90 degree upright position. At 11 AM, client #7 was in his seated in his wheelchair in the home's living room area. Client #7 asked RM to help him sit upright. RM coached and encouraged client #7 to push himself upright, gesturing and coaching to put his feet flat on the floor, use his arms on the arm rests and reminding him to attempt before physically assisting. At 11:35 AM, client #7 participated in the home's family style lunchtime meal. Client #7 was provided an adaptive large grip spoon. Client #7 was not able to hold the spoon to transfer bites of his meal to his mouth. Staff #5 verbally encouraged client #7 to use his spoon before offering full physical assistance to assist client #7 feed himself. Staff #5 was present at the table while client #7 ate his meal and stated, "This is not normal for him. He used to be independent." RM and staff #4 were interviewed on 10/6/21 at 11:15 AM. RM stated, "[client #7] had declined. He was able to walk and bear weight. Went from walking, using a walker, to a PRN (as needed)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	wheelchair and now to a full time wheelchair." RM stated, "He can't position himself. He falls out of the chair. Just scoots down." RM stated, "[Client #7] was Covid-19 positive and had been at the hospital. The hospital says he arrived with (pressure) wounds on his heel and bottom. Staff says this happened at the hospital." Staff #4 stated, "[Client #7's] been a rapid decline over the last year. He can't position himself in the wheelchair." Staff #4 stated, "he needs full staff assistance to shower and transfer. Constant assistance to stay upright in the chair." Staff #5 was interviewed on 10/5/21 at 11:30 AM. Staff #5 indicated client #7's mobility and functioning had declined. Staff #5 indicated client #7 was not able to position himself in his wheelchair. Client #7's record was reviewed on 10/6/21 at 10:39 AM. Client #7's ISP (Individual Support Plan) Addendum dated 8/26/21 -"Fall investigations completed. On 8/19/21, [client #7] fell out of his bed. The fall was not witnessed.... [Client #7] does have a bed alarm, staff thought the alarm was on the bed. Nurse (unknown) was at the home and checked [client #7] out. Nurse reported [client #7] was laying up against bed in a seated position and when asked what happened [client #7] pointed to something on the floor and said he was trying to get that. Staff report they feel the recent falls are associated with both behavioral and weakness issues. Staff report falls are not actual falls but he 'slides, slithers' out of bed and chairs." -"[Client #7] was walking with a walker but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	recently received order for a PRN wheelchair. Vascular (blood circulation) testing has been completed to determine origin of weakness -test results no changes from previous tests. He has a bed alarm - 0 8/22/21 when staff was lifting him up in the wheelchair, she pulled the wires out of the alarm - new one on order. As preventive measures team is seeking orders for a ½ bed rail, new bed alarm/chair alarm; Reacher, wheelchair with seatbelt, and gait belt. [Medical Doctor] signed order for requested items. Possibly discuss with psychiatric if no improvement with above interventions." Client #7's Dining Plan dated 10/1/21 indicated, "[Client #7] can feed himself independently." Client #7's ISP dated 1/2/21 indicated the following: -"Strengths: Feeding self... eats on his own... toilets self, bathes self, does his own laundry, undresses self, ties his own shoes, has good balance, can walk and run, has good hand control, has good arm functions... prepares some food in the microwave, cleans table, washes dishes, makes his bed, helps with chores, loads dishwasher, uses small kitchen appliances, can perform simple jobs...." Client #7's CFA dated 1/8/21 indicated the following: -"A. Eating: Feeds self neatly with spoon or fork." -"B. Toilet Use: Never has toilet accidents." -"C. Prepares and completes bathing unaided." -"B. Motor Development Item 27: Stands without			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	support for 5 minutes or more." -"B. Motor Development Item 28: Walks alone, walks up/down stairs alone, walks down stairs by alternating feet and runs without falling often." -"B. Motor Development Item 29 Control of Hands: catches a ball, throws a ball overhand, lifts cup or glass and grasps with thumb/finger." -"Completely dresses self." Client #7's record did not indicate documentation of re-assessment of client #7's functional skills and abilities. Program Manager was interviewed on 10/7/21 at 3:57 PM. PM indicated CFA's should be reviewed and updated annually or as needed. 9-3-4(a)			
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Health Care Services for 3 of 3 sampled clients (#1, #2 and #3), plus 2 additional clients (#6 and #7). The facility's nursing services failed to meet the health needs of clients #1, #3 and #7 and to ensure staff administering medication did not dispense clients #2, #6 and #7's medication prior to administration. Findings include:	W 0318	**W318: The facility must ensure that specific health care services requirements are met.** **Corrective action:** · Nurse trained on completing nursing responsibilities per policy and procedure; including thorough documentation including all assessments, medical appointments, testing, immunizations, instructions given to staff, if you have spoken to the doctor etc. **(Attachment A).**	11/06/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	1. The facility's nursing services failed to meet the health needs of clients #1, #3 and #7. Please see W331. 2. The facility failed to ensure staff administering medication did not dispense clients #2, #6 and #7's medications at the time of administration. Please see W367. 9-3-6(a)		· Nurse received a corrective action for failure to document thoroughly in the clients notes. · Nurse Manager or designee is at the facility 5 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment B)** · Nurse Manager contacted LinnCare, the oxygen supplier for the facility and had all empty oxygen cylinders picked up that were sitting in the living room area of the facility. · All other oxygen cylinders in the facility are in the proper storage container when not in use. · The facility had one oxygen in use sign on the main entry door but not the additional entries into the facility, signs have been placed on the end door as well as the 2 additional back doors. · Nurse Manager will complete medication administration observations 3 times weekly to ensure proper procedures are followed for medication administration for no less than three months. **(Attachment C)** · All staff in-serviced by the Nurse regarding adaptive equipment, medication administration, medical consults, when to call the nurse, meal refusals, incontinence issues,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
