DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED
OMB NO. 0938-039

MAIL OF PROVIDER OR SUPPLIER STREET ADDRESS, CTY, STAT, 2P COD BIO VOCA CORPORATION OF INDIANA SUMMARY STATEMENT OF DEPICIENCIE (ACH DEPICENCY MOST BE REACED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION ID PREFIX (CACH DEPICENCY MOST BE REACED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION ID PREFIX (CACH DEPICENCY MOST BE REACED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION ID PREFIX (CACH DEPICENCY MOST BE REACED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION ID PREFIX (CACH DEPICENCY MOST BE REACED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION ID PREFIX (CACH DEPICENCY MOST BE REACED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION ID PREFIX (CACH DEPICENCY MOST BE REACED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION ID PREFIX (CACH DEPICENCY (CACH DEPICENCY MOST BE REACED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION (CACH DEPICENCY (CACH DEPICENCY MOST BE REACED BY FULL REGILATORY OR LSC IDENTIFYING INFORMATION ID PREFIX (CACH DEPICENCY (CACH D		IT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G814	` <i>´</i>	ILDING	NSTRUCTION	(X3) DATE COMPI 12/21	LETED
PRETX TAG (FACH DEFICIENCY MUST RE PRECEDED N FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFX Interconstruction of the APPROPRATE COMMETTION CONSTRUCTION OF COMMETTION COMMETTICA CO					8307 CA	ASTLETON BLVD		
An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.E 0000Survey Date: 12/21/22Facility Number: 010433 Provider Number: 15G814 AIM Number: 201408320	PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §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)	Bldg E 0037	conducted by the In accordance with 42 Survey Date: 12/2 Facility Number: 0 Provider Number: 201 At this Emergency Corporation of Ind compliance with E Requirements for M Participating Provi 483.475. The facility has 8 c certified for Medic the census was 7. Quality Review coo The requirement at NOT MET as evid 403.748(d)(1), 41 441.184(d)(1), 48	ndiana Department of Health in 2 CFR 483.475. 1/22 010453 15G814 408320 Preparedness survey, Voca iana Inc was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR ertified beds. All 8 beds are aid. At the time of the survey, mpleted on 12/22/22 42 CFR, Subpart 483.475 is enced by: 6.54(d)(1), 418.113(d)(1), 2.15(d)(1), 483.475(d)(1), .102(d)(1), 485.625(d)(1),	E 00	00			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		486.360(d)(1), 49 EP Training Prog §403.748(d)(1), § §441.184(d)(1), § §483.73(d)(1), §4 §485.68(d)(1), §4 (1), §485.920(d)(1.12(d)(1) ram 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 83.475(d)(1), §484.102(d)(1), 485.625(d)(1), §485.727(d) 1), §486.360(d)(1),					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATOR		IIILE	(X6) DATE
Robert Morris	QIDP Manager		01/06/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ENT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G814	A. B	UILDING /ING	NSTRUCTION	CO	ATE SURVEY MPLETED /21/2022
	PROVIDER OR SUPPLIE			8307 C/	ADDRESS, CITY, STATE, ZIP ASTLETON BLVD APOLIS, IN 46256	COD	
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TAG	§491.12(d)(1).	OR LSC IDENTIFYING INFORMATION		TAG			DATE
	Hospitals at §48: HHAs at §484.10 §485.727, OPOs at §491.12:] (1) Training pro- all of the followin (i) Initial training policies and pro- existing staff, inc under arrangeme consistent with th (ii) Provide emer at least every 2 y (iii) Maintain doc preparedness tra (iv) Demonstrate emergency pro- (v) If the emerge and procedures [facility] must con updated policies *[For Hospices at The hospice mus (i) Initial training policies and pro- existing hospice providing service consistent with th (ii) Demonstrate emergency pro- (iii) Provide emer at least every 2 y (iv) Periodically r emergency prep employees (inclu	in emergency preparedness cedures to all new and lividuals providing services ent, and volunteers, heir expected roles. gency preparedness training years. umentation of all emergency aining. e staff knowledge of edures. ncy preparedness policies are significantly updated, the nduct training on the and procedures. et §418.113(d):] (1) Training. st do all of the following: in emergency preparedness cedures to all new and employees, and individuals es under arrangement, heir expected roles. staff knowledge of edures. rgency preparedness training					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CO A. BUILDING B. WING		COM	te survey ipleted 2 1/2022
	PROVIDER OR SUPPLIE		8307 C	ADDRESS, CITY, STATE, ZIP CO ASTLETON BLVD JAPOLIS, IN 46256	D	
