STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		15G814	B. WING		07/13/2021
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD	
.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		INIDIANIA		ASTLETON BLVD	
VOCA CO	ORPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46256	
(X4) ID	SUMMARY	MMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
E 0000					
Bldg					
	An Emergency Pre	paredness Survey was	E 0000		
	conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.		L 0000		
		0110 10011701			
	Survey Date: 07/13	3/21			
		··			
	Facility Number: 0	010453			
	Provider Number:				
	AIM Number: 201				
	At this Emergency	Preparedness survey, Voca			
	Corporation of Indiana Inc was found not in compliance with Emergency Preparedness				
	_	Medicare and Medicaid			
	-	ders and Suppliers, 42 CFR			
	483.475.	acis and Suppliers, 12 Crit			
	103.173.				
	The facility has 8 co	ertified beds. All 8 beds are			
	-	aid. At the time of the survey,			
	the census was 8.	and. The time of the survey,			
	Ouality Review cor	mpleted on 07/20/21			
	Quality 110 / 10 // 001	npreced on 6 // 20/21			
	The requirement at	42 CFR, Subpart 483.475 is			
	NOT MET as evide	•			
E 0024	403.748(b)(6), 41	6.54(b)(5), 418.113(b)(4),			· ·
	` ' ' '	2.15(b)(6), 483.475(b)(6),			
Bldg	, , , ,	.102(b)(5), 485.625(b)(6),			
	, , , ,	.727(b)(4), 485.920(b)(5),			
	491.12(b)(4), 494.				
	` ' ' '	es-Volunteers and Staffing			
		416.54(b)(5), §418.113(b)(4),			
	- , , , , -	460.84(b)(7), §482.15(b)(6),			
	. , , , ,	83.475(b)(6), §484.102(b)(5),			
		85.625(b)(6), §485.727(b)(4),			
		65.625(b)(6), §465.727(b)(4), 491.12(b)(4), §494.62(b)(5).			
		73 1. 12(D)(4), 3434.02(D)(3).			

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

TITLE (X6) DATE

Any defiency statement 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 disclodays 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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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/13/2021		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION		
	must develop and preparedness pol on the emergency (a) of this section, paragraph (a)(1) communication pl section. The polic be reviewed and years [annually for minimum, the polic address the follow (6) [or (4), (5), or of volunteers in an emergency staffin process and role frederally designal professionals to a an emergency. *[For RNHCIs at & procedures. (6) The emergency and or strategies to address the address to address the follow and the emergency. *[For Hospice at & procedures. (4) The emergency staffin process and role frederally designal process and role frederally designal frederally desi	(7) as noted above] The use in emergency or other g strategies, including the for integration of State and ited health care ddress surge needs during (\$403.748(b):] Policies and the use of volunteers in an other emergency staffing ess surge needs during an (\$418.113(b):] Policies and the use of hospice emergency and other g strategies, including the for integration of State and					
	Based on record rev failed to ensure eme and procedures incl	view and interview, the facility ergency preparedness policies lude the use of volunteers in her emergency staffing	E 0024	CORRECTION: [Facilities] must develop and implement emergency preparedness policies and	08/12/2021		

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Facility ID: 010453

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	ì	UILDING	ONSTRUCTION	(X3) DATE COMPI 07/13	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	strategies, including integration of State care professionals than emergency in act 483.475(b)(6). This all occupants. Findings include: Based on review of Preparedness Manudated 11/15/20 and Evacuation Plans and dated 10/01/20 with record review from 07/13/21, the emergency include the use or other emergency the process and role Federally designate address surge needs on interview at the Maintenance Aide apreparedness docuremergency preparefor the use of volunt. This finding was read Aide during exit contact that the strategies of the use of volunt.	g the process and role for or Federally designated health o address surge needs during cordance with 42 CFR s deficient practice could affect states affect of the designation of the Maintenance Aide during 19:25 a.m. to 10:45 a.m. on gency preparedness plan did of volunteers in an emergency staffing strategies, including the for integration of State or old health care professionals to a during an emergency. Based time of record review, the agreed emergency mentation did not include dness policies and procedures affers in an emergency.			procedures, based on the emergency plan. Specifically, facility will incorporate the following policies into its emergency preparedness platuse of volunteers in an emergor or other emergency staffing strategies, including the proceand role for integration of State and Federally designated heat care professionals to address surge needs during an emergor PREVENTION: Members of the Operations To (comprised of the Operations Managers, Program Manager, Executive Director, Quality Assurance Manager, Quality Assurance Manager, Quality Assurance Coordinators, QID Manager and QIDP) will incorporate reviews of the fact emergency preparedness professional monthly audits assure all required componer are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annu RESPONSIBLE PARTIES: Quality Area Supervisor, Residential Manager, Direct Support Staff Operations Team, Regional Director	n: the gency ess te alth sigency. Feam rs, nager, oppositive so to although the storage storag	
E 0026 Bldg	(iv), 441.184(b)(8)	6.54(b)(6), 418.113(b)(6)(C)), 482.15(b)(8), 483.475(b) 485.625(b)(8), 485.920(b)					
-·-g·	(7), 494.62(b)(7)	100.020(8)					

