STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G326	A. BUILDING -- B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

(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 Department of Health in accordance with 42 CFR 483.475. Survey Date: 04/16/24 Facility Number: 000844 Provider Number: 15G326 AIM Number: 100243650 At this Emergency Preparedness survey, Voca Corporation of Indiana was found 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 04/24/24	E 0000		
E 0023 Bldg. --	403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4) Policies/Procedures for Medical Documentation §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anna Brison	Program Director	05/09/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and	E 0023	**E023: Policies/Procedures- for Medical Documentation** **Corrective action:** The Maintenance Technician	05/10/2024

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	secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review on 04/16/2024 between 11:30 AM and 2:00 PM with the Site Supervisor, the facility did not address a system to preserve, protect and secure medical documentation in the Emergency Preparedness Policy. Based on interview concurrent with record review with the Site Supervisor, there was no documentation for preserving, protecting, or securing medical documentation during an emergency. This finding was reviewed with the Site Supervisor at the exit conference.		has purchased a locking tote for all homes to ensure all consumer documentation including the company laptop is secured at all times during an emergency situation. This was put in place in 2019. I am attaching the work order that was in the facility at the time of review. **(Attachment A)** All staff will be trained **(Attachment B)**. The documentation is kept locked in the homes for security and will be secured at all times in the locked totes during an emergency situation. The Rescare Continuity of Operations has been updated to include ensuring paper and electronic documentation is secure in the event of an emergency. **(Attachment C)** All staff trained on the updated Continuity of Operations. **(Attachment B)** **Monitoring of Corrective Action**: Staff trained on securing documentation will be secured in the locking tote and transported to the designated location in the event of an emergency evacuation of the facility. All trainings are sent to the Program Manager and Human Resources. **Completion Date: 5-10-24**	

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E 0033 Bldg. --	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).			

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	*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants. Findings include: Based on record review on 04/16/2024 between 11:30 AM and 2:00 PM with the Area Supervisor and Site Supervisor, no documentation was available for the policy regarding sharing of medical documentation during an emergency. Based on interview at the time of record review, the Area Supervisor stated the records are on a secure electronic location, but she was not aware	E 0033	**E033: Methods for Sharing Information** **Corrective action:** The Continuity of Operations Plan **(Attachment C)** provides information on how all information will be shared and the protection of client information will be secured including electronic information. Maintenance Technician purchased a locking tote to transport consumer paper and electronic documentation in the event of an emergency. **(Attachment A)** All staff will be trained **(Attachment B)** on the Continuity of Operations Plan. The EPP plan will be discussed and shared with family members, the consumer, guardians and representatives of the consumers at their quarterly IDT meetings.	05/10/2024

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	of any written documentation of the policy. This finding was reviewed with the Site Supervisor at the exit conference.		QIDP-D will provide any updates to family members, the consumer, guardians and representatives of the consumers as the EPP is updated. **Monitoring of Corrective Action**: The Continuity of Operations Plan will be updated as needed to include additional information by the Program Manager. Locking tote delivered to the home by Maintenance Technician. **Completion Date: 5-10-24**	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:			

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	(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is			

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	community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is			

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	exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based			

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	or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every			

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	15G326	A. BUILDING -- B. WING	04/16/2024

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	2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the			

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	following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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 [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual,			

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VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G326	A. BUILDING -- B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	(B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:			

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	15G326	A. BUILDING -- B. WING	04/16/2024