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	and others. (v) Maintain docu preparedness tra (vi) If the emerge and procedures in hospice must co- updated policies procedures. *[For PRTFs at § program. The PF following: (i) Initial training policies and proce- existing staff, include under arrangeme consistent with th (ii) After initial tra- preparedness tra (iii) Demonstrate emergency proce- (iv) Maintain doc- preparedness tra (v) If the emerge- and procedures in PRTF must conc- policies and proce- *[For PACE at §4 organization mus- (i) Initial training policies and proce- existing staff, include and procedures in policies and proce- *[For PACE at §4 organization mus- (i) Initial training policies and proce- existing staff, include services under and participants, and their expected ro- (ii) Provide emer- at least every 2 y	ency preparedness policies are significantly updated, the nduct training on the and 441.184(d):] (1) Training RTF must do all of the in emergency preparedness cedures to all new and lividuals providing services ent, and volunteers, neir expected roles. staff knowledge of edures. umentation of all emergency aining. ncy preparedness policies are significantly updated, the luct training on the updated cedures. 460.84(d):] (1) The PACE at do all of the following: in emergency preparedness cedures to all new and lividuals providing on-site rrangement, contractors, volunteers, consistent with les. gency preparedness training				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 12/21/2022 15G814 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8307 CASTLETON BLVD VOCA CORPORATION OF INDIANA INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 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 XQ4921 Facility ID: 010453 Page 4 of 21 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G814	(X2) MULTIPLE CC A. BUILDING B. WING		COM 12/2	te survey ipleted 21/2022
	PROVIDER OR SUPPLI		8307 C/	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
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	systems and sig equipment. (v) If the emerg and procedures CORF must cor policies and pro *[For CAHs at § program. The C following: (i) Initial training policies and pro reporting and ex protection, and of patients, pers prevention, and and disaster aut existing staff, in- under arrangem consistent with f (ii) Provide eme at least every 2 (iii) Maintain doo (iv) Demonstrate emergency proc (v) If the emerg and procedures CAH must cond policies and pro *[For CMHCs at The CMHC must emergency prep procedures to a individuals prov arrangement, at their expected r	485.625(d):] (1) Training AH must do all of the in emergency preparedness cedures, including prompt tringuishing of fires, where necessary, evacuation connel, and guests, fire cooperation with firefighting thorities, to all new and dividuals providing services tent, and volunteers, their expected roles. rgency preparedness training years. cumentation of the training. e staff knowledge of cedures. gency preparedness policies are significantly updated, the uct training on the updated				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 12/21/2022 15G814 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8307 CASTLETON BLVD VOCA CORPORATION OF INDIANA INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility E 0037 CORRECTION: 01/20/2023 failed to ensure staff received training in regards The facility must have a training to emergency preparedness policies and program on place with (i) Initial procedures. The ICF/IID facility must do all of the training in emergency following: (i) Provide initial training in emergency preparedness policies and preparedness policies and procedures to all new procedures to all new and existing and existing staff, individuals providing services staff, individuals providing on-site under arrangement, and volunteers, consistent services under arrangement, and with their expected roles; (ii) Provide emergency volunteers, consistent with their preparedness training at least every two years; expected roles. (ii) Provide (iii) Maintain documentation of the training; (iv) emergency preparedness training Demonstrate staff knowledge of emergency at least annually. (iii) Maintain procedures in accordance with 42 CFR 483.475(d) documentation of the training. (iv) (1). This deficient practice could affect all Demonstrate staff knowledge of occupants. emergency procedures. Specifically, the facility will provide Findings include: an emergency preparedness training program that includes the Based on review of "Emergency/Disaster following. Initial training in Preparedness Manual" documentation dated emergency preparedness policies 07/25/22 and "Emergency, Disaster, Evacuation and procedures to all new and Plans and Responses" documentation dated existing staff, individuals providing 07/01/22 with the Maintenance Aide during record services under arrangement, and review from 10:20 a.m. to 11:25 a.m. on 12/21/22, volunteers. consistent with their the facility lacked documentation of staff training expected roles; and provide on the emergency preparedness plan within the emergency preparedness training most recent two year period. Based on interview at least annually; and maintain at the time of record review, the Maintenance documentation of the training; and Aide stated staff training documentation on demonstrate staff knowledge of emergency preparedness policies and procedures emergency procedures. Facility within the most recent two year period was not Specific Emergency Preparedness available for review at the time of the survey. Training has been added to new hire On-the-Job Training This finding was reviewed with the Maintenance curriculum and Area Supervisors Aide during the exit conference. and the QIDP will be responsible for providing annual retraining as well as training when the plan is XQ4921 Event ID: Facility ID: 010453 If continuation sheet Page 6 of 21 FORM CMS-2567(02-99) Previous Versions Obsolete