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	OF CORRECTION	IDENTIFICATION NUMBER 15G814	A. BUILDING B. WING	onstruction 	COMPLETED 07/13/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	§403.748(b)(8), §4(C)(iv), §441.184(l) §482.15(b)(8), §48 §485.625(b)(8), §4 [(b) Policies and properties policies policies and properties policies properties policies properties policies policies policies properties policies properties policies properties properties policies properties policies properties p	(7), or (9)] The role of the raiver declared by the radance with section 1135 provision of care and ternate care site identified magement officials. (403.748(b):] Policies and the role of the RNHCI under a py the Secretary, in section 1135 of Act, in the at an alternative care site gency management						
	failed to ensure eme and procedures incl facility under a wai in accordance with provision of care an	riew and interview, the facility ergency preparedness policies ude the role of the ICF/IID wer declared by the Secretary, section 1135 of the Act, in the did treatment at an alternate by emergency management	E 0026	CORRECTION: [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan. Specifically, facility will incorporate the	08/12/2021 the			

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PRINTED: 08/04/2021 FORM APPROVED OMB NO. 0938-039

	of Correction identification number 15G814	A. BUILDING B. WING	COMPLETED 07/13/2021			
	PROVIDER OR SUPPLIER ORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 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 officials in accordance with 42 CFR 483.475(b)(8).	ID PREFIX CROSS-REFERENCED TO THE APP TAG PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) following policies into its	JLD BE COMPLETION DATE			
	This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster	emergency preparednes The role of the facility ur waiver declared by the S in accordance with section the Act, in the provision	der a Secretary, on 1135 of			
	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.	and treatment at an alter site identified by emerge management officials. PREVENTION: Members of the Operation (comprised of the Execut Director, Operations Managers, Are Supervisors, Quality Assimanger, QIDP Manager Quality Assurance Coord Nurse Manager and Assimurse Manager will increviews of the facility's expreparedness program is scheduled twice monthly assure all required compare present. Additionally agency Safety committee review and revise the planeeded but no less than RESPONSIBLE PARTIE Area Supervisor, Reside Manager, Direct Support Operations Team, Region Director	enate care ency ons Team tive chagers, a curance r, QIDP, dinators, istant corporate mergency onto r audits to conents , the e will an as annually. S: QIDP, ential is Staff,			
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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED		
		15G814	B. WING		07/13/2021		
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	8		CASTLETON BLVD			
VOCA CO	ORPORATION OF I	INDIANA		NAPOLIS, IN 46256			
				1			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRI			
TAG		LSC IDENTIFYING INFORMATION	TAG	DEPOLENCY)	DATE		
	- ,,,,	460.84(d)(1), §482.15(d)(1),					
	- ,,,,	83.475(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),						
	. ,), §480.360(d)(1),					
	§491.12(d)(1).						
	*IFor RNCHIs at 8	403.748, ASCs at §416.54,					
		15, ICF/IIDs at §483.475,					
		2, "Organizations" under					
	_	at §486.360, RHC/FQHCs					
	at §491.12:]	at 3 100.000, 14 10/1 Q1100					
		am. The [facility] must do					
	all of the following						
	(i) Initial training in emergency preparedness						
	policies and procedures to all new and						
		viduals providing services					
	under arrangemer						
	consistent with the						
	(ii) Provide emerg	ency preparedness training					
	at least every 2 ye	ears.					
	(iii) Maintain docui	mentation of all emergency					
	preparedness trair	-					
	(iv) Demonstrate s	staff knowledge of					
	emergency proced						
	, ,	cy preparedness policies					
		re significantly updated, the					
		duct training on the					
	updated policies a	and procedures.					
	4r= 11	0.440 4.40(1) 1 (4) =					
		§418.113(d):] (1) Training.					
		do all of the following:					
	.,	n emergency preparedness					
		edures to all new and					
		mployees, and individuals					
	' '	under arrangement,					
	consistent with the						
	(ii) Demonstrate s	-					
	emergency proced						
	, ,	gency preparedness training					
	at least every 2 ye	ears.					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
AND TEAN	or condition.	15G814	B. W			07/13/	
NAME OF I	PROVIDER OR SUPPLIEF	,	<u> </u>		ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
	ORPORATION OF				ASTLETON BLVD APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Eview and rehearse its	+	TAG	DIA TOLENOT?		DATE
	, ,	redness plan with hospice					
		ling nonemployee staff),					
		asis placed on carrying out					
	1	ecessary to protect patients					
	and others.						
	preparedness trail	mentation of all emergency					
		ncy preparedness policies					
		re significantly updated, the					
	hospice must con-	duct training on the					
	updated policies a	and					
	procedures.						
	 *[For PRTFs at &4	l41.184(d):] (1) Training					
	-	TF must do all of the					
	following:						
		n emergency preparedness					
		edures to all new and					
	_	viduals providing services					
	under arrangemer consistent with the						
		ning, provide emergency					
	` '	ning every 2 years.					
		staff knowledge of					
	emergency proced	dures.					
	, ,	mentation of all emergency					
	preparedness train	_					
	, ,	cy preparedness policies					
	-	re significantly updated, the uct training on the updated					
	policies and proce						
	*F DAGE : 3:	20 04/ IV 1 /4) TI					
	_	60.84(d):] (1) The PACE					
	_	do all of the following: n emergency preparedness					
		edures to all new and					
		viduals providing on-site					
	•	rangement, contractors,					
		olunteers, consistent with					