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VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is 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. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional 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 an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator 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.	E 0039	**E039: EP Testing Requirements** **Corrective action:** The facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually and will use the Mock Drill Form for completion and proof of the exercise. I have attached the mock drill that was present in the facility at the time of review. **(Attachment D)** Staff training to ensure the facility will conduct at least two full scale or one full scale exercise and a table top exercise (completed as an inservice in monthly house meetings) to test the emergency plan at least annually and will use the Mock Drill Form for completion and proof of the exercise. I have attached the Mock Drill and Inservice including tabletop exercise that was present in the facility at the time of review. **(Attachment E)** Staff will be tested annual on	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G326	A. BUILDING -- B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	(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 record review on 04/16/2024 from 11:30 AM to 2:00 PM with the Area Supervisor, the facility failed to complete an after action report for the full-scale exercise and the second annual exercise. Based on interview at the time of record review, the Area Supervisor agreed there was no after action report for either annual exercise. This finding was reviewed with the Site Supervisor at the exit conference.		the EPP. I have attached the staff testing that was present in the facility at the time of the review. **(Attachment F)** Area Supervisor and Program Manager trained to ensure the after action report is completed following the Mock Drill and Tabletop Exercise training. **(Attachment G)** **Monitoring of Corrective Action**: Copies of the completed drills will be sent to the Program Manager and will also remain in the EPP binder in the facility. Completed staff tests will be kept in the EPP binder and will be sent to Human Resource to remain in staff file. The after action reports will be sent to the Program Director for review and to ensure completion and kept in the EPP binder in the facility. **Completion Date: 5-10-24**	
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).	K 0000		

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	15G326	A. BUILDING 02 B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Survey Date: 04/16/24 Facility Number: 000844 Provider Number: 15G326 AIM Number: 100243650 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 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 facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and client sleeping rooms. 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 Slow with an E-Score of 2.16 Quality Review completed on 04/24/24			
K S168 Bldg. 02	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING (Slow) In Slow Evacuation Capability facilities, the facility shall be housed in a building where the interior is fully sheathed with lath and plaster or other material providing a 15-minute thermal barrier, including all portions of bearing walls, bearing partitions, floor construction, and roofs.			

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	15G326	A. BUILDING 02 B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	All columns, beams, girders, and trusses shall be similarly encased or otherwise shall provide not less than a 1/2-hour fire resistance rating, unless modified by the modified by the following: * Exposed steel or wood columns, girders, and beams (but not joists) located in the basement shall be permitted. * Buildings of Type I, Type II (222), Type II (111), Type III (211), Type IV, Type V (111) construction shall not be required to meet the requirements of 33.2.1.3.2 (See 8.2.1). * Areas protected by approved automatic sprinkler systems in accordance with 33.2.3.5. shall not be required to meet the requirements of 33.2.1.3.2. * Unfinished, unused, and essentially inaccessible loft, attic, or crawl space shall not be required to meet the requirements of 33.2.1.3.2. * Where the facility achieves an E-score of 3 or less using the board and care occupancies evacuation capability determination methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety. The requirements of 33.2.1.3.2 shall not apply. 33.2.1.3.2.1 through 33.2.1.3.2.7			
	Based on observation and interview, the facility failed to ensure the facility was fully sheathed to provide a 15-minute thermal barrier. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation during a tour of the facility with the Site Supervisor on 04/16/2024 between 2:00 PM and 2:30 PM, an 18 inch by 12 inch penetration in the wall behind the water heater was located in the water heater closet. Based on	K S168	**K0168: Building Construction Type and Height** **Corrective Action:** Program Director sent a work order to have maintenance technician patch and paint the wall in the mechanical closet behind the water heater. **(Attachment H)** Site Reviews are completed monthly at the facility by Rescare Management to monitor all	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G326	A. BUILDING 02 B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	interview at the time of observation, the Site Supervisor agreed there was a penetration in the wall and provided the measurement. This finding was reviewed with the Site Supervisor at the exit conference.		environmental issues. **(Attachment I)** **Monitoring of Corrective Action:** Rescare Administration will complete monthly Site Reviews and send to the Program Director and Executive Director for monitoring of completion. Program Manager will follow up on issues noted on the Site review and submit to the Program Director for follow up on the issues. **Completion Date: 5-10-24**	
K S338 Bldg. 02	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING (Slow) In Slow Evacuation Capability facilities, interior wall and ceiling finish materials in accordance with 10.2. Class A or Class B is permitted. There are no requirements for interior floor finish. 33.2.3.3.2, 33.2.3.3.3 Based on observation and interview, the facility failed to ensure the interior finish in 1 of 1 Basement was rated in accordance with 33.2.3.3.2. LSC 33.2.3.3.2 requires interior wall and ceiling finish materials comply with Section 10.2 meeting a Class A, Class B flame spread rating for this Slow rated facility. This deficient practice could	K S338	**K0338: Interior Wall and Ceiling Finish** **Corrective Action:** Program Manager sent a work order to the Maintenance Technician to have Flame Spread	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G326	A. BUILDING 02 B. WING	04/16/2024