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MUL A. BUII B. WIN	DING	DNSTRUCTION	СОМ	e survey pleted 1/2022
	PROVIDER OR SUPPLIE			8307 C	ADDRESS, CITY, STATE, ZIP CO ASTLETON BLVD	D	
VOCA C	ORPORATION OF	INDIANA		INDIAN	IAPOLIS, IN 46256		
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E 0039 Bldg	441.184(d)(2), 48 483.73(d)(2), 48 485.68(d)(2), 485 486.360(d)(2), 48 EP Testing Requ	16.54(d)(2), 418.113(d)(2), 32.15(d)(2), 483.475(d)(2), 32.15(d)(2), 483.475(d)(2), 32.15(d)(2), 485.625(d)(2), 32.727(d)(2), 485.920(d)(2), 32.727(d)(2), 485.920(d)(2), 32.12(d)(2), 494.62(d)(2), 33.12(d)(2), §441.184(d)(2),			updated. The QIDP Manager will the Human Resources T facility management to or reproducible system, to implemented 1/1/2023 to training documentation to regulatory agencies. PREVENTION: Members of the Operation (comprised of the Execu- Director, Operations Ma Program Managers, Are Supervisors, Quality Ass Manager, QIDP Manage Quality Assurance Coor and Nurse Manager) will incorporate reviews of the emergency preparedness into scheduled twice mo audits to assure all requi- components are present Additionally, the agency Committee will review at the plan as needed but of than annually. RESPONSIBLE PARTIE Area Supervisor, Direct Lead, Safety Committee Resources Department, Operations Team, Regio Director	Team and develop a be o provide to ons Team utive nagers, ea surance er, QIDP, dinators, l ne facility's ss program onthly ired t. Safety nd revise no less ES: QIDP, Support e, Human	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G814	(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/21/2022
	PROVIDER OR SUPPLI		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD IAPOLIS, IN 46256)
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	§460.84(d)(2), § §483.475(d)(2), §485.625(d)(2),	482.15(d)(2), §483.73(d)(2), §484.102(d)(2), §485.68(d)(2), §485.727(d)(2), §485.920(d) 2), §494.62(d)(2).			
	OPO, "Organiza CMHCs at §485	416.54, CORFs at §485.68, tions" under §485.727, .920, RHCs/FQHCs at SRD Facilities at §494.62]:			
	exercises to test	[facility] must conduct the emergency plan acility] must do all of the			
	community-base (A) When a com not accessible, of functional exerci (B) If the [fa natural or man-r	a full-scale exercise that is ed every 2 years; or munity-based exercise is conduct a facility-based ise every 2 years; or icility] experiences an actual made emergency that requires			
	is exempt from e community-base functional exerci actual event.	emergency plan, the [facility] engaging in its next required ed or individual, facility-based ise following the onset of the additional exercise at least			
	every 2 years, o or functional exe (i) of this section include, but is ne (A) A second ful	pposite the year the full-scale ercise under paragraph (d)(2) i is conducted, that may ot limited to the following: I-scale exercise that is			
	functional exerci (B) A mock disa (C) A tabletop et led by a facilitate	ster drill; or xercise or workshop that is or and includes a group			
	discussion using clinically-relevar	a narrated, It emergency scenario, and a			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G814	(X2) MULTIPLE CC A. BUILDING B. WING		COMI	e survey Pleted 1/2022
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	messages, or pr to challenge an (iii) Analyze the maintain docum exercises, and e the [facility's] en *[For Hospices a (2) Testing for h the patient's hor conduct exercis plan at least and the following: (i) Participate in community base (A) When a com accessible, com based functional (B) If the hospic man-made eme of the emergend exempt from en scale communit facility-based fu onset of the emergend exempt from en scale communit facility-based fu onset of the emergend (ii) Conduct an years, opposite functional exerce of this section is include, but is n (A) A second fu community-base functional exerce (B) A mock disa (C) A tabletop e led by a facilitate discussion using clinically-relevant	nospices that provide care in me. The hospice must es to test the emergency hually. The hospice must do a full-scale exercise that is ed every 2 years; or imunity based exercise is not duct an individual facility I exercise every 2 years; or e experiences a natural or rgency that requires activation ey plan, the hospital is gaging in its next required full y-based exercise or individual nctional exercise following the ergency event. additional exercise every 2 the year the full-scale or ise under paragraph (d)(2)(i) conducted, that may ot limited to the following: II-scale exercise that is ed or a facility based ise; or exercise or workshop that is or and includes a group				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G814		LTIPLE CON ILDING NG	ISTRUCTION	со	ate survey mpleted /21/2022
	PROVIDER OR SUPPLIEI			8307 CAS	DDRESS, CITY, STATE, ZIP STLETON BLVD POLIS, IN 46256	COD	
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	to challenge an ei	pared questions designed mergency plan.					