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COM	ie survey ipleted 13/2021
	OF PROVIDER OR SUPPLIES		8307 0	ADDRESS, CITY, STATE, ZIP CO CASTLETON BLVD NAPOLIS, IN 46256	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	their expected rol (ii) Provide emergat least every 2 ye (iii) Demonstrate emergency proce participants of whom to contact is (iv) Maintain docustory (v) If the emerge and procedures at least annually. (iii) Provide emergat least annually. (iii) Maintain docustory procedures and existing services under an consistent with the provide emergat least every 2 yeuron in the provide emergation in the provi	gency preparedness training gears. staff knowledge of dures, including informing at to do, where to go, and in case of an emergency. Imentation of all training. Incy preparedness policies re significantly updated, the fuct training on the updated edures. Ses at §483.73(d):] (1) The LTC facility must do all in emergency preparedness edures to all new and viduals providing services int, and volunteers, eir expected role. Igency preparedness training in emergency ining. Staff knowledge of dures. 485.68(d):](1) Training. The I of the following: raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. Igency preparedness training rangement, and volunteers, eir expected roles. Igency preparedness training				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G814	A. BU B. W	JILDING DIC		COMPL 07/13/	
		15G614	B. W.			07/13/	72021
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
VOCA CORPORATION OF INDIANA				ASTLETON BLVD APOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		and assigned specific garding the CORF's					
		vithin 2 weeks of their first					
		ning program must include					
	1	ocation and use of alarm					
	systems and signa	als and firefighting					
	equipment.						
	(v) If the emergency preparedness policies						
	and procedures are significantly updated, the						
	policies and proce	uct training on the updated					
	policies and proce	duics.					
	*[For CAHs at §48	35.625(d):] (1) Training					
	program. The CAH must do all of the						
	following:						
		n emergency preparedness					
		edures, including prompt					
	reporting and exti	nguisning of fires, nere necessary, evacuation					
	-	nnel, and guests, fire					
		ooperation with firefighting					
	-	orities, to all new and					
		viduals providing services					
	under arrangemei	nt, and volunteers,					
		eir expected roles.					
	1 ' '	ency preparedness training					
	at least every 2 ye	ears. mentation of the training.					
	, ,	staff knowledge of					
	emergency proce	_					
		ncy preparedness policies					
	` '	re significantly updated, the					
		ct training on the updated					
	policies and proce	edures.					
	*[For CMHCs at 8	485.920(d):] (1) Training.					
	-	provide initial training in					
		redness policies and					
	-	new and existing staff,					
	individuals providi	ng services under					

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Facility ID: 010453

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MUI A. BUI B. WIN	LDING	NSTRUCTION	(X3) DATE COMPI 07/13	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	their expected role documentation of must demonstrate emergency proces. CMHC must provipreparedness trail Based on record revisite to emergency preparedness. The IC following: (i) Provipreparedness polici and existing staff, in under arrangement, with their expected preparedness trainin (iii) Maintain documentate staff k procedures in accord (1). This deficient p	the training. The CMHC is staff knowledge of dures. Thereafter, the de emergency ning at least every 2 years. View and interview, the facility if received training in regards redness policies and interview and volunteers, consistent roles; (ii) Provide emergency and at least every two years; mentation of the training; (iv) mowledge of emergency dance with 42 CFR 483.475(d) practice could affect all "Emergency/Disaster al: Castleton" documentation "Emergency, Disaster, and Responses" documentation in the Maintenance Aide during 9:25 a.m. to 10:45 a.m. on ylacked documentation of staff regency preparedness plan ent two year period. Based on e of record review, the	E 003	37	CORRECTION: The facility must have a train program on place with (i) Inititating in emergency preparedness policies and procedures to all and existing staff, individuals providing on-site services und arrangement, and volunteers consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training Demonstrate staff knowledge emergency procedures. Specifically, the facility will pran emergency preparedness training in emergency preparedness training program that includes following. Initial training in emergency preparedness poland procedures to all new an existing staff, individuals provide services under arrangement, volunteers, consistent with the expected roles; and provide emergency preparedness trait least annually; and maintaid documentation of the training demonstrate staff knowledge emergency procedures.	der der dist dist dividing and eir dining in grand	08/12/2021