			dressing changes, following all client plans, liquids, creams, dressing changes and documentation. **(Attachment D)** · Med lead medication audit updated to include topical treatments and creams and when to notify the nurse that supplies are needed. **(Attachment E)** · Client #7 had OT evaluation and a fitted wheelchair was ordered. **(Attachment F)** · Client #3 had OT evaluation and a new fitted wheelchair was ordered. **(Attachment G)** · Nurse updated client #7 dining plan. **(Attachment T)** · High Risk Plans updated and staff trained for client #1. **(Attachment U)** · High Risk Plans updated and staff trained for client #7**.** **(Attachment V)** · Nurse Manager updated the positioning schedule for client #3. **(Attachment I)** · Client #1 had an appointment with psych on 10/27/21. **(Attachment H)** · Rescare administrative observations to be completed three times a week including medication administrations observation for no less than three months. **(Attachment J)** · Staff received a corrective action for presetting the medications which resulted in termination. **(Attachment L)** · All staff trained on hygiene,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
			hand washing prior to meals and medication administration.**(Attachment D)** · Area Supervisor trained on continued oversight of home cleanliness, oxygen storage, client hygiene prior to medication administration and mealtime. **(Attachment P)** · QIDP completed updated comprehensive functional assessments, completed an addendum to his BSP, updated his goals and behavior tracking for client #1. · Site Reviews are completed monthly to ensure home cleanliness, proper storage of medical supplies, etc. **(Attachment Q)**. **Monitoring of Corrective Action:** · All training sent to the Rescare trainer for filing in staff files. · All oversight observations will be sent to the Program Manager for monitoring and to ensure completion. · Site Reviews will be completed monthly by Rescare management and entered into the database. · Nurse updates High Risk Plans annually and as health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
			needs change. · Nurse Manager will send medication administration observations to the Program Manager for tracking and review. · Nurse updates High Risk Plans and trains staff and sends out to the IDT for team review. The Providers Site Review Team will perform service reviews to ensure that all nursing standards, including documentation, medical interventions, treatments are being performed per policy and procedure and per physician orders. The governing body will ensure compliance with policies and procedures through oversight by the QIDP in a monthly review of documents and data tracking. Training and postings of procedures will be consistently monitored and revised as needed. An administrative Site Review/ observation Team identified to provide oversight for no than less than 90 days. An administrative Site Review/ observation Team identified to provide oversight for no than less than three months. Completion Date:11/6/21	
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 2 of 3 sampled clients (#1 and #3), plus 1 additional client (#7), the facility nursing	W 0331	**W331**: The facility must provide clients with nursing services in accordance with their needs.	11/06/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	services failed to meet the health needs of clients #1, #3 and #7. Findings include: 1. An additional BDDS (Bureau of Developmental Disabilities Services) report was provided and reviewed on 10/7/21 at 4:50 PM. The review indicated the following: -BDDS report dated 10/7/21 indicated, "[Client #1] has been experiencing schizophrenic episodes including refusals to eat, not wanting to take his medications or breathing treatments, incontinence, staring into space, memory loss for ordinary tasks, hallucinations and believing he is talking to God. Yesterday, he was sitting at the dining room table and staff heard a loud noise. When staff entered the dinning room [client #1] was laying (sic) on the floor next to his chair. He was hallucinating, staff helped him up, checked for injuries finding (his) left elbow bleeding with a 2" (inch) cut, right elbow bleeding with two 2" cuts and a 4" vertical cut on his right forearm - all cuts have bruising developing around them. EMS (Emergency Medical Services) was called to transport for evaluation at the hospital. [Client #1] initially refused but stated he wanted to drink his boost (dietary supplement) first. [Client #1] drank the boost and was taken to ER (Emergency Room) via 911. At the ER labs and a UA (Urine Analysis) were completed. UA results negative for UTI (Urinary Tract Infection) and lab work revealed his potassium (was) low 3.2 (range 3.6 - 5). He was released from the ER with orders to follow up with his PCP (Primary Care Physician)." -BDDS report dated 7/28/21 indicated, "[Client #1's brother] called [client #1] on the phone yesterday morning. Staff took the phone to [client		**Corrective action:** · Nurse trained on completing nursing responsibilities per policy and procedure; including thorough documentation including all assessments, medical appointments, testing, immunizations, instructions given to staff, if you have spoken to the doctor etc. **(Attachment A).** · Nurse received a corrective action for failure to document thoroughly in the clients notes. · Nurse Manager or designee is at the facility 5 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment B)** · Nurse Manager contacted LinnCare, the oxygen supplier for the facility and had all empty oxygen cylinders picked up that were sitting in the living room area of the facility. · All other oxygen cylinders in the facility are in the proper storage container when not in use. · The facility had one oxygen in use sign on the main entry door but not the additional entries into the facility, signs have been placed on the end door as well as the 2 additional back doors. · Nurse Manager will complete medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	#1], he asked who was calling, staff told him his brother and handed him the phone. When [client #1] got on the phone he began acting as though he could not speak and did not participate in a conversation with his brother. He was taken to [hospital] for evaluation. At the ER findings were his condition was consistent with his chronic behavioral condition Schizophrenia. ER notes there is no evidence of metabolic encephalopathy (chemical imbalance) , TIA (stoke like condition) or stroke. He was released from the ER with orders to follow up with his PCP." Observations were conducted at the group home on 10/4/21 from 4:20 PM through 6:50 PM. At 5:35 PM, client #1 was in his bedroom and seated on the side of his bed. Client #1 was nude with only a pair of socks on his body. Client #1's oxygen tubing was wrapped around his legs. Client #1's bed and floor were wet. There was a puddle of urine on the floor and client #1's feet. Staff #1 entered