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VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	affect staff and all residents. Findings include: Based on observation during a tour of the facility on 04/16/2024 between 2:00 PM and 2:30 PM with the Site Supervisor, wood paneling was observed in the living room area of the home and a plastic panel covered with what appeared to be wallpaper in the kitchen. Based on interview at the time of the observation, the Site Supervisor stated she was unaware if the paneling in the kitchen and living room had been treated for a flame spread rating. This finding was reviewed with the Site Supervisor at the exit conference.		Retardant applied to the wood casing surrounding the TV in the living room. **(Attachment J)** Program Manager sent a work order to the Maintenance Technician to remove the splash guard from behind the kitchen trash can that had wallpaper on it and was not flame resistant. **(Attachment J)** Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues. **(Attachment I)** **Monitoring of Corrective Action:** Rescare Administration will complete monthly Site Reviews and send to the Program Director and Executive Director for monitoring of completion. Program Manager will follow up on issues noted on the Site review and submit to the Program Director for follow up on the issues. **Completion Date: 5-10-24**	

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	15G326	A. BUILDING 02 B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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K S341 Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels were protected. LSC 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observation during a tour of the facility on 04/16/24 between 2:00 PM and 2:30 PM with the Site Supervisor, the key to the fire panel was in the fire panel. Based on interview at the time of the observation, the Site Supervisor agreed the key was in the fire panel and stated the door to the room is kept unlocked as the residents do their own laundry.	K S341	**K0341:** Testing and Maintenance **Corrective Action:** Program Director sent inservice to the facility to train all staff on not leaving the key in the fire panel in the mechanical room. **(Attachment B)** Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues. **(Attachment I)** **Monitoring of Corrective Action:** Rescare Administration will complete monthly Site Reviews and send to the Program Director and Executive Director for monitoring of completion. Program Manager will follow up on issues noted on the Site review and submit to the Program Director for follow up on the issues.	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G326	A. BUILDING 02 B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	This finding was reviewed with the Site Supervisor at the exit conference.		**Completion Date: 5-10-24**	
K S345 Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time information in accordance with the requirements of NFPA 101- 2012 edition, Sections 33.3.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation of the fire alarm control panel during a tour of the facility with the Site Supervisor on 04/16/2024 at 2:18 PM, the display on the fire alarm control panel indicated the time to be 4:26 PM. Based on interview at the time of observation, the Site Supervisor confirmed the control panel was displaying the incorrect time.	K S345	**K0345:** Fire Alarm System-Installation **Corrective Action:** Program Manager sent a request to Koorsen to change the time on the fire panel to ensure the time was correct for the time zone. **(Attachment L)** Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues. **(Attachment I)** **Monitoring of Corrective Action:** Rescare Administration will	05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G326	A. BUILDING 02 B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	This finding was reviewed with the Site Supervisor at the exit conference.		complete monthly Site Reviews and send to the Program Director and Executive Director for monitoring of completion. Koorsen inspects quarterly to monitor for issues with the fire panel. Program Manager will follow up on issues noted on the Site review and submit to the Program Director for follow up on the issues. **Completion Date: 5-10-24**	
K S353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G326	A. BUILDING 02 B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and			

