STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G814	A. BUILDING -- B. WING	02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	8307 CASTLETON BLVD INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/01/19 Facility Number: 010453 Provider Number: 15G814 AIM Number: 201408320 At this Emergency Preparedness survey, Voca Corporation of Indiana Inc was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 02/05/19 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0015 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to	E 0015	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its	03/03/2019

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
	15G814	A. BUILDING -- B. WING	02/01/2019

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	maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Castleton" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 10:15 a.m. to 11:10 a.m. on 02/01/19, the plan did not address subsistence needs provisions for sewage and waste disposal. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in December 2018 and agreed the plan for the Castleton facility did not address subsistence needs provisions for sewage and waste disposal.		emergency preparedness plan: the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: Sewage and waste disposal. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0022 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility in accordance with 42 CFR	E 0022	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the*	03/03/2019

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	483.475(b)(4). This deficient practice could affect all occupants. Findings included: Based on review of "Emergency/Disaster Preparedness Manual: Castleton" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 10:15 a.m. to 11:10 a.m. on 02/01/19, documentation of emergency preparedness policies and procedures for sheltering in place clients, staff and volunteers who remain in the facility during an emergency was not available for review. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in December 2018 and agreed the emergency preparedness plan for the Castleton facility did not include documentation of emergency preparedness policies and procedures for sheltering in place clients, staff and volunteers who remain in the facility during an emergency.		*emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: A means to shelter in place for patients, staff, and volunteers who remain in the facility or a means to shelter in place for patients, staff, and volunteers who remain in the facility. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0024 Bldg. --				

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	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Castleton" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 10:15 a.m. to 11:10 a.m. on 02/01/19, the emergency preparedness plan did not include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in December 2018 and agreed emergency preparedness documentation did not include emergency preparedness policies and procedures for the use of volunteers in an emergency.	E 0024	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	03/03/2019

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E 0026 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Castleton" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 10:15 a.m. to 11:10 a.m. on 02/01/19, the emergency preparedness plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview at the time of record review, the Maintenance Aide agreed the plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act.	E 0026	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: The role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential	03/03/2019

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E 0030 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Castleton" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 10:15 a.m. to 11:10 a.m. on 02/01/19, the emergency preparedness communication plan for the facility did not include names and contact information for volunteers. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in December 2018 and agreed the communication plan did not include names and contact information for volunteers.	E 0030	Manager, Direct Support Staff, Operations Team, Regional Director **CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan will include names and contact numbers of volunteers. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise	03/03/2019

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			the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Castleton" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 10:15 a.m. to 11:10 a.m. on 02/01/19, the emergency preparedness plan did not include a training and testing program on the emergency preparedness plan. Based on interview at the time of record review, the Maintenance Aide stated there has been no	E 0037	**CORRECTION:** *The facility must have a training program on place with (i) Initial training in emergency preparedness* *policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.* Specifically, the facility will provide an emergency preparedness training program that includes the following. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; and provide emergency preparedness training at least annually; and maintain	03/03/2019

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	change to emergency preparedness documentation since the review of the documentation for other group homes in December 2018 and agreed the emergency preparedness plan did not include a training and testing program which documented staff training in all emergency preparedness policies and procedures within the most recent twelve month period.		documentation of the training; and demonstrate staff knowledge of emergency procedures. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of the following: The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility	E 0039	**CORRECTION:** *The [facility] must conduct exercises to test the emergency plan at least annually.* Specifically, the facility will work with local law enforcement and emergency personnel to arrange bi-annual "table talk" disaster exercises on a bi-annual basis.	03/03/2019

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	experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Castleton" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 10:15 a.m. to 11:10 a.m. on 02/01/19, documentation of a community based disaster drill or table top exercise conducted within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in December 2018 and agreed the facility has not conducted a community based disaster drill, a table top exercise or experienced an actual natural		**PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components, including but not limited to bi-annual community based disaster exercises, are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	or man-made emergency within the most recent twelve month period and agreed testing documentation was not available for review at the time of the survey.			
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 02/01/19 Facility Number: 010453 Provider Number: 15G814 AIM Number: 201408320 At this Life Safety Code survey, Voca Corporation of Indiana was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has smoke detectors hard wired to the fire alarm system installed in all bedrooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.1.	K 0000		

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	Quality Review completed on 02/05/19			
K S362 Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING (Prompt) Unless otherwise indicated below, corridor walls shall meet all of the following: * Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier. * Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity. * Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are wired glass not exceeding 9 square feet each in area and installed in approved frames. This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels. In Prompt Evacuation facilities, all sleeping rooms shall be separated from the escape route by smoke partitions in accordance with 8.2.4. Sleeping arrangements that are not located in sleeping rooms shall be permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.			

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	In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms shall be separated from escape routes by walls and doors that are smoke resistant. 33.2.3.6 Based on observation and interview, the facility failed to ensure 1 of 4 sleeping room doors were capable of resisting smoke for at least 1/2 hour. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 4.8.4.2 states the clearance under the bottom of a door shall be a maximum of 3/4 inch. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Maintenance Aide during a tour of the facility from 11:10 a.m. to 11:30 a.m. on 02/01/19, a large irregular shaped hole was noted in the corridor door to Bedroom #4 which was not capable of resisting the passage of smoke. Based on interview at the time of the observations, the Maintenance Aide stated the client in Bedroom #4 hit the door with an object or his fist and created the hole in the door and agreed the corridor door to Bedroom #4 was not capable of resisting the passage of smoke.	K S362	**CORRECTION:** *Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity.* Specifically, bedroom #4's door will be repaired to assure it can prevent the passage of smoke. **PREVENTION:** Facility staff will be retrained regarding the need to complete work orders immediately to assure timely repairs to assure compliance with liefe safety requirements. The Operations Team comprised of the Program Managers, Training Coordinator, Nurse Manager, Quality Assurance Manager, Quality Assurance Coordinator and Executive Director will conduct reviews of the home environment no leess than monthly to assure compliance with life safety code requirements.. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Environmental Services Team, Direct Support Staff,	03/03/2019

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	15G814	A. BUILDING 01 B. WING	02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	8307 CASTLETON BLVD INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Operations Team, Regional Director	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring according to 33.2.5.1. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Maintenance Aide during a tour of the facility from 11:10 a.m. to 11:30 a.m. on 02/01/19, a freezer was plugged into a power strip on the floor in the office area. Based on interview at the time of the observations, the Maintenance Aide agreed a power strip was being used as a substitute for fixed wiring at the aforementioned location.	K S511	**CORRECTION:** *Electrical wiring and equipment complies with NPFA 70, National Electric Code.* Specifically, the refrigeration unit in the medication room will be moved to a new outlet to eliminate the need to use a power strip as a substitute for fixed wring. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate visual observations of the facility's appliances into scheduled twice monthly audits to assure flexible cords such as extension cords or power strips are not used as a substitute for fixed wiring. **RESPONSIBLE PARTIES:** QIDP,	03/03/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	