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	07/13/2021

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 Department of Health in accordance with 42 CFR 483.475. Survey Date: 07/13/21 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 07/20/21 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0024 Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5).			

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	07/13/2021

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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:] (6) [or (4), (5), or (7) as noted above] 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. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and 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.			
	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	E 0024	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and*	08/12/2021

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	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" documentation dated 11/15/20 and "Emergency, Disaster, Evacuation Plans and Responses" documentation dated 10/01/20 with the Maintenance Aide during record review from 9:25 a.m. to 10:45 a.m. on 07/13/21, 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 agreed emergency preparedness documentation did not include emergency preparedness policies and procedures for the use of volunteers in an emergency. This finding was reviewed with the Maintenance Aide during exit conference.		*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, Area Supervisors, Nurse Manager, Assistant Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators, QIDP Manager and QIDP) will incorporate reviews of the facility's emergency preparedness program into scheduled 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 0026 Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7)			

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	Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(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:] (8) [(6), (6)(C)(iv), (7), or (9)] 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. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. 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	E 0026	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the	08/12/2021

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	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" documentation dated 11/15/20 and "Emergency, Disaster, Evacuation Plans and Responses" documentation dated 10/01/20 with the Maintenance Aide during record review from 9:25 a.m. to 10:45 a.m. on 07/13/21, 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. This finding was reviewed with the Maintenance Aide during the exit conference.		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 Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse 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 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1),			

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	§441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [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 every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years.			

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	(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF 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) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with			

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	their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC 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 role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide 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 every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel			

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	must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, 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 every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under			

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	arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure staff received training in regards to emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Provide 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 every two years; (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" documentation dated 11/15/20 and "Emergency, Disaster, Evacuation Plans and Responses" documentation dated 10/01/20 with the Maintenance Aide during record review from 9:25 a.m. to 10:45 a.m. on 07/13/21, the facility lacked documentation of staff training on the emergency preparedness plan within the most recent two year period. Based on interview at the time of record review, the Maintenance Aide stated staff training documentation on emergency preparedness policies and procedures within the most recent two year period was not available for review at the time of the survey.	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 documentation of the training; and demonstrate staff knowledge of emergency procedures.	08/12/2021

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	This finding was reviewed with the Maintenance Aide during the exit conference.		The QIDP Manager will work with the agency Training Coordinator to develop a specific emergency preparedness curriculum, including competency testing, that will be presented during new-hire orientation as will be included in the operation's annual retraining requirements. Development of the curriculum is in progress and will be completed by 8/12/21. **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, Safety Committee, Human Resources Department, Operations Team, Regional Director **CORRECTIONS COMPLETED BY:** 8/12/21	
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),			

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	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: (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			

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	(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 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			

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	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 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			

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	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 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.			

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	*[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 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):]			

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	(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 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			

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	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, 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			

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	(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 (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			

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	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: (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 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: (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 experiences an actual natural or man-made emergency that requires activation of the	E 0039	**CORRECTION:** *The [facility] must conduct exercises to test the emergency plan at least annually.* Specifically, the agency's Quality Assurance Department has submitted a formal request to the Indianapolis Metropolitan Police Department/Department of Homeland Security Community	08/12/2021

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	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" documentation dated 11/15/20 and "Emergency, Disaster, Evacuation Plans and Responses" documentation dated 10/01/20 with the Maintenance Aide during record review from 9:25 a.m. to 10:45 a.m. on 07/13/21, documentation of a community based disaster drill within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Aide agreed the facility is currently experiencing an actual natural emergency due to Covid-19 and Covid-19 policy and procedures currently in effect for the pandemic are stated in the emergency preparedness documentation but agreed the facility has not conducted a second community based disaster drill or conducted a tabletop exercise within the most recent twelve		Emergency Response Team (CERT) to conduct an initial “table talk” disaster exercise, with bi-annual exercises thereafter. Additionally the ResCare Quality Assurance Department has requested assistance from the IMPD District Commander to coordinate with CERT to facilitate this process. ResCare Facility supervisors, the QIDP and administrative level management (Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will participate in the exercises to assure facility emergency preparedness protocols are consistent with community emergency management practices. The facility will develop documentation of the activation of the Emergency Preparedness Plan during the 2020-2021 COVID-19 epidemic, by 8/12/21 using the current state of emergency as a platform. At the time of this exercise, a “table talk exercise will be scheduled with local emergency management officials within 6 months of the full-scale event. **PREVENTION:** Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area	

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	month period and agreed additional testing documentation was not available for review at the time of the survey. This finding was reviewed with the Maintenance Aide during the exit conference.		Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse 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	
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: 07/13/21 Facility Number: 010453 Provider Number: 15G814 AIM Number: 201408320 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	K 0000		

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	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. Quality Review completed on 07/20/21			
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.			