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PRINTED: 08/04/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814 STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256 ID PROVIDER SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION This finding was reviewed with the Maintenance Aide during the exit conference. INDIANAPOLIS AND PROVIDER STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256 ID PROVIDERS PLAN OF CORRECTION (CASTLETON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG 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	CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039		
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA INDIANAPOLIS, IN 46256 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION This finding was reviewed with the Maintenance Aide during the exit conference. Aide during the exit conference. STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256 (X5) PREFIX PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE 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	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG This finding was reviewed with the Maintenance Aide during the exit conference. STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256 (X5) PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 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	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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			15G814	B. W	ING		07/13	/2021	
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	NAME OF F VOCA CO (X4) ID PREFIX	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIEF ORPORATION OF SUMMARY (EACH DEFICIEN REGULATORY OF	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814 INDIANA STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Viewed with the Maintenance	A. BU	STREET A 8307 CA INDIAN ID PREFIX	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD IAPOLIS, IN 46256 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPED DEFICIENCY) The QIDP Manager will work the agency Training Coordin develop a specific emergency preparedness curriculum, including competency testing will be presented during new orientation as will be include the operation's annual retrain requirements. Development curriculum is in progress and be completed by 8/12/21. PREVENTION: Members of the Operations (comprised of the Operations Managers, Program Managers)	(X3) DATE COMPI 07/13 ERATE (with ator to c) g, that y-hire d in ning of the d will Team s	SURVEY LETED //2021 (X5) COMPLETION	
Operations Team, Regional Director	E 0039	403.748(d)(2), 41	6.54(d)(2), 418.113(d)(2),			CORRECTIONS COMPLETE BY: 8/12/21	ĒD		

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Bldg. --

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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED		
		15G814	B. W	ING		07/13	/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ASTLETON BLVD			
VOCA C	ORPORATION OF	INDIANA	_		APOLIS, IN 46256			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	. , , , ,	.727(d)(2), 485.920(d)(2),						
	, , , ,	1.12(d)(2), 494.62(d)(2)						
	EP Testing Requirements							
		18.113(d)(2), §441.184(d)(2),						
		82.15(d)(2), §483.73(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).							
	(2), 8491.12(a)(2)	, 3454.02(u)(z).						
	*[For ASCs at §41	l6.54, CORFs at §485.68,						
	OPO, "Organization	ons" under §485.727,						
	CMHCs at §485.9	20, RHCs/FQHCs at						
	§491.12, and ESF	RD Facilities at §494.62]:						
	(2) Testing. The [f	acility] must conduct						
		he emergency plan						
		ility] must do all of the						
	following:	,,						
	(i) Participate in a	full-scale exercise that is						
	community-based							
	1	nunity-based exercise is						
	1 ' '	onduct a facility-based						
		e every 2 years; or						
		ility] experiences an actual						
	, , -	ade emergency that requires						
		mergency plan, the [facility]					1	
		gaging in its next required						
	-	or individual, facility-based					1	
	1	e following the onset of the						
	actual event.	-						
	(ii) Conduct an ad	ditional exercise at least						
	1 ' '	posite the year the full-scale						
	or functional exerc	cise under paragraph (d)(2)						
	(i) of this section is	s conducted, that may						
	include, but is not	limited to the following:						
	(A) A second full-s	scale exercise that is						
	community-based	or individual, facility-based						
	functional exercise	e; or						
	(B) A mock disast	er drill: or					1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BUILDING B. WING			COMPLETED 07/13/2021		
NAME C	F PROVIDER OR SUPPLIEF	?			DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
VOCA	CORPORATION OF	INDIANA		INDIANA	APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ΛTE	(X5) COMPLETION DATE
	(C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an elementary (iii) Analyze the [famaintain document exercises, and enthe [facility's] emethe [faci	ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. acility's] response to and nation of all drills, tabletop nergency events, and revise ergency plan, as needed. 418.113(d):] sepices that provide care in e. The hospice must so to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not let an individual facility exercise every 2 years; or experiences a natural or lency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. dditional exercise every 2 le year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based e; or					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G814		(X2) MULT A. BUILI B. WING			(X3) DATE : COMPL 07/13/	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
TAG	led by a facilitator discussion using a clinically-relevant set of problem star messages, or pre to challenge an er (3) Testing for hos care directly. The exercises to test to per year. The hos (i) Participate in a that is community (A) When a community (A) When a community (B) If the hospice man-made emergency exempt from engage full-scale community functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop extenditator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan.	and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual ctional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required hity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared		AG	DEFICIENCY		DATE	
		ntation of all drills, tabletop nergency events and revise						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/13/2021		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	` ·	R LSC IDENTIFYING INFORMATION			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
TAG	*[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu facility-based func (B) If the [PRTF, I an actual natural of that requires activ plan, the [facility] i its next required fro or individual, facili following the onse (ii) Conduct a exercise or and the limited to the follor (A) A second full- community-based facility-based func (B) A mo (C) A tabletop is led by a facilitat discussion, using clinically-relevant set of problem star messages, or pre- to challenge an er (iii) Analyze the	ergency plan, as needed. 441.184(d), Hospitals at a sat §485.625(d):] PRTF, Hospital, CAH] must at to test the emergency ar. The [PRTF, Hospital, a following: an annual full-scale exercise abased; or annual individual, actional exercise; or Hospital, CAH] experiences for man-made emergency attion of the emergency attion of the emergency attion of the emergency attion of the emergency attional exercise at of the emergency event. In [additional] annual ant may include, but is not wing: I actional exercise that is a or individual, a citional exercise; or a ck disaster drill; or a exercise or workshop that to and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed		TAG	DEFICIENCY		DATE	
	•	s, and emergency events cility's] emergency plan, as						