the bedroom and began verbally directing client #1 to put on clothing so he could walk to the home's shower and clean himself up. Client #1 was unable to follow staff #1's directions to stand up, put on his shorts, put on his shirt, reposition his oxygen tubing from his body and go to the shower. Client #1 was confused and made inarticulate statements. Staff #1's verbal cues were not sufficient in assisting client #1. Staff #1 began physically prompting and assisting client #1. Staff #1 requested staff #3 to come to client #1's bedroom to assist. Staff #1 and staff #3 physically assisted client #1 with dressing and going to the shower. At 6:21 PM, the home began the evening family style meal. Client #1 was still in the shower and had not completed cleaning up after being incontinent at 5:35 PM. Staff #1 stated, "[Client #1's] still in the shower. He's just been sitting in there. I'm going to go check on him and get him		administration observations 3 times weekly to ensure proper procedures are followed for medication administration for no less than three months. **(Attachment C)** · All staff in-serviced by the Nurse regarding adaptive equipment, medication administration, medical consults, when to call the nurse, meal refusals, incontinence issues, dressing changes, following all client plans, liquids, creams, dressing changes and documentation. **(Attachment D)** · Med lead medication audit updated to include topical treatments and creams and when to notify the nurse that supplies are needed. **(Attachment E)** · Client #7 had OT evaluation and a fitted wheelchair was ordered. **(Attachment F)** · Client #3 had OT evaluation and a new fitted wheelchair was ordered. **(Attachment G)** · Nurse updated client #7 dining plan. **(Attachment T)** · High Risk Plans updated and staff trained for client #1. **(Attachment U)** · High Risk Plans updated and staff trained for client #7. **(Attachment V)** · Nurse Manager updated the positioning schedule for client #3. **(Attachment I)** · Client #1 had an appointment with psych on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	out for dinner." Staff #1 was interviewed on 10/4/21 at 5:35 PM. Staff #1 indicated he had worked at the home with client #1 since June 2021. Staff #1 stated, "[Client #1] has changed since I've known him and worked with him." Staff #1 indicated client #1 was not incontinent. Staff #1 indicated client #1 had been independent with dressing himself and showering. Staff #2 was interviewed on 10/4/21 at 5:40 PM. Staff #2 indicated client #1's mental status had changed. Staff #2 indicated client #1 had become confused when attempting tasks, incontinent and required multiple verbal cues and physical assistance to complete tasks. Staff #2 indicated client #1 had routine cycles of schizophrenia and confusion. Staff #2 indicated client #1's current behavior was more intense and was longer in duration. Staff #3 was interviewed on 10/4/21 at 4:45 PM. Staff #3 indicated clients #1 and #7 had Covid-19 in September 2021 and were not fully recovered. Staff #3 stated client #1 was "still sluggish and hasn't fully recovered his energy." Observations were conducted at the group home on 10/5/21 from 10:30 AM through 1:20 PM. At 11:20 AM, client #1 sat at the dining room table to eat his lunch. Client #1 sat at the table and did not eat his meal. Client #1 looked around the room and spoke inarticulate words. Staff encouraged client #1 his meal. Client #1 responded to staff's prompting but then resumed looking around while not eating. Staff #5 was interviewed on 10/5/21 at 11:30 AM. Staff #5 indicated client #1's functional abilities to complete tasks had changed. Staff #5 indicated		10/27/21. **(Attachment H)** · Rescare administrative observations to be completed three times a week including medication administrations observation for no less than three months. **(Attachment J)** · Staff received a corrective action for presetting medications and not following Rescare's medication administration policies which resulted in termination.**(Attachment L)** · All staff trained on hygiene, hand washing prior to meals and medication administration.**(Attachment D)** · Area Supervisor trained on continued oversight of home cleanliness, oxygen storage, client hygiene prior to medication administration and mealtime. **(Attachment P)** · QIDP completed updated comprehensive functional assessments, completed an addendum to his BSP, updated his goals and behavior tracking for client #1. · Site Reviews are completed monthly to ensure home cleanliness, proper storage of medical supplies, etc. **(Attachment Q)**. **Monitoring of Corrective Action:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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 #5 had been independent with toileting, bathing, dressing himself and eating. Staff #5 indicated client #5 was now incontinent, needed additional verbal and physical assistance to complete bathing, dressing and eating tasks. Staff #5 stated, "At breakfast this morning he just sat there staring at his food. He made comments about God. He finally ate after prompting." RM (Resident Manager) was interviewed on 10/5/21 at 10:45 AM. RM stated, "[Client #1] had Covid-19 a couple of months ago. He's always had cycles but not like this. Can't get him to do anything. He came to the table this morning and just had his head down refusing to eat. He was talking to himself." RM stated, "It's been communicated. Not visited psych. It's all been online. His last (in-person) psych was in August 2020. Just not seen him get like this." Client #1's record was reviewed on 10/6/21 at 9:50 AM. Client #1's ISP (Individual Support Plan) dated 4/29/21 indicated the following: -"[Client #1] ambulates independently. At times, [client #1] chooses to walk with a cain (sic), but he is not ordered to do so by a doctor." -"[Client #1] takes pride in being very independent-minded and he likes to make his own decisions regarding the future even though he needs a great deal of guidance to do so." -"[Client #1] is largely independent with performing basic self-care tasks." -"[Client #1] is diagnosed with Schizophrenia and may display anxiousness, staying up late drinking excessive amounts of coffee. Will ask and talk about things that are not related to the task at hand. May express excessive worrying, feelings of uneasiness, difficulty staying on task...." Client #1's CFA dated 4/29/21 indicated the		· All training sent to the Rescare trainer for filing in staff files. · All oversight observations will be sent to the Program Manager for monitoring and to ensure completion. · Site Reviews will be completed monthly by Rescare management and entered into the database. · Nurse updates High Risk Plans annually and as health needs change. · Nurse Manager will send medication administration observations to the Program Manager for tracking and review. · Nurse updates High Risk Plans and trains staff and sends out to the IDT for team