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	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. 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 corridor doors to 1 of 4 client bedrooms were 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity and would resist the passage of smoke. 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 10:45 a.m. to 11:05 a.m. on 07/13/21, a two inch in diameter hole was noted in the corridor door on the corridor side of the door to Bedroom #3 which did not ensure	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 and must be capable of resisting smoke for at least 1/2 hour.* Specifically, the facility will replace the door to bedroom #3 with a door with 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity that will withstand the	08/12/2021

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	the door was 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity and would resist the passage of smoke when the door was in the fully closed and latched position. Based on interview at the time of the observations, the Maintenance Aide agreed the hole in the corridor door to Bedroom #3 did not ensure the door was 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity and would not resist the passage of smoke. This finding was reviewed with the Maintenance Aide during the exit conference.		passage of smoke. **PREVENTION:** The QIDP Manager will retrain members of the Operations Team comprised of the Quality Assurance Manager, Quality Assurance Coordinators, QIDP, Area Supervisors, Executive Director, Program Managers, Assistant Nurse Manager, and Nurse Manager to assure their familiarity with Life Safety Code requirements for limitation of passage of smoke through doorways. The Operations Team will conduct reviews of the home environment no less than monthly to assure compliance with life safety code requirements. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Environmental Services Team, Direct Support Staff, 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 electrical receptacles in 1 of 3 bathrooms were properly wired and grounded in accordance with NFPA 70. LSC 33.2.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2	K S511	**CORRECTION:** *Electrical wiring and equipment complies with NPFA 70, National Electric Code.* Specifically, The facility will repair the damaged	08/12/2021

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	15G814	A. BUILDING 01 B. WING	07/13/2021

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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
	requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130.		electrical outlet receptacles in the small bathroom and laundry room. **PREVENTION:** Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate visual observations of the facility's electrical outlets into scheduled monthly audits to assure they are in good repair and properly grounded. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Contracted Environmental Services Staff, Operations Team	

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	This deficient practice could affect one client and staff. Findings include: Based on observations with the Maintenance Aide during a tour of the facility from 10:45 a.m. to 11:05 a.m. on 07/13/21, the electrical receptacles in the wall mounted outlet box by the sink in the small bathroom in the laundry room were found to have an "open ground" when tested with an Ideal Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Aide agreed the testing device showed the aforementioned electrical receptacles needed repair. This finding was reviewed with the Maintenance Aide during the exit conference.			
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation			

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	drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second shift for 1 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Emergency Evacuation Drill: Fire" documentation with the Home Manager and the Maintenance Aide during record review from 9:25 a.m. to 10:45 a.m. on 07/13/21, documentation of a fire drill conducted on the second shift in the first quarter (January, February, March) 2021 was not available for review. Based on interview at the time of record review, the Home Manager stated the facility operates two shifts per day, additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the second shift in the first quarter 2021 was not available for review. This finding was reviewed with the Maintenance Aide during the exit conference.	K S712	**CORRECTION:** *The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions.* Specifically, the facility will conduct additional evacuation drills on the each shift during the current quarter. **PREVENTION:** Professional staff will be retrained regarding the need to conduct evacuation drills at varied times on each shift for all staff each quarter. Training will also focus on proper completion of evacuation drill forms and assessment of individual drill compliance. The Operations (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will review and track all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled and follow up with the	08/12/2021

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			agency Safety Committee accordingly. **Responsible Parties:** Environmental Services Team, Area Supervisor, Residential Manager, Direct Support Staff, QIDP, Operations Team	
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on observation and interview, the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 outdoor areas where smoking is permitted. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Home Manager and the Maintenance Aide during a tour of the facility from 10:45 a.m. to 11:05 a.m. on 07/13/21, a smoking tower for dispensing cigarette butts was noted on the back patio outside the facility. In addition, a plastic open top ashtray was filled with cigarette butts on a table near the smoking tower. Based on interview at the time of the observations, the Home Manager stated three	K S741	**CORRECTION:** *Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations.* Specifically, the facility will provide a noncombustible covered ash container for the designated smoking area and non-covered, potentially combustible ashtray will be removed and properly disposed of. Additionally, staff and supervisors will be retrained toward proper implementation of the facility smoking policy. **PREVENTION:** Members of the Operations Team	08/12/2021

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	clients and staff are allowed to smoke outside the facility on the back patio. The Home Manager and the Maintenance Aide agreed the ashtray for the cigarette butts was not equipped with a self-closing cover device and was not of noncombustible material and safe design. This finding was reviewed with the Maintenance Aide during the exit conference.		(comprised of the Quality Assurance Manager, Quality Assurance Coordinators, QIDP, Area Supervisors, Executive Director, Program Managers, Assistant Nurse Manager, and Nurse Manager) will incorporate reviews of the home environment, including designated smoking areas into scheduled monthly audits to assure clients and staff smoke in the designated area and follow the facility's smoking policy, including disposal of cigarette butts in covered, non-combustible containers. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	