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		IDENTIFICATION NUMBER 15G814	A. BUILDING B. WING		COMPI 07/13	LETED
NAME O	F PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP COD		
VOCA	CORPORATION OF	INDIANA	INDIANAPOLIS, IN 46256			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	B	(X5) COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE
	conduct exercises plan at least annuorganization musti (i) Participate in a that is community (A) When a community-based functional exercises of the emer (ii) Conduct a 2 years opposite functional exercise of this section is community-based functional exercise of the exempt from error (ii) Conduct a 2 years opposite functional exercise of this section is community-based functional exercise of this section is community-based functional (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the Finaintain documel exercises, and en	PACE organization must a to test the emergency cally. The PACE and the following: an annual full-scale exercise abased; or cally the pace of the tot an annual individual, and the pace of				

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 07/13/2021
	PROVIDER OR SUPPLIE		8307	ET ADDRESS, CITY, STATE, Z 7 CASTLETON BLVD IANAPOLIS, IN 46256	ZIP COD
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO	ON SHOULD BE COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENC	
	_ ` ' -	lity] must conduct exercises			
	_	ency plan at least twice per nannounced staff drills using			
	1 -	-			
	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				
		nunity-based exercise is not			
		uct an annual individual,			
	facility-based fun				
	· ·	cility] 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				
	1	-based functional exercise			
	-	et of the emergency event.			
	_	additional annual exercise			
	1 ' '	but is not limited to the			
	following:				
	(A) A second ful	l-scale exercise that is			
	community-base	d or an individual, facility			
	based functional	exercise; or			
	(B) A mock disas	ster drill; or			
	(C) A tabletop ex	xercise or workshop that is			
	led by a facilitato	r includes a group			
	discussion, using	յ a narrated,			
	clinically-relevant	t emergency scenario, and a			
		atements, directed			
		epared questions designed			
	to challenge an e				
	. ,	[LTC facility] facility's			
	response to and maintain documentation of				
		exercises, and emergency			
	1	e the [LTC facility] facility's			
	emergency plan,	as needed.			
	***************************************	2400 475/-13			
	*[For ICF/IIDs at	- ' '-			
		ICF/IID must conduct			
	exercises to test	the emergency plan at least			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BUILDING B. WING			COMPLETED 07/13/2021	
NAME OF P	ROVIDER OR SUPPLIEF			T ADDRESS, CITY, STATE, ZIP COD CASTLETON BLVD		
VOCA CO	ORPORATION OF	INDIANA		ANAPOLIS, IN 46256		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE	: IIATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION LE ICF/IID must do the	TAG	DEFICIENCY)		DATE
	following: (i) Participate in all that is community. (A) When a community. (A) When a community. (B) If the ICF/IID enatural or man-manactivation of the eis exempt from enfull-scale communifacility-based functionset of the emergian Conduct an adthat may include, following:	n annual full-scale exercise -based; or nunity-based exercise is not lect an annual individual, etional exercise; or. experiences an actual lade emergency that requires mergency plan, the ICF/IID ligaging in its next required lity-based or individual, etional exercise following the ligency event. ditional annual exercise but is not limited to the				
	community-based facility-based function (B) A mock disast (C) A tabletop excelled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an er (iii) Analyze the IC maintain documer exercises, and em the ICF/IID's emeritation of th	etional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. CF/IID's response to and atation of all drills, tabletop mergency events, and revise rgency plan, as needed. 34.102]				
	exercises to test the least annually. The following:	e HHA must conduct he emergency plan at e HHA must do the full-scale exercise that is ; or				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		15G814	B. W	ING		07/13	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	t .			ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	, ,	ommunity-based exercise					
		conduct an annual					
	-	based functional exercise					
	every 2 years; or.						
	, ,	A experiences an actual					
		ade 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						
		•					
		limited to the following:					
	, ,	full-scale exercise that is					
	community-based						
	facility-based fund						
	, ,	isaster drill; or					
	, ,	exercise or workshop that					
	-	or and includes a group					
	discussion, using						
	· ·	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	i ile i ina s emerge	ency plan, as needed.					
	*[For OPOs at §48	-					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the	following:					
	(i) Conduct a pape	er-based, tabletop exercise					
	or workshop at lea	ast annually. A tabletop					
	exercise is led by	a facilitator and includes a					
	group discussion, using a parrated, clinically						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BUILDING B. WING		COMPLETED 07/13/2021	
	ROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	problem statement prepared question emergency plan. It actual natural or marequires activation OPO is exempt from required testing exporting of the emergency (ii) Analyze the OF maintain document exercises, and emathe [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paper at least annually. Agroup discussion In narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain document exercises, and emathe RNHCl's emertication.	PO's response to and tation of all tabletop ergency events, and revise OPO's] emergency plan, as a 2.748]: RNHCI must conduct the emergency plan. The efollowing: A tabletop exercise is a ed by a facilitator, using a crelevant emergency et of problem statements, as, or prepared questions ange an emergency plan. IHCI's response to and tation of all tabletop ergency events, and revise gency plan, as needed.		CODDECTION	00/12/2021
	failed to conduct at emergency plan on a emergency procedur do all of the followi exercise that is com community-based ex individual, facility-based experiences an actual	iew and interview, the facility least two exercises to test the an annual basis using the res. The ICF/IID facility must ng: (i) participate in a full-scale munity-based or when a xercise is not accessible, an based. If the ICF/IID facility al natural or man-made tires activation of the	E 0039	CORRECTION: The [facility] must conduct exercises to test the emergency plan at least annually. Specific the agency's Quality Assurance Department has submitted a formal request to the Indianap Metropolitan Police Department/Department of Homeland Security Community	cally, ce olis