	care directly. The exercises to test t per year. The hos	spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following:					
	that is community						
	accessible, condu	nunity-based exercise is not ict an annual individual					
	(B) If the hospice man-made emerg of the emergency	ctional exercise; or experiences a natural or lency that requires activation plan, the hospice is aging in its next required					
	full-scale commun functional exercis emergency event	nity based or facility-based e following the onset of the					
	that may include, following:	dditional annual exercise but is not limited to the					
	community-based functional exercis						
		ter drill; or ercise or workshop led by a udes a group discussion					
		rio, and a set of problem					
	questions designe emergency plan.	ted messages, or prepared ed to challenge an					
	maintain documer exercises, and en	nospice's response to and ntation of all drills, tabletop nergency events and revise					
	the hospice's eme	ergency plan, as needed.					
	*[For PRFTs at §4	141.184(d), Hospitals at					

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AND PLAN	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G814	A. BUILDING B. WING	CONSTRUCTION	CO	TE SURVEY MPLETED 21/2022
	PROVIDER OR SUPPLIEF		8307	ET ADDRESS, CITY, STATE, ZIP CASTLETON BLVD ANAPOLIS, IN 46256	COD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
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	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 fund (B) If the [PRTF, H an actual natural that requires activ plan, the [facility] its next required ff or individual, facilit following the onset (ii) Conduct a exercise or and the limited to the follo (A) A second full- community-based facility-based fund (B) A mo (C) A tabletop is led by a facilitat discussion, using clinically-relevant set of problem stat messages, or pre- to challenge an en (iii) Analyze t and maintain docu tabletop exercises and revise the [fac needed. *[For PACE at §44 (2) Testing. The F	PRTF, Hospital, CAH] must a to test the emergency ar. The [PRTF, Hospital, e following: an annual full-scale exercise -based; or nunity-based exercise is not act an annual individual, ctional exercise; or Hospital, CAH] experiences or man-made emergency vation of the emergency is exempt from engaging in ull-scale community based ity-based functional exercise et of the emergency event. an [additional] annual nat may include, but is not wing: -scale exercise that is l or individual, a ctional exercise; or ock disaster drill; or o exercise or workshop that tor and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. he [facility's] response to umentation of all drills, s, and emergency plan, as				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 12/21/2022 15G814 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8307 CASTLETON BLVD VOCA CORPORATION OF INDIANA INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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):] (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, Event ID: XQ4921 Facility ID: 010453 Page 12 of 21 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CC A. BUILDING B. WING	COM	(X3) DATE SURVEY COMPLETED 12/21/2022	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD	•	
VOCA C	ORPORATION OF	INDIANA		IAPOLIS, IN 46256		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	that is communit (A) When a comm accessible, cond facility-based fun (B) If the [LTC fa actual natural or requires activation LTC facility is ex- required a full-so- individual, facility following the ons- (ii) Conduct an a that may include following: (A) A second full community-base based functional (B) A mock disa (C) A tabletop e- led by a facilitato discussion, using clinically-relevan set of problem st messages, or pro- to challenge an e- (iii) Analyze the response to and all drills, tabletop events, and revis emergency plan, *[For ICF/IIDs at (2) Testing. The exercises to test twice per year. T following:	an annual full-scale exercise y-based; or munity-based exercise is not uct an annual individual, actional exercise. cility] facility experiences an man-made emergency that on of the emergency plan, the empt from engaging its next ale community-based or -based functional exercise et of the emergency event. additional annual exercise et of the emergency event. additional annual exercise , but is not limited to the I-scale exercise that is d or an individual, facility exercise; or ster drill; or xercise or workshop that is r includes a group g a narrated, t emergency scenario, and a atements, directed epared questions designed emergency plan. [LTC facility] facility's maintain documentation of exercises, and emergency se the [LTC facility] facility's as needed. §483.475(d)]: ICF/IID must conduct the emergency plan at least he ICF/IID must do the an annual full-scale exercise				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	FATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/21/2022		