review. The Providers Site Review Team will perform service reviews to ensure that all nursing standards, including documentation, medical interventions, treatments are being performed per policy and procedure and per physician orders. The governing body will ensure compliance with policies and procedures through oversight by the QIDP in a monthly review of documents and data tracking. Training and postings of procedures will be consistently monitored and revised as needed. An administrative Site Review/ observation Team identified to provide oversight for no than less	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	following: -"B. Toilet use: Never has toilet accidents." -"Item 6: (Yes) Lowers pants at the toilet without help; Sits on toilet seat without help; Uses toilet tissue; Flushes toilet after use; Puts on clothes without help; Wash hands without help." -"F. Dressing and undressing: Dresses self by putting all clothes on with verbal promoting and by fastening." -"Item 8 Bathing: Washes and dries self with help." Client #1's Hypokalemia (Low Potassium) High Risk Health Plan dated 9/10/21 indicated, "Abnormal potassium levels." Client #1's Progress Notes dated 8/1/21 through 10/5/21 indicated the following: -10/4/21: 8a -4p shift, "[Client #1] sat in bathroom for 3 hours refusing to shower then wet his pants." -10/3/21 8a- 8p shift, "[Client #1] has been very distant again today. Didn't eat much (and) refusing to shower." -10/1/21: 6a-2p shift, "[Client #1] sat in the dining room for 2 hours after breakfast saying 'pull the chain' repeatedly. He was speaking about delusions all day. Refused lunch. Was incontinent multiple times and had to be asked 3 times to shower. Then was in the shower over an hour." 4p- 10p shift, "[Client #1] sat in his room with delusions. Refused to eat." -10/1/21: 8a- 8p shift, "Had a hard time understanding		than 90 days. An administrative Site Review/ observation Team identified to provide oversight for no than less than three months. **Completion Date: 11/6/21**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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 #1]. Refused breathing treatment, took his pills and inhaler but didn't want to come out of his room. Tried to get staff to get his clothes for him after already getting in the bathroom and peeing himself. Refused meals." -9/30/21: 8a-4p shift, "[Client #1] refused lunch, he take (sic) his 11 am breathing treatment." 4p- 10 pm shift, "[Client #1] returned in room. Took meds. Refused to eat supper. Was in the bathroom for almost 2 hours talking to himself and trying to get staff to hold his penis so he could urinate. Staff got him to get out of the bathroom and go to bed." -9/29/21: 4p-12 a shift, "[Client #1] didn't leave his room. Called nurse because he refused all meds and refused to eat. Bed at 7p." Client #1's Behavior Tracking Record dated 10/2021 indicated the following: -"Schizophrenia: Defined as Anxiousness, staying up late drinking excessive amounts of coffee, wanting to smoke. Will ask and talk about things that are not related to the task at hand. May express excessive worrying, feeling of uneasiness, difficulty staying on task, excessive talking or movement and poor socialization skills. May yell, scream and curse." Client #1's Behavior Tracking did not indicate client #1's incontinence, meal refusal or general cognitive confusion were included in the targeted Schizophrenia behavior. Client #1's Quarterly Nursing Assessment dated 7/29/21 indicated the following: -"Bladder Continence- (checked for yes)."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	-"Psychiatry, 5/12/21." Client #1's Nurse Notes indicated the following: -8/5/21: "In home today. Completed book review." -8/12/21: "[Client #1] doing well medically." -8/19/21: "In house and book review completed. [Client #1] is doing well." -8/26/21: "In house to [illegible]. [Client #1] is alert, ambulating well. Appetite good. Having regular BM's (Bowel Movements). With and vitals stable." -9/2/21: "In house for visit and book review. [Client #1] is alert, pleasant and wearing oxygen." -9/9/21: In house for visit and book review. [Client #1] is alert and orientated." -9/23/21: "In house for visit. [Client #1] is doing well. Alert and orientated." -9/30/21: "In house for visit and book review. [Client #1] saw PCP (Primary Care Physician) on 9/29/21 for ER follow-up.... Follow-up with Mental Health Provider." -9/30/21, "[Client #1] sees and is followed by psych every 3 months." Client #1's Nurse Notes did not indicate documentation of Psychiatry review or follow-up since 5/12/21. The nurse notes did not indicate documentation of follow-up regarding client #1's progress notes regarding changes in the intensity and duration of client #1's behavior, bladder incontinence or meal refusals. The nurse notes did not indicate documentation of nursing interventions or instructions for monitoring client #1's health needs. NM (Nurse Manager) was interviewed on 10/6/21 at 12:04 PM. NM indicated client #1 was not incontinent. NM indicated changes in continence			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	should be reported to the nurse. NM indicated she was not aware of client #1's incontinence. NM indicated client #1 had behavioral cycles but was not aware of increased changes. 2. The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 10/5/21 at 2:06 PM. The review indicated the following: -BDDS report dated 9/14/21 indicated, "[Client #3] ambulates in a wheelchair and is on a repositioning schedule. Last night when staff got [client #3] ready for bed (they) found an open area on his left hip approximately 3 inches. [Client #3] has an order for paste and dressing for any open areas. Staff applied the paste but [client #3] refused to allow staff to place the dressing. Staff followed doctor order for open skin areas. Paste applied but [client #3] would not allow staff to apply the dressing. Staff will continue to follow doctor orders and encourage the dressing. Staff will report any changes to the open areas to ensure [client #3's] optimum health and care." -BDDS report dated 6/24/21 indicated, "Today, while the nurse was completing her weekly review she noted staff had been charting on the skin assessment broken skin. Nurse completed assessment on his coccyx (tailbone) area. [Client #3] has 3 areas about the size of a pen (each area) in the middle of the coccyx. Staff are applying the PRN (As Needed) barrier cream. [Client #3] ambulates with a wheelchair. He has a repositioning schedule. Staff will apply the PRN barrier cream and report any changes to ensure his optimum health and care." Client #3's record was reviewed on 10/5/21 at 3:20 PM. Client #3's MAR (Medication Administration			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	Record) dated 9/2021 indicated the following: -"Hibiclens Liquid 4%. Use small amount to buttocks between dressing changes. Reorder when needs. Not a cycle fill med. Diagnosis: Preventative Corresponds with dressing Changes. Skin Irritation. 