

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G493	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/21/2013
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4160 N CAMPBELL AVE INDIANAPOLIS, IN 46220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 05/21/13</p> <p>Facility Number: 001007 Provider Number: 15G493 AIM Number: 100245090</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist,</p> <p>At this Life Safety Code survey, Voca Corporation of Indiana was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, all living areas and bedrooms. The facility has a capacity of 8 and had a census of 7 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K010000		

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

TITLE

(X6) DATE

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

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	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.8.</p> <p>Quality Review by Dennis Austill, Life Safety Code Supervisor on 05/22/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010130	<p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Aide during a tour of the facility from 10:35 a.m. to 11:10 a.m. on 05/21/13, the portable fire extinguisher located in the laundry room and the portable fire extinguisher located in the south hallway each had an affixed inspection and maintenance tag lacking a</p>	K010130	<p><b>CORRECTION:</b> Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. Specifically, monthly checks have been performed on the facility's portable fire extinguishers.</p> <p><b>PREVENTION:</b> The Residential Manager or designee will incorporate monthly fire extinguisher checks into the facility's monthly Home Environment Safety Inspection. Additionally, members of the Quality Assurance Team will periodically review documentation of fire extinguisher checks as part of an ongoing safety audit process to assure the facility meets the requirements of NFPA 10. 4-3.4.2. <b>RESPONSIBLE PARTIES:</b> Clinical Supervisor, Residential Manager, Direct Support Staff, Maintenance Team, Quality Assurance Team, Operations Team</p>	06/20/2013
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	monthly inspection for the most recent twelve month period. Based on interview at the time of observation, the Maintenance Aide stated no other documentation of monthly fire extinguisher inspections was available for review and acknowledged monthly inspections for the most recent twelve month period for the aforementioned portable fire extinguishers had not been documented.			