	PROVIDER OR SUPPLIEF		8307 0	ADDRESS, CITY, STATE, ZIP CASTLETON BLVD NAPOLIS, IN 46256	COD		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETIO	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	accessible, condu facility-based funct (B) If the ICF/IID e natural or man-ma activation of the e is exempt from en full-scale commun facility-based funct onset of the emer (ii) Conduct an ad that may include, following: (A) A second full-s community-based facility-based funct (B) A mock disast (C) A tabletop exe led by a facilitator discussion, using clinically-relevant set of problem sta messages, or prej to challenge an er (iii) Analyze the IC maintain documer exercises, and en the ICF/IID's emer *[For HHAs at §48 (d)(2) Testing. The exercises to test t least annually. Th following: (i) Participate in a community-based (A) When a c is not accessible,	ditional annual exercise but is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. CF/IID's response to and natation of all drills, tabletop mergency events, and revise rgency plan, as needed. CR4.102] e HHA must conduct he emergency plan at e HHA must do the full-scale exercise that is					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 12/21/2022 15G814 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8307 CASTLETON BLVD VOCA CORPORATION OF INDIANA INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (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 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 XQ4921 Event ID: Facility ID: 010453 Page 15 of 21 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

01/11/2023

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 12/21/2022 15G814 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8307 CASTLETON BLVD VOCA CORPORATION OF INDIANA INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. 01/20/2023 Based on record review and interview, the facility E 0039 CORRECTION: failed to conduct at least two exercises to test the The [facility] must conduct emergency plan on an annual basis using the exercises to test the emergency emergency procedures. The ICF/IID facility must plan at least annually. Specifically, do all of the following: (i) participate in a full-scale the agency's Quality Assurance exercise that is community-based or when a Department has submitted a community-based exercise is not accessible, an formal request to the Indianapolis individual, facility-based. If the ICF/IID facility Metropolitan Police experiences an actual natural or man-made Department/Department of emergency that requires activation of the Homeland Security Community emergency plan, the ICF/IIC facility is exempt from Emergency Response Team engaging in a community-based or individual, (CERT) to conduct an initial "table facility-based full-scale exercise for 1 year talk" disaster exercise. with following the onset of the actual event; (ii) bi-annual exercises thereafter. XQ4921 Event ID: Facility ID: 010453 Page 16 of 21 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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01/11/2023

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION (X)	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
	15G814		B. WING		12/21/2022		
AME OF	PROVIDER OR SUPPLIE	2		ADDRESS, CITY, STATE, ZIP COD			
				ASTLETON BLVD			
OCA C	ORPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46256			
(4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	conduct an addition	nal exercise that may include,		Additionally, the ResCare Quality	/		
	but is not limited to	the following: (A) a second		Assurance Department has			
	full-scale exercise	that is community-based or		requested assistance from the			
	individual, facility-	based. (B) a tabletop exercise		IMPD District Commander to			
	that includes a grou	p discussion led by a		coordinate with CERT to facilitate	e		
	facilitator, using a	narrated, clinically-relevant		this process. ResCare Facility			
	emergency scenario	o, and a set of problem		supervisors, the QIDP and			
	statements, directed	d messages, or prepared		administrative level managemen	t l		
		to challenge an emergency		(Operations Managers, Program			
		he ICF/IID facility's response to		Managers, Quality Assurance			
		nentation of all drills, tabletop		Manager, QIDP Manager, Qualit	v		
		rgency events, and revise the		Assurance Coordinators, and	,		
		mergency plan, as needed in		Nurse Manager) will participate i	n		
		2 CFR 483.475(d)(2). This		the exercises to assure facility			
		ould affect all occupants.		emergency preparedness			
	deficient practice e	ourd arreet an occupants.		protocols are consistent with			
	Findings include:			-			
	Findings include.			community emergency			
	Deced on nervicery of	S''Em angen av/Disasten		management practices.			