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/13/2021			
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	TAG	emergency plan, the engaging in a comm facility-based full-s following the onset conduct an addition but is not limited to full-scale exercise to individual, facility-but that includes a grout facilitator, using a remergency scenarios statements, directed questions designed plan; (iii) analyze thand maintain docume exercises, and emer ICF/IID facility's eraccordance with 42 deficient practice compared from the properties of the emergency prepagreed the facility has community based displayed and comm	e ICF/IIC facility is exempt from nunity-based or individual, cale exercise for 1 year of the actual event; (ii) al exercise that may include, the following: (A) a second that is community-based or based. (B) a tabletop exercise p discussion led by a narrated, clinically-relevant to challenge an emergency ne ICF/IID facility's response to nentation of all drills, tabletop gency events, and revise the mergency plan, as needed in CFR 483.475(d)(2). This build affect all occupants. "Emergency/Disaster al: Castleton" documentation "Emergency, Disaster, and Responses" documentation in the Maintenance Aide during 9:25 a.m. to 10:45 a.m. on tation of a community based the most recent twelve month lable for review. Based on the of record review, the negreed the facility is currently used natural emergency due to disposite or the pandemic are stated in aredness documentation but has not conducted a second is aster drill or conducted a fithin the most recent twelve			Emergency Response Team (CERT) to conduct an initial "ta talk" disaster exercise, with bi-annual exercises thereafter. Additionally the ResCare Qual Assurance Department has requested assistance from the IMPD District Commander to coordinate with CERT to facilit this process. ResCare Facility supervisors, the QIDP and administrative level manageme (Operations Managers, Progra Managers, Quality Assurance Manager, QIDP Manager, Qua Assurance Coordinators, Nurs 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 the Emergency Preparedness Plan during the 2020-2021 COVID-19 epidemic, by 8/12/2 using the current state of emergency as a platform. At the time of this exercise, a "table to exercise will be scheduled with local emergency management officials within 6 months of the full-scale event. PREVENTION: Members of the Operations Tea (comprised of the Executive Director, Operations Managers Program Managers, Area	able ity ate ent ality e e and ality e e and	DATE

