STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G507	A. BUILDING -- B. WING	11/22/2021

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 11/22/21 Facility Number: 001021 Provider Number: 15G507 AIM Number: 100245130 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. At the time of the survey, the census was 8. Quality Review completed on 11/23/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 11/22/21 Facility Number: 001021 Provider Number: 15G507 AIM Number: 100245130 At this Life Safety Code survey, Voca Corporation of Indiana was found not in compliance with Requirements for Participation in Medicaid, 42	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	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, all living areas and bedrooms, plus heat detection located in the attic and connected to the fire alarm system. 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 3.18. Quality Review completed on 11/23/21			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 3 fire extinguishers in the facility were protected. NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4 requires that portable fire extinguishers types shall be (1) secured on a hanger (2) in the bracket supplied by the manufacturer (3) in a listed bracket approved for such purpose (4) in cabinets or wall recesses.	K S100	**K0100:** General Requirements **Corrective Action:** · The Program Manager completed a work order to Aramark to have the fire extinguisher properly mounted in the laundry room of the facility.	11/23/2021

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	This deficient practice could affect all occupants. Findings include: Based on observations on 11/22/21 between 10:15 a.m. and 12:00 p.m. during a tour of the facility with the Home Manager, the fire extinguisher in the laundry room was sitting unsupported on the floor. The Home Manager said the metal wall support rod was bent and could not hold the fire extinguisher. This finding was reviewed with the Home Manager during the exit conference.		**(Attachment A)** · Residential Manager signs off on the fire extinguishers monthly and will report to the Program Manager if there is a problem with an extinguisher. · Area Supervisor completes a weekly check at the facility and that includes checking the fire extinguishers in the facility and that they are mounted properly. **(Attachment B)** · Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues including fire extinguishers being checked monthly by the Residential Manager and annually by Koorsen. **(Attachment C)** **Monitoring of Corrective Action:** · Program Manager will contact Aramark for all issues with the fire extinguishers. · Site Reviews are entered into the CRM database and tracked by the Quality Assurance Manager to ensure completion and follow up on all issues with the Program Manager. **Completion Date: 11/23/21**	

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K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation and interview; the facility failed to ensure 1 of 8 closet doors can be readily opened from the inside. LSC 33.2.2.5.3 states every closet door latch shall be readily opened from the inside. This deficient practice could affect 1 client. Findings include:	K S222	**K0222: Egress Doors** **Corrective Action:** · Residential Manager removed the lock from the closet door following the report from the surveyor. · Area Supervisor completes weekly checks at the facility	11/22/2021

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	Based on observations on 11/22/21 between 10:15 a.m. and 12:00 p.m. during a tour of the facility with the Home Manager, the left side closet door in the northwest client bedroom had a padlock on the outside of the door which would not allow the door to be unlocked from the inside of the closet if the padlock were locked. The padlock was not locked at the time of observation. The Home Manager acknowledged the padlock on the closet door at the time of observation. This finding was reviewed with the Home Manager during the exit conference.		including any environmental or safety concerns. **(Attachment B)** · Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues. **(Attachment C)** **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 Director will follow up on issues noted on the Site review and submit to the Program Manager for follow up on the issues. **Completion Date: 11/22/21**	
K S345 Bldg. 01	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			

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	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 ensure all fire alarm system initiating devices, such as a pull station, was not obstructed. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 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 Electric Code and NFPA 72, National Fire Alarm and Signaling Code. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations on 11/22/21 between 10:15 a.m. and 12:00 p.m. during a tour of the facility with the Home Manager, the fire alarm pull station near the front door was blocked by a plastic tote on top of a wood dresser. Based on interview at the time of observation, the Home Manager said the plastic tote was just placed there because they had just gotten out the Christmas decorations for the house and it had not yet been put away. This finding was reviewed with the Home Manager during the exit conference.	K S345	**K0345:** Testing and Maintenance **Corrective Action:** · Upon completion of the review with the surveyor the Residential Manager removed the totes that were obstructing the pull station near the front door of the facility. · All extra storage will be kept in the outside storage shed and not in the facility to ensure there is no obstructed areas in the facility that could be a health and safety concern. · Area Supervisor completes a weekly check at the facility and that includes checking the fire alarm pull stations to ensure there is no obstruction. **(Attachment B)** · Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues. **(Attachment C)** **Monitoring of Corrective Action:** · Area Supervisor sends completed weekly checks to the Program Manager for review. · Rescare Administration will complete monthly Site Reviews and send to the Program Director and Executive Director for	11/22/2021

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			monitoring of completion. **Completion Date: 11/22/21**	