1st, 2nd and 3rd shift." The Medication Notes section on the back of the 9/2021 MAR indicated client #3 was out of Hibiclens 4% Liquid from 9/9/21 through 9/22/21. -"Cover Bilateral (both sides) Buttocks with Mepilex dressing and change every 3 days and PRN. Put Zinc Paste under the Mepilex Dressing. Diagnosis: Wound Care Preventative. PRN." The review did not indicate documentation of staff attempting to administer client #3's PRN Mepilex dressing with Zinc paste and/or client #3's response or refusal of the treatment. Client #3's Nursing Notes dated 9/1/21 through the 10/5/21 date of review indicated the following: -9/9/21: "In home for visit and book review." -9/16/21: "In house for visit. [Client #3] is doing well." The 9/16/21 Nursing Note did not indicate documenting regarding client #3's skin irritation, Hibiclens Liquid 4% supply status or instructions or measures to monitor/treat client #3's skin irritation. -9/23/21: "In house for visit." The 9/23/21 Nursing Note did not indicate documentation regarding client #3's skin irritation, Hibiclens Liquid 4% supply status or instructions or measures to monitor/treat client #3's skin irritation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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 #3's Skin Assessment form dated 9/6/21 through 10/5/21 indicated the following: -"9/11/21: Bed sore on right buttock." -"9/12/21: Bed sore on right buttock." -"9/13/21: Bed sore on both right and left buttock." -"9/14/21: Bed sore on both right and left buttock." -"9/15/21: Abrasion on both right and left buttock." -"9/16/21: Abrasion on both right and left buttock." -"9/17/21: Abrasion on both right and left buttock." -"9/18/21: Abrasion on both right and left buttock. Healing." -"9/19/21: Abrasion on both right and left buttock. Opened back up." -"9/20/21: Abrasion on right and left buttock." -"9/21/21: Abrasion on right and left buttock." -"9/22/21: Abrasion on right and left buttock." -"9/23/21: Small red spot with dry skin." -"9/24/21: Slight redness on buttocks." -"9/25/21: Slight redness on buttocks." -"9/26/21: Butt healed." Client #3's Skin Integrity Risk Plan dated 9/21/21 indicated the following: -"History of Candidiasis (yeast/fungus infection) (groin area and scrotum) History of Stage 2 wounds on bottom, has a Kabooti cushion (pressure relief)." "1. Interventions a. Staff will reposition [client #3] every 2 hours to prevent any skin breakdown." "2. Monitoring			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	a. Staff will monitor skin daily." "3. Documentation a. Staff will document in the progress notes and on the skin assessment sheet daily." "4. Notification a. Staff will notify nurse of any issues noted to skin b. Staff will notify MD (Medical Doctor) as needed of any issues." "1. Record Review and analysis ResCare Nurse. Reviewed monthly and as needed." PM (Program Manager) and NM (Nurse Manager) were interviewed on 10/6/21 at 12:04 PM. PM indicated client #3's 9/2021 MAR documented he was out of Hibiclens 4% Liquid from 9/9/21 through 9/22/21. PM indicated client #3's MAR dated 9/2021 did not document PRN administration of Mepilex dressing or Zinc paste. NM indicated she was not aware of client #3's Hibiclens being unavailable. NM indicated client #3's wound care prevention included daily use of Hibiclens 4% Liquid. NM indicated she was aware client #3 had skin irritation during the month of 9/2021. NM indicated nursing had directed staff to administer client #3's PRN Mepilex dressing and zinc paste to treat client #3's skin irritation. NM indicated nursing should document directions and measures in the nursing notes. NM indicated nursing should document monitoring and characteristics of client #3's wounds and healing in the nursing notes. 3. An additional BDDS report was provided and reviewed on 10/6/21 at 10:18 AM. The review indicated the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	-BDDS report dated 10/5/21 indicated, "[Client #7] was sitting in his wheelchair and unhooked the seatbelt. [Client #7] slid out of the wheelchair and fell onto the floor. Staff assisted back into the wheelchair and checked him for injuries. Staff found no injuries. A fall investigation will be completed to provide recommendations to avoid future falls of this nature." An initial review of the the facility's BDDS reports was completed on 10/5/21 at 2:06 PM. The review indicated the following: -BDDS report dated 10/4/21 indicated, "Staff was assisting [client #7] from his wheelchair to the toilet. When staff got him on the toilet he slid off the toilet onto the floor. Staff was unable to lift him back onto the toilet. Staff called the non-emergency EMS for a lift assistance. EMS arrived at the home and lifted [client #7] off (of) the floor and onto the toilet. Staff checked [client #7] for injuries finding no visual injuries. [Client #7] is a fall risk and has a fall plan. A fall investigation will be completed to provide recommendations to avoid future falls of this nature." Observations were conducted at the group home on 10/5/21 from 10:30 AM through 1:50 PM. Client #7 was present in the home throughout the observation period. Client #7 utilized a manual wheelchair with an adjustable reclining back for his mobility. Client #7 was not able to self-propel the wheelchair. Client #7 was not able to re-position his body in the wheelchair to sit in an upright position. Client #7's positioning in the wheelchair was not upright. Client #7 was in a reclined position while the wheelchair backrest was in a 90 degree upright position. At 11 AM,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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 #7 was in his seated in his wheelchair in the home's living room area. Client #7 asked RM to help him sit upright. RM coached and encouraged client #7 to push himself upright, gesturing and coaching to put his feet flat on the floor, use his arms on the arm rests and reminding him to attempt before physically assisting. At 11:35 AM, client #7 participated in the home's family style lunchtime meal. Client #7 was provided an adaptive large grip spoon. Client #7 was not able to hold the spoon to transfer bites of his meal to his mouth. Staff #5 verbally encouraged client #7 to use his spoon before offering full physical assistance to assist client #7 to feed himself. Staff #5 was present at the table while client #7 ate his meal and stated, "This is not normal for him. He used to be independent." RM and staff #4 were interviewed on 10/6/21 at 11:15 AM. RM stated, "[client #7] had declined. He was able to walk and bear weight. Went from walking, using a walker, to a PRN (as needed) wheelchair and now to a full time wheelchair." RM stated, "He can't position himself. He falls out of the chair. Just scoots down." RM stated, "[Client #7] was Covid-19 positive and had been at the hospital. The hospital says he arrived with (pressure) wounds on his heel and bottom. Staff says this happened at the hospital." Staff #4 stated, "[Client #7's] been a rapid decline over the last year. He can't position himself in the wheelchair." Staff #4 stated, "he needs full staff assistance to shower and transfer. Constant assistance to stay upright in the chair." Staff #5 was interviewed on 10/5/21 at 11:30 AM. Staff #5 indicated client #7's mobility and functioning had declined. Staff #5 indicated client #7 was not able to position himself in his wheelchair.