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 15G814	A. BUILDING B. WING		COMPLETED 07/13/2021
	ROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD	
VOCA C	ORPORATION OF I	NDIANA	INDIAN	IAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	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, QID Quality Assurance Coordinator Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emerge preparedness program into scheduled twice monthly audit assure all required component including but not limited to bi-annual community-based disaster exercises, are present Additionally, the agency Safety Committee will review and review plan as needed but no less than annually. RESPONSIBLE PARTIES: QII Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	te ency s to ss, t. / ise
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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		15G814	B. W	ING		07/13/	/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER			8307 CA	ASTLETON BLVD			
	ORPORATION OF I	NDIANA		INDIANAPOLIS, IN 46256				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
	,) 101, Life Safety Code (LSC), g Residential Board and Care						
	Occupancies.	g Residential Board and Care						
	Occupancies.							
	This one story build	ling was determined to be fully						
	-	cility has a fire alarm system						
	with smoke detection in corridors and all living							
	areas. The facility l	nas smoke detectors hard wired						
		tem 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							
	lacinty i rompt with	ran E-Score of 0.1.						
	Quality Review con	npleted on 07/20/21						
K S362	NFPA 101							
	Corridors - Constr	uction of Walls						
Bldg. 01	Corridors - Constr	uction of Walls						
	2012 EXISTING (F	Prompt)						
		indicated below, corridor						
	walls shall meet al	•						
		ng sleeping rooms have a						
		fire resistance rating,						
		ed to be achieved if the						
	· -	hed on both sides with lath						
		erials providing a 15-minute						
	thermal barrier.	doors are substantial						
		ose of 1-3/4 inch thick,						
		d-core construction or other						
		ual or greater stability and						
	fire integrity.	J. g. 22.31 Stability and						
		els are fixed fire window						
	•	ordance with 8.3.4 or are						
		ceeding 9 square feet each						
	-	ed in approved frames.						
							ī	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDII	NG	01	COMPL	
		15G814	B. WING			07/13/	/2021
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
VOCA C	ORPORATION OF	INDIANA			ASTLETON BLVD APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE
		shall not apply to corridor					
		oke partitions in accordance					
		are protected by automatic					
	l .	dance with 33.2.3.5 on					
		vall and door. In such					
		hall be no limitation on the					
	type or size of gla						
		tion facilities, all sleeping					
	rooms shall be separated from the escape route by smoke partitions in accordance with						
	8.2.4.						
		ments that are not located in					
		nall be permitted for					
	nonresident staff members, provided that the						
		arm in the sleeping area is					
		en staff that might be					
	sleeping.	G					
	In previously appr	oved facilities, where the					
	group achieves ar	E-score of three or less					
	using the board ar	nd care methodology of					
	NFPA 101A, Guid	e on Alternative					
		e Safety, sleeping rooms					
		d from escape routes by					
		at are smoke resistant.					
	33.2.3.6						
		on and interview, the facility	K S362		CORRECTION:		08/12/2021
		ridor doors to 1 of 4 client			Sleeping room doors are		
		/4 inch thick, solid-bonded			substantial doors, such as the		
		tion or other construction of pility and fire integrity and			of 1-3/4 inch thick, solid-bonde		
		sage of smoke. This deficient			wood-core construction or oth construction of equal or greate		
		t all clients, staff and visitors.			stability and fire integrity and r		
	practice could affect	t an enems, start and visitors.			be capable of resisting smoke		
	Findings include:				at least 1/2 hour. Specifically,		
	Based on observations with the Maintenance				facility will replace the door to		
					bedroom #3 with a door with	1-3/4	
		of the facility from 10:45 a.m. to			inch thick, solid-bonded wood-		
	_	3/21, a two inch in diameter hole			construction or other construction		
		rridor door on the corridor side			of equal or greater stability and		
		of the door to Bedroom #3 which did not ensure			integrity that will withstand the		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE (A. BUILDING B. WING	O1	X3) DATE SURVEY COMPLETED 07/13/2021				
	PROVIDER OR SUPPLIER		8307	STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE				
	wood-core constructed equal or greater stable would resist the pass was in the fully closs Based on interview observations, the Mole in the corridor ensure the door was solid-bonded wood-construction of equal integrity and would smoke.	aintenance Aide agreed the door to Bedroom #3 did not 1-3/4 inch thick, core construction or other al or greater stability and fire not resist the passage of viewed with the Maintenance		passage of smoke. PREVENTION: The QIDP Manager will retrain members of the Operations Tecomprised 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 Tea will conduct reviews of the homenvironment no less than mont to assure compliance with life safety code requirements. RESPONSIBLE PARTIES: QID Area Supervisor, Residential Manager, Environmental Service Team, Direct Support Staff, Operations Team, Regional Director	o, im ne thly				
K S511	NFPA 101 Utilities - Gas and	Electric							
Bldg. 01	complies with NFF Code, electrical with NPF Code. 32.2.5.1, 33.2.5.1, Based on observation failed to ensure electroms were pro- accordance with NFF	gas or related gas piping PA 54, National Fuel Gas iring and equipment FA 70, National Electric	K S511	CORRECTION: Electrical wiring and equipment complies with NPFA 70, Nation Electric Code. Specifically, The facility will repair the damaged	nal				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/13/2021				
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE		