		"Emergency/Disaster		The facility will develop	£		
	-	al" documentation dated		documentation of the activation of	DT		
		rgency, Disaster, Evacuation		the Emergency Preparedness			
	-	es" documentation dated		Plan during the 12/22/22 –			
		Maintenance Aide during record		12/24/22 weather emergency, by	,		
		a.m. to 11:25 a.m. on 12/21/22,		1/20/23. At the time of this			
		community based disaster drill		exercise, a "table talk exercise w	ill		
		ent twelve month period was		be scheduled with local			
		view. Based on interview at the		emergency management officials	6		
		ew, the Maintenance Aide		within 6 months of the full-scale			
		s currently experiencing an		event.			
		gency due to Covid-19 and					
	Covid-19 policy an	d procedures currently in effect		The QIDP Manager will collabora	ate		
	for the pandemic an	re stated in the emergency		with other residential providers to			
	preparedness docur	nentation but agreed the		determine a functional approach	to		
	facility has not con	ducted a second community		correct this deficient practice.			
		or conducted a tabletop		PREVENTION:			
		most recent twelve month		Members of the Operations Tear	n		
	period and agreed a	additional testing		(comprised of the Executive			
		not available for review at the		Director, Operations Managers,			
	time of the survey.			Program Managers, Area			
	´			Supervisors, Quality Assurance			
	1		1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COM	(X3) DATE SURVEY COMPLETED 12/21/2022	
	NAME OF PROVIDER OR SUPPLIER					DD		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION eviewed with the Maintenance	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY) Manager, QIDP Manag	er, QIDP,	(X5) COMPLETION DATE	
		i conference.			Quality Assurance Cool and Nurse Manager) wi incorporate reviews of t emergency preparedne into scheduled twice mo audits to assure all requ components, including I limited to bi-annual community-based disas exercises, are present. Additionally, the agency Committee will review a the plan as needed but than annually. RESPONSIBLE PARTI Area Supervisor, Direct Lead, Direct Support St Operations Team, Regi Director	II he facility's ss program onthly uired but not ster / Safety and revise no less ES: QIDP, Support aff,		
K 0000								
Bldg. 01		•	K 000	0				
	Facility Number: Provider Number: AIM Number: 20	010453 15G814						
	of Indiana was fou Requirements for 1 CFR Subpart 483.4 the 2012 edition of	Code survey, Voca Corporation nd not in compliance with Participation in Medicaid, 42 470(j), Life Safety from Fire and f the National Fire Protection A) 101, Life Safety Code (LSC),						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G814	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 12/21/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O Chapter 33, Existin Occupancies.	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ng Residential Board and Care		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	sprinklered. The f with smoke detect areas. The facility to the fire alarm sy The facility has a c of 7 at the time of Calculation of the (E-Score) using NI Approaches to Life	ding was determined to be fully acility has a fire alarm system on in corridors and all living has smoke detectors hard wired stem installed in all bedrooms. apacity of 8 and had a census this survey. Evacuation Difficulty Score FPA 101A, Alternative e Safety, Chapter 6, rated the h an E-Score of 0.1.					
K S511 Bidg. 01	NFPA 101 Utilities - Gas and Equipment using complies with NF Code, electrical w complies with NF Code. 32.2.5.1, 33.2.5.7 Based on observat failed to ensure 2 of power strips were fixed wiring accorr Edition, Article 40 specifically permit shall not be used a	d Electric gas or related gas piping PA 54, National Fuel Gas <i>v</i> iring and equipment FA 70, National Electric , 9.1.1, 9.1.2 on and interview, the facility of 2 extension cords including not used as a substitute for ling to 33.2.5.1. NFPA 70, 2011 0.8 requires that, unless ted, flexible cords and cables is a substitute for fixed wiring of efficient practice could affect all	K S	511	CORRECTION: Electrical wiring and equipme complies with NPFA 70, Nati Electric Code. Specifically, T facility will rearrange the gara and plug the freezer and refrigerator directly into the w outlet as required. PREVENTION: Members of the Operations T (comprised of the Executive	onal he age vall ēam	01/20/2023
	Based on observat	ons with the Maintenance			Director, Operations Manage Program Managers, Area	rs,	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 2	(X3) DATE SURVEY COMPLETED 12/21/2022		
		15G814	B. WING				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD				
VOCA C	ORPORATION OF	INDIANA		ANAPOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	-	of the facility from 11:25 a.m. to		Supervisors, Quality Assurance			
		21/22, the refrigerator in the		Manager, QIDP Manager, QIDF			
		d into a power strip on the floor		Quality Assurance Coordinators	; ,		
		ddition, the freezer in the		and Nurse Manager) will			
	0 0 1 00	d into an extension cord on the		incorporate visual observations			
	00	. Based on interview at the time		the facility's electrical outlets int	0		
		s, the Maintenance Aide agreed		scheduled monthly audits to	- 4		
		an extension cord were being e for fixed wiring in the garage.		assure multiplug adapters are n used as a substitute for fixed	ot		
				wiring.			