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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 #7's record was reviewed on 10/6/21 at 10:39 AM. Client #7's ISP (Individual Support Plan) Addendum dated 8/26/21 -"Fall investigations completed. On 8/19/21, [client #7] fell out of his bed. The fall was not witnessed.... [Client #7] does have a bed alarm, staff thought the alarm was on the bed. Nurse (unknown) was at the home and checked [client #7] out. Nurse reported [client #7] was laying up against bed in a seated position and when asked what happened [client #7] pointed to something on the floor and said he was trying to get that. Staff report they feel the recent falls are associated with both behavioral and weakness issues. Staff report falls are not actual falls but he 'slides, slithers' out of bed and chairs." -"[Client #7] was walking with a walker but recently received order for a PRN wheelchair. Vascular (blood circulation) testing has been completed to determine origin of weakness -test results no changes from previous tests. He has a bed alarm - 8/22/21 when staff was lifting him up in the wheelchair, she pulled the wires out of the alarm - new one on order. As preventive measures team is seeking orders for a ½ bed rail, new bed alarm/chair alarm; Reacher, wheelchair with seatbelt, and gait belt. [Medical Doctor] signed order for requested items. Possibly discuss with psychiatric if no improvement with above interventions." Client #7's Dining Plan dated 10/1/21 indicated, "[Client #7] can feed himself independently." Client #7's ISP dated 1/2/21 indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	following: -"Strengths: Feeding self... eats on his own... toilets self, bathes self, does his own laundry, undresses self, ties his own shoes, has good balance, can walk and run, has good hand control, has good arm functions... prepares some food in the microwave, cleans table, washes dishes, makes his bed, helps with chores, loads dishwasher, uses small kitchen appliances, can perform simple jobs...." Client #7's CFA dated 1/8/21 indicated the following: -"A. Eating: Feeds self neatly with spoon or fork." -"B. Toilet Use: Never has toilet accidents." -"C. Prepares and completes bathing unaided." -"B. Motor Development Item 27: Stands without support for 5 minutes or more." -"B. Motor Development Item 28: Walks alone, walks up/down stairs alone, walks down stairs by alternating feet and runs without falling often." -"B. Motor Development Item 29 Control of Hands: catches a ball, throws a ball overhand, lifts cup or glass and grasps with thumb/finger." -"Completely dresses self." PCP Request Form dated 8/18/21 indicated the following: -"8/18/21: [Unknown staff] called and stated his leg weakness is getting worse. He currently has			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	an order for a PRN wheelchair but he is in it all the time. He cannot walk, stand or do much of anything. He just has no strength in his legs. Is there anything they can go to find out what is going on with him?" -"Can set him up with some PT and let them evaluate him and work with him. If he's not had any back MRI (medical test) or x-rays would probably need to get that and then follow him up in the office in about a month." -"8/18/21: Submitted orders for DIAG (diagnosis)- Lumbar Spine 2-3 views and PT/OT- speech order...." Client #7's IDT (Interdisciplinary Team) note dated 9/2/21 indicated the following: -"[Client #7] has experienced falls on 8/19/21 and 8/22/21. Fall investigations completed." -"On 8/19/21, [client #7] fell out of his bed. The fall was not witnessed." -"Staff report they feel the recent falls are associated with both behavioral and weakness issues. Staff report falls are not actual falls but he 'slides, slithers' out of bed and chairs." -"On 8/22/21, [client #7] kept sliding out of his wheelchair." -"[Client #7] had slide (sic) himself out to the wheelchair 3 times. The third time, staff called the non-emergency EMS number for a lift assist. Staff stated [client #7] is tall and awkward to lift. In interview, both staff stated they believed the sliding out of the chair was a behavior because he was uncomfortable inn the wheelchair. In interviews, [client #7] stated he was uncomfortable and it hurt to sit in the wheelchair.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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 #7] was too long for the wheelchair and did sit scrunched up in the chair. A new wheelchair was ordered and delivered on 8/26/21." -"[Client #7] did not have a history of falls until May 2021. On 8/19/21 slid out of bed, no injury. On 5/13/21 [client #7] fell in his bedroom while getting ready for a shower- ER. Antibiotic drainage from elbow. On 5/13/21 [client #7] fell in the dining room. Clients had just finished dinner and he fell getting up form the chair- ER. On 5/17/21, [client #7] fell in the hallway. He had been taking a nap. Staff heard his walker hit the floor and rushed back (to) the hallway. He was laying (sic) on the floor with his pants around his ankles. [Client #7] told staff he needed to use the restroom but it was occupied - he was take to [hospital] ER for evaluation and was admitted. [Hospital] admission- CT scan (medical test), blood work, chest x-ray and urinalysis. No findings. Doctor felt the weakness and falls related to his psych medication. [Client #7] is very sensitive to any psych med changes." -"[Client #7] was walking with a walker but recently received order for a PRN wheelchair. Vascular testing has been completed to determine origin of weakness- test results no changes from previous test. He has a bed alarm. On 8/22/21 when staff was lifting him up in the wheelchair she pulled the wires out of the alarm- new one on order." -"As preventive measures orders and equipment received on 8/26/21 a bed rail (brackets not rails- sent back for new unit) has the bedrolls arrived yet? New bed alarm, chair alarm, wheelchair with seatbelt (wheelchair back tilts for comfort) gait belt- all arrived on 8/26/21. Possibly discuss with psychiatric if no improvement with above			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	interventions." Client #7's IDT (Interdisciplinary Team) note dated 9/30/21 indicated the following: -"IDT met to discuss current concerns with [client #7]. Discussed mobility for interventions. [Client #7] shows more weakness on his left side. A lumbar x-ray and MRI