	requires electrical with NFPA 70, Nat 70, 2011 Edition at Requirements state located in branch c III of Article 210. requirements shall through (F). (A) Grounding Typand 20-ampere brangrounding type. Grounding-type reconcircuits of the which they are rate 210.21(B)(2) and Texception: Nongroinstalled in accorda (B) To Be Groundeconnectors that have conductor contacts connected to an equexception No. 1: R and vehicle-mounte with 250.34. Exception No. 2: R permitted by 406.4 (C) Methods of Gragrounding conductor connectors shate to the equipment goircuit supplying the The branch-circuit provide an equipment which the equipment contacts of the recent connected. Informational Note acceptable grounding rounding conductions of the recent connected.	wiring and equipment to comply tional Electrical Code. NFPA 406.4 General Installation is receptacle outlets shall be incuits in accordance with Part General installation is in accordance with 406.4(A) be. Receptacles installed on 15-min circuits shall be installed on 15-min circuits shall be installed only obtage class and current for individual distriction of the captacles and current for individual distriction of the captacles and current for individual distriction of the captacles and cord in the captacles and conductor. In the captacles are captacles and cord in the captacles and cord in the captacles and cord in the captacles and captacles and cord in the captacles and capt			electrical outlet receptacles in small bathroom and laundry ropreventions: Members of the Operations Te (comprised of the Executive Director, Operations Managers Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDQuality Assurance Coordinato Nurse Manager and Assistant Nurse Manager) will incorporavisual observations of the facil electrical outlets into schedule monthly audits to assure they in good repair and properly grounded. RESPONSIBLE PARTIES: QII Area Supervisor, Residential Manager, Contracted Environmental Services Staff, Operations Team	eam es, ee PP, rs, ate ity's d aare			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		ì í	ILDING	nstruction 01	(X3) DATE COMPL 07/13/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
VOUAC	ON ONATION OF	INDIANA		INDIAN				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	This deficient pract staff.	ice could affect one client and						
	Findings include:							
	Aide during a tour of 11:05 a.m. on 07/13 the wall mounted of small bathroom in thave an "open grous Industries UL listed Based on interview observations, the M testing device show electrical receptacles."	aintenance Aide agreed the ed the aforementioned es needed repair.						
K S712	NFPA 101							
Bldg. 01	least quarterly for under varied cond a. Ensure that a trained to perform b. Ensure that a familiar with the usemergency and diprocedures. 2. The facility muse. Actually evacone drill each year b. Make special evacuation of client disabilities; c. File a report a	Il personnel on all shifts are assigned tasks; Il personnel on all shifts are se of the facility's saster plans and st: uate clients during at least r on each shift; provisions for the						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUII	a. Building <u>01</u>		COMPLETED	
15G814		15G814	B. WIN	B. WING 07/			/2021
<u> </u>				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ASTLETON BLVD		
VOCA CORPORATION OF INDIANA					IAPOLIS, IN 46256		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	drills, including ac	cidents and take corrective					
	action; and						
	_	ills, clients may be					
		fe area in facilities certified					
		Care Occupancies Chapter					
	of the Life Safety						
		meet the requirements of					
		and (2) of this section for					
		ief staff that they utilize.					
	42 CFR 483.470(i	,	17.07	10	CORRECTION		00/12/2021
		view and interview, the facility	K S7	12	CORRECTION:		08/12/2021
	failed to provide documentation of a fire drill				The facility must hold evacuat		
	conducted on the second shift for 1 of 4 quarters. This deficient practice affects all clients, staff and				drills at least quarterly for each shift of personnel and under v		
	visitors.	dee affects aff chefits, staff and			conditions. Specifically, the fa		
	VISITOIS.				will conduct additional evacua	-	
	Findings include:				drills on the each shift during t		
	i manigs metade.				current quarter.	ii iC	
	Based on review of "Emergency Evacuation Drill: Fire" documentation with the Home Manager and				PREVENTION:		
					Professional staff will be retrain	ined	
		ide during record review from			regarding the need to conduct		
		a.m. on 07/13/21, documentation			evacuation drills at varied time		
		cted on the second shift in the			each shift for all staff each qua		
	first quarter (Januar	ry, February, March) 2021 was			Training will also focus on pro		
	not available for re-	view. Based on interview at the			completion of evacuation drill		
	time of record revie	ew, the Home Manager stated			forms and assessment of		
		s two shifts per day, additional			individual drill compliance. The	е	
		ation was not available for			Operations (comprised of the		
		documentation of a fire drill			Executive Director, Operations		
		econd shift in the first quarter			Managers, Program Managers	S,	
	2021 was not availa	able for review.			Area Supervisors, Quality		
					Assurance Manager, QIDP		
		viewed with the Maintenance			Manager, QIDP, Quality		
	Aide during the exi	t conference.			Assurance Coordinators, Nurs		
					Manager and Assistant Nurse		
					Manager) will review and track		
					facility evacuation drill reports		
					follow up with professional sta		
					needed to assure drills occur		
		1		scheduled and follow up with t	ıne		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/13/2021			
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				agency Safety Committee accordingly. Responsible Parties: Environmental Services Tean Area Supervisor, Residential Manager, Direct Support Staf QIDP, Operations Team			
K S741 Bldg. 01	administration of be occupancies. When noncombustible sareceptacles shall be locations. 32.7.4.1, 32.7.4.2. Based on observation failed to ensure smooth into ashtrays and me self-closing covered can be emptied of nearly safe design in 1 of the s	ons shall be adopted by the board and care ere smoking is permitted, afety type ashtrays or pe provided in convenient 33.7.4.1, 33.7.4.2 on and interview, the facility oking materials were deposited etal containers with evices into which ashtrays oncombustible material and outdoor areas where smoking deficient practice could affect visitors. ons with the Home Manager e Aide during a tour of the a.m. to 11:05 a.m. on 07/13/21, a dispensing cigarette butts was atto outside the facility. In pen top ashtray was filled with table near the smoking tower.	K S741	CORRECTION: Smoking regulations shall be adopted by the administration board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall provided in convenient locatic Specifically, the facility will propose a container for the designated smoking area and non-covere potentially combustible ashtrawill be removed and properly disposed of. Additionally, staff supervisors will be retrained toward proper implementation the facility smoking policy. PREVENTION: Members of the Operations T	be ons. ovide h ed, ay f and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		<u>01</u>	(X3) DATE SURVEY COMPLETED 07/13/2021		
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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, QIDF Area Supervisors, Executive Director, Program Managers, Assistant Nurse Manager, and Nurse Manager) will incorpora reviews of the home environm including designated smoking areas into scheduled monthly audits to assure clients and sta smoke in the designated area follow the facility's smoking po including disposal of cigarette butts in covered, non-combust containers. RESPONSIBLE PARTIES: QII Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	te ent, aff and licy, ible DP,	

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