		eviewed with the Maintenance		RESPONSIBLE PARTIES: QID	P,		
	Aide during the ex	it conference.		Area Supervisor, Residential			
				Manager, Contracted			
				Environmental Services Staff,			
				Operations Team			
(S741	NFPA 101						
	Smoking Regulat	tions					
Bldg. 01	Smoking Regulat	tions					
	Smoking regulati	ons shall be adopted by the					
	administration of	board and care					
	occupancies. W	here smoking is permitted,					
	noncombustible s	safety type ashtrays or					
	receptacles shall	be provided in convenient					
	locations.						
		2, 33.7.4.1, 33.7.4.2					
		eview, observation and	K S741	CORRECTION:	01/23/202		
		lity failed to ensure smoking		The facility must hold evacuatio	n		
	-	oosited into ashtrays and metal		drills at least quarterly for each			
		f-closing cover devices into		shift of personnel and under val			
		be emptied of noncombustible		conditions. Specifically, the faci			
		lesign in 1 of 1 outdoor areas		will conduct additional evacuation	on		
	U	permitted. This deficient		drills on each shift during the			
	practice could affe	ct all clients, staff and visitors.		current quarter.			
				PREVENTION:			
	Findings include:			Professional staff will be retrain	ed		
				regarding the need to conduct			
		f "Smoking" policy		evacuation drills at varied times			
		h the Area Supervisor and the		each shift for all staff each quar			
	I Maintenance Aide	during record review from		Training will also focus on prope	er l		

	T OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED 1B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	01	COMP	LETED	
		15G814	B. W	ING		12/21	/2022	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
VOCA C	ORPORATION OF	INDIANA		8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CODRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	10:20 a.m. to 11:25 a.m. on 12/21/22, assessed				completion of evacuation dril			
	clients are allowed to smoke in a designated outdoor area. Based on interview at the time of record review, the Area Supervisor stated two clients, AR and BM, are allowed to smoke on the back patio for the facility. Based on observations				forms and assessment of			
					individual drill compliance. T	he		
					Operations (comprised of the	e		
					Executive Director, Operation	ns		
					Managers, Program Manage	ers,		
	with the Maintenance Aide during a tour of the				Area Supervisors, Quality			
	facility from 11:25 a.m. to 11:45 a.m. on 12/21/22, a				Assurance Manager, QIDP			
	plastic open top ashtray was filled with cigarette				Manager, QIDP, Quality			
	butts on a table outside the facility on the back patio. Cigarette butts were also scattered on the ground near the back patio. A smoking tower for dispensing cigarette butts was in two pieces and laying on its side on the ground near the back				Assurance Coordinators, and			
					Nurse Manager) will review a	and		
					track all facility evacuation di	rill		
					reports and follow up with			
					professional staff as needed	to		
	*	cility. Based on interview at			assure drills occur as schedu	uled		
		ervations, the Maintenance			and follow up with the agenc	5		
	Aide agreed the ashtray for the cigarette butts				Safety Committee according	ly.		
		vith a self-closing cover device			Responsible Parties:			
		combustible material and safe			Environmental Services Tea			
	design, the smoking tower was not being utilized				Area Supervisor, Residential			
	and cigarette butts were strewn on the ground at				Manager, Direct Support Sta	iff,		
	this designated loc allowed.	ation where smoking was			QIDP, Operations Team			
	This finding was re	eviewed with the Maintenance						
	Aide during the ex	it conference.					1	

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XQ4921 Facility ID: 010453

If continuation sheet

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