have been ordered and an OT/PT referral was given. Discussed current posture in chair at mealtime. Nurse will review the swallow study evaluation that was completed while he was at the hospital to see what trigger (sic) the honey thick liquids. [AS (Area Supervisor)] will completed an in-service with staff for consistent redirection to prompt [client #7] to do as much for himself as possible as he is able. Once testing has been competed the team will reconvene to discuss further interventions." Nurse Notes dated 8/1/21 through 10/5/21 indicated the following: -"9/30/21: "In house for visit and book review. [Client #7] has been home a week now (from hospital). He is still needing a lot of assistance of (sic) ADL's (activities of daily living). He remains on honey thick liquids. Sometimes they become thicker and he needs spooned to him. His appetite is good. He does remain very week. Meeting held via phone to make sure we are doing what is needed for him." -"9/30/21: [Client #7] saw PCP on 9/24/21. He wrote for duoneb (inhaler) 4 x day for a couple of weeks. He wasn't to revisit in a month if remains stable and repeat chest x-ray. Will continue to monitor." There was no documentation of OT (Occupational			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	Therapy)/PT (Physical Therapy) assessment, consultation or follow-up regarding the 8/18/21 PCP order. There was not documentation of MRI testing regarding client #7's spine or follow-up noted. The nursing notes did not indicate documentation of psychiatric follow-up (as described in IDT dated 9/2/21. The nursing notes did not indicate documentation of nursing interventions (wedges, cushions, non-slip materials for body mechanics or sliding) or specific monitoring for psychiatric, behavior or body weakness tracking relating to falls. The nursing notes did not indicate documentation of a wheelchair evaluation. PM, Manager, QIDP and NM were interviewed on 10/6/21 at 12:04 PM. QIDP indicated client #7 had fallen on 10/5/21. QIDP indicated client #7 had unhooked his seat belt on his wheelchair and slid out on the floor with no injury reported. QIDP indicated she would complete a fall investigation to determine the circumstances of the fall. Manager indicated her recommendation was for a lap tray to prevent client #7 from unhooking his seat belt and sliding out. PM indicated client #7 had been working with PT and doing leg exercises. PM indicated client #7 had been walking with a walker and was interested in returning to his day program and then had Covid-19. PM indicated he had been hospitalized with Covid -19 and since returning to the home from the hospital had declined. Manager indicated her recollection was decline prior to Covid-19. Manager indicated in May 2021 he began utilizing a PRN wheelchair, had a few falls and was weak. QIDP indicated client #7 had received PT services and had made progress before being discharged (no specific timeframe was noted). NM indicated she had consulted with the adaptive equipment provider and based client #7's current wheelchair			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	on his height and weight. NM indicated client #7's wheelchair was not evaluated for body mechanics or alignment to address his sliding down and out tendency. NM indicated the team had discussed getting him back to OT/PT for evaluation and treatment. NM and QIDP indicated client #7 had a PCP visit on 10/7/21 to follow up regarding his progressed weakness. 9-3-6(a)			
W 0367 Bldg. 00	483.460(k) DRUG ADMINISTRATION The facility must have an organized system for drug administration that identifies each drug up to the point of administration. Based on observation and interview for 1 of 3 sampled clients (#2), plus 4 additional clients (#4, #5, #6 and #7), the facility failed to ensure staff administering medication dispensed clients #2, #4, #5, #6 and #7's medications at the time of administration. Findings include: Observations were conducted at the group home on 10/4/21 from 4:20 PM through 6:50 PM. At 4:35 PM, staff #3 had started the evening medication administration. Upon entering the medication room where staff #3 was in the process of preparing for med pass there were plastic cups with medications inside of them on the counter with names written on them with a sharpie. Clients #5 and #2's names were on the cups with pills on the counter. Staff #3 dispensed clients #4, #6 and #7's medications from their pharmacy bubble packs into plastic cups. Staff #3 then labeled each cup with the client's name and placed them on the counter with clients #2 and #5's cups. No clients were present in the med room. At 4:53 PM, staff #3	W 0367	**W367:** The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. **Corrective action:** · Staff received a corrective action for presetting the medications which resulted in termination. **(Attachment L)** ·Nurse will complete medication administration observations 3 times weekly to ensure proper procedures are followed for medication administration for no less than three months. **(Attachment C)** ·Rescare administrative observations to be completed for no less than 90 days. **(Attachment J)** ·Medication lead trained on completing weekly audit	11/06/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	began calling clients to the medication room door and then administered the medication from the pre-set cups. Staff #3 was interviewed on 10/4/21 at 4:43 PM. Staff #3 indicated she dispensed clients #2, #4, #5, #6 and #7's medications from the pharmacy package into cups. Staff #3 indicated she pre-set the medications for administration with no clients in the room/area. Staff #3 indicated she labeled the plastic cups and then had each client individually come to the med room door to receive the medications she had already dispensed. RM (Resident Manager) was interviewed on 10/5/21 at 12:47 PM. RM indicated staff should dispense client medication individually with the client at the time of administration. Staff #5 was interviewed on 10/5/21 at 11:30 AM. Staff #5 indicated staff should have the client's present in the med room and dispense each client medications individually at the time of administration. PM, Manager and NM (Nurse Manager) were interviewed on 10/6/21 at 12:04 PM. NM indicated staff are trained to dispense each client's medication individually at the time of administration. PM indicated staff should not pre-set medications. 9-3-6(a)		**(Attachment E)** of medications to ensure the needed medications/ treatments are present in the home. · Nurse trained on completing nursing responsibilities per policy and procedure; including documentation, skin assessments, wound care, measuring wound, timely nursing assessments, Physician orders, timely physician appointments and interventions, documentation of new orders, including topical treatments, monitoring client's medical condition **(Attachment A).** · Staff trained on the medication administration policy **(Attachment D)** **Monitoring of Corrective Action:** · All training sent to the Rescare trainer for filing in staff files. · All oversight observations will be sent to the Program Manager for monitoring and to ensure completion. · Nurse Manager will send medication administration observations to the Program Manager for tracking and review. · Nurse updates High Risk Plans and trains staff and sends out to the IDT for team review. All medication observation forms	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