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	15G326	A. BUILDING 02 B. WING	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff. Findings include: Based on record review with the Site Supervisor on 04/16/2024 between 11:30 AM and 2:00 PM, no quarterly sprinkler inspection report for the 1st quarter of 2024 was available for review. The last available sprinkler inspection report available was dated 11/17/2023. Based on interview at the time	K S353	**K0353: Sprinkler System – Maintenance and Testing** **Corrective action:** Program Manager contacted Koorsen to have 5 additional spare sprinkler heads, a wrench for installation of the heads and a cabinet to store the spare heads and wrench in, in the mechanical room. Koorsen contacted me back and stated the requested items were in the facility and described the location of the items. I facetimed the staff and they were able to show me where in the home the cabinet containing the spare heads and wrench were located. **(Attachment M)** Program Director sent a work order to have maintenance technician patch and paint the ceiling where holes were present from having the HVAC replaced. **(Attachment N)** Program Director contacted Koorsen for a copy of the 1st quarter sprinkler inspection. A	05/10/2024

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	15G326	A. BUILDING 02 B. WING	04/16/2024

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VOCA CORPORATION OF INDIANA	9 SUMMIT DR AURORA, IN 47001

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	of record review, the Site Supervisor agreed there was no sprinkler inspection report paperwork for the 1st quarter of 2024 available for review. This finding was reviewed with the Site Supervisor at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation during a tour of the facility on 04/16/2024 between 2:00 PM and 2:30 PM with the Site Supervisor, 1 sprinkler head could be located and no spare sprinkler cabinet, special sprinkler wrench or additional 5 spare sprinkler heads could be located on the premises. Based on interview at the time of observation, the Site Supervisor agreed only 1 sprinkler head could be located and no additional 5 spare sprinkler heads, spare sprinkler cabinet, or special sprinkler wrench		copy has been placed in the facility as well as attached here. **(Attachment P)** **Monitoring of Corrective Action**: Program Manager to review Koorsen Reports for filing and follow-up if warranted. Program Manager will follow-up with Residential Lead to ensure Koorsen has completed the request to place the needed items in the facility. **Completion Date: 5-10-24**	

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	could be located. This finding was reviewed with the Site Supervisor at the exit conference. 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 water heater rooms. NFPA 12, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation during a tour of the facility on 04/16/2024 between 2:00 PM and 2:30 PM with the Site Supervisor, a 1.5 inch by 1 inch penetration in the ceiling by the white pipe was located in the water heater closet and a 3 inch by 4 inch penetration in the ceiling by the silver pipe was located in the water heater closet. Based on interview at the time of the observations, the Site Supervisor agreed there were penetrations in the ceiling in the aforementioned locations and provided the measurements. This finding was reviewed withe the Site Supervisor at the exit conference.			
K S711 Bldg. 02	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan The administration of every resident board and care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in			

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	the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility. All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk. 32.7.1, 32.7.2, 33.7.1, 33.7.2			
	Based on record review and interview, the facility failed to provide a written evacuation and relocation plan in the event of fire and failed to provide documentation of periodic staff instruction on the written fire plan not less than every two months. This deficient practice affects all clients, staff and visitors. Findings include:	K S711	**K0711: Evacuation and Relocation Plan** **Corrective Action:** ·Area supervisor completed an inservice with the all staff over the drill schedule and evacuation plan	05/10/2024

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	Based on record review with the Site Supervisor on 04/16/2024 between 11:30 AM and 2:00 PM, a written fire safety plan was not available for review. Based on interview at the time of record review, the Site Supervisor agreed the written fire safety plan was not available for review. This finding was reviewed with the Site Supervisor at the exit conference.		as well as the Emergency Disaster Policy. (**Attachment O**) ·During on the job training and during monthly house meetings all staff are trained on the evacuation plan for the facility that is posted at all exits in the facility. **(Attachment Q)** ·Rescare Administration will complete monthly site reviews to ensure all drills are completed as scheduled**. (Attachment I)** **Monitoring of Corrective Action:** ·The Area Supervisor will conduct a weekly check to ensure scheduled completions of the drills and send to the Program Manager. ·The Safety Committee will monitor quarterly for completion of scheduled drills. ·Rescare Administration Site Reviews wills be sent to the Program Director and Executive Director once completed. **Completion Date: 5-10-24**	

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