			will be sent to Program Manager and Nurse Manager for review. PM and NM will review observation forms and follow-up on any issues including any additional training or progressive corrective action if necessary. An administrative Site Review/ observation Team identified to provide daily oversite for no than less than 90 days. **(Attachment ??)** **Completion Date-11/6/21**	
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), plus 5 additional clients (#4, #5, #6, #7 and #8), the facility failed to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 practiced hand hygiene before medication administration and meals and to ensure staff wore face masks and screened visitors to the home. Findings include: Observations were conducted at the group home on 10/4/21 from 4:20 PM through 6:50 PM. At 4:20 PM, staff #1, staff #2 and staff #3 were present in the home with clients #1, #2, #3, #4, #5, #6, #7 and #8. Staff #1, staff #2 and staff #3 did not utilize	W 0455	**W455:** The facility must provide a sanitary environment to avoid sources and transmission of infections. **Corrective Action:** · All staff trained on hygiene and hand washing prior to medication administration and mealtime. **(Attachment D)** · All staff trained on the covid policy including the mask policy and visitor screening.**(Attachment D)**	11/06/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	face masks while working clients #1, #2, #3, #4, #5, #6, #7 and #8 in their home. Upon entry, staff did not complete a visitor Covid-19 screening questionnaire or complete a temperature check. At 5:15 PM, staff #2 approached surveyor/visitor and requested screening be completed. At 4:35 PM through 4:55 PM, staff #3 completed the evening medication administration. Staff #3 did not sanitize/wash her hands between dispensing client medication or between administering client medication. Staff #3 did not encourage clients #2, #4, #5, #6 or #7 to wash/sanitize their hands before administering medications to them. At 6:15 PM, staff #2 prompted clients #1, #2, #3, #4, #5, #6, #7 and #8 to come to the dining room table to participate in the family style evening meal. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were not prompted or encouraged to wash/sanitize their hands before eating their meal. RM (Resident Manager) was interviewed on 10/4/21 at 5:45 PM. RM indicated staff had been trained to wear face masks while working with clients and complete Covid-19 screening with visitors before entering the home. Staff #3 was interviewed on 10/4/21 at 6:36 PM. Staff #3 indicated visitors should complete Covid-19 screening questions and temperature check before entering the home. Staff #3 indicated staff working in the home should wear face masks while working with the clients. Observations were conducted at the group home on 10/5/21 from 10:30 AM through 1:20 PM. At 11:20 AM, Clients #1, #2, #3, #4, #5, #7 and #8 (client #6 was at the hospital) participated in the		· Site Supervisor will model and monitor daily while on shift to ensure staff are completing their covid screening, staff wearing masks when they can't maintain 6ft of distance, handwashing for clients and staff prior to medication administration and mealtime. **(Attachment W)** · Rescare administrative observations to be completed three times a week including medication administrations observation for no less than three months. **(Attachment J)** · Area Supervisor will do daily monitoring 2 times weekly for no less than 90 days to ensure staff are completing their covid screening, handwashing for clients and staff prior to medication administration and mealtime. **(Attachment P)** · Program Manager will participate in the daily administrative observations and an additional observation visit weekly to monitor and ensure proper procedures are followed. **(Attachment X)** **Monitoring of Corrective Action:** · The Area Supervisor and Site Supervisor will send completed observations to the Program Manager for monitoring and to ensure completion. · Staff are trained on the covid policy upon hire and as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	home's family style lunch meal. Clients #1, #2, #3, #4, #5, #7 and #8 were not encouraged to wash/sanitize hands prior to eating their meal. RM was interviewed on 10/5/21 at 12:47 PM. RM indicated clients should be encouraged and assisted with hand washing/sanitization prior to meals and medication administration. Staff #5 was interviewed on 10/5/21 at 11:30 AM. Staff #5 indicated visitors should complete Covid-19 screening questions and temperature check before entering the home. Staff #5 indicated staff working in the home should wear face masks while working with the clients. Staff #5 indicated clients should be encouraged and assisted with hand washing/sanitization prior to meals and medication administration. Program Manager (PM) was interviewed on 10/6/21 at 12:04 PM. PM indicated visitors should complete a Covid-19 screening questions and temperature check before entering the home. PM indicated staff working in the home should wear face masks while working with the clients. PM indicated clients should be encouraged and assisted with hand washing/sanitization prior to meals and medication administration. The facility's policy and procedures were reviewed on 10/6/21 at 10 AM. The facility's Infection Control Policy dated 9/2021 indicated the following: -"All personnel providing direct care and support performing their job-related duties will observed Standard Precautions, which includes the use of appropriate personal protective equipment to prevent exposure to blood and other body fluids. Standard precautions will be followed in all direct		needed and as the CDC updates the guidelines. · Administrative observations completed 3 times a week for no less than 90 days are sent to the Program Manager for review and are also in a binder in the facility for review and monitoring. · All trainings are sent to the Rescare trainer for tracking for staff files. **Completion Date: 11/6/21**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	2900 KENTUCKY AVE MADISON, IN 47250

(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
	care setting. When in close contact and will include the the of Personal Protective Equipment (PPE). -"Hand washing (20 seconds). Wet hands and apply soap (preferably liquid soap); rub all surfaces; rinse hands and dry thoroughly with a single-use towel; use towel to turn off faucet." 9-3-7(a)			