PRINTED: 02/22/2023 FORM APPROVED

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OMB NO. 0938-039
PLE CONSTRUCTION	(X3) DATE SURVEY
ING	COMPLETED

	IT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G814		JILDING NG	NSTRUCTION	COME	e survey pleted 5/2023	
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, 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 B CROSS-REFERENCED TO THE APPROPR		COMPLETION	
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000								
Bldg	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 12/21/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/06/23		E 00	000				
	Facility Number: ( Provider Number: AIM Number: 201	010453 15G814						
	survey, Voca Corpo found not in compl Preparedness Requ	he Emergency Preparedness oration of Indiana Inc was iance with Emergency irements for Medicare and ting Providers and Suppliers, 42						
	-	ertified beds. All 8 beds are aid. At the time of the survey,						
	Quality Review con	mpleted on 02/06/23						
	The requirement at NOT MET as evide	42 CFR, Subpart 483.475 is enced by:						
E 0037 Bldg	441.184(d)(1), 48 483.73(d)(1), 484 485.68(d)(1), 485 486.360(d)(1), 49 EP Training Progu §403.748(d)(1), § §441.184(d)(1), § §483.73(d)(1), §4	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),						
	<u>8403.00(u)(1),</u> 84	485.625(d)(1), §485.727(d)						
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURI	3	TITLE		(X6) DATE	

**QIDP** Manager

02/16/2023

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 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 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 02/06/2023 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 (1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). \*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. \*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), XQ4922 Event ID: Facility ID: 010453 Page 2 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 02/06/2023	
			8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD	-	
VUCAC	ORPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRC DEFICIENCY)	DBE	(X5) COMPLETIO DATE
	the procedures n and others. (v) Maintain docu preparedness tra (vi) If the emerge and procedures a hospice must con updated policies procedures. *[For PRTFs at § program. The PF following: (i) Initial training policies and proc existing staff, ind 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 a PRTF must cond policies and proc *[For PACE at §4 organization mus (i) Initial training policies and proc	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 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 02/06/2023 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 (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. \*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. \*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first XQ4922 Facility ID: 010453 Page 4 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 02/06/2023 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 workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. \*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. \*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC XQ4922 Facility ID: 010453 Page 5 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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 02/06/2023 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 must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility E 0037 CORRECTION: 03/08/2023 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 with the Maintenance Aide during record and procedures to all new and review from 9:35 a.m. to 9:40 a.m. on 02/06/22, the existing staff, individuals providing facility lacked documentation of staff training on services under arrangement, and the emergency preparedness plan within the most volunteers, consistent with their recent two year period. Based on interview at the expected roles; and provide time of record review, the Maintenance Aide emergency preparedness training stated staff training documentation on emergency at least annually; and maintain preparedness policies and procedures within the documentation of the training; and most recent two year period was not available for demonstrate staff knowledge of review at the time of the survey. emergency procedures. Facility Specific Emergency Preparedness This finding was reviewed with the Maintenance Training has been added to new Aide during the exit conference. hire On-the-Job Training curriculum and Area Supervisors This deficiency was cited on 12/21/22. The facility and the QIDP will be responsible failed to implement a systemic plan of correction for providing annual retraining as XQ4922 Facility ID: 010453

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		- 1	PLETED
		15G814	B. WING		02/06/2023	
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CO	D	
	ORPORATION OF			CASTLETON BLVD NAPOLIS, IN 46256		
VOCAC		INDIANA		NAFOLIS, IN 40250		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP		COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	to prevent recurrent	nce.		well as training when the		
				updated. The Quality As		
				Department will coordina		
				Human Resources to im	-	
				an annual agency wide		
				the On-the-Job Training		
				including the emergency	/	
				Preparedness plan.		
				PREVENTION:		
				Members of the Operation		
				(comprised of the Execu Director, Operations Ma		
				Program Managers, Are	•	
				Supervisors, Quality As		
				Manager, QIDP Manage		
				Quality Assurance Coor		
				and Nurse Manager) wil		
				incorporate reviews of th		
				emergency preparednes	-	
				into scheduled twice mo		
				audits to assure all requ	-	
				components are present		
				Additionally, the agency		
				Committee will review a	•	
				the plan as needed but		
				than annually.		
				RESPONSIBLE PARTIE	<b>ES:</b> QIDP,	
				Area Supervisor, Direct	Support	
				Lead, Safety Committee	e, Human	
				Resources Department,		
				Operations Team, Regio	onal	
				Director		
0000						
0039		16.54(d)(2), 418.113(d)(2),				
Dida		82.15(d)(2), 483.475(d)(2),				
3ldg		4.102(d)(2), 485.625(d)(2),				
		5.727(d)(2), 485.920(d)(2),				
		91.12(d)(2), 494.62(d)(2)				
	EP Testing Requ					
	<u></u> 3410.54(0)(∠), §4	418.113(d)(2), §441.184(d)(2),		1		

	Г OF HEALTH AND HU R MEDICARE & MEDIC					TED: 02/22/2023 RM APPROVED B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION	(X3) DATE COMPL 02/06/	SURVEY ETED
	PROVIDER OR SUPPLIE		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE) REGULATORY O §460.84(d)(2), §4 §483.475(d)(2), § §485.625(d)(2), § (2), §491.12(d)(2 *[For ASCs at §4 OPO, "Organizat CMHCs at §485.1 §491.12, and ES (2) Testing. The [ exercises to test annually. The [fac following: (i) Participate in a community-based (A) When a com not accessible, co functional exercis (B) If the [fac natural or man-m activation of the 6 is exempt from el community-based functional exercis actual event. (ii) Conduct an ac every 2 years, op or functional exercis actual event. (ii) of this section include, but is no (A) A second full- community-based functional exercis (B) A mock disas (C) A tabletop ex led by a facilitato discussion using	* STATEMENT OF DEFICIENCIE         NCY MUST BE PRECEDED BY FULL         R LSC IDENTIFYING INFORMATION         182.15(d)(2), §483.73(d)(2),         \$484.102(d)(2), §485.68(d)(2),         \$485.727(d)(2), §485.920(d)         ), §494.62(d)(2).         16.54, CORFs at §485.68,         ions" under §485.727,         920, RHCs/FQHCs at         RD Facilities at §494.62]:         *facility] must conduct         the emergency plan         cility] must do all of the         a full-scale exercise that is         d every 2 years; or         munity-based exercise is         onduct a facility-based         see every 2 years; or         cility] experiences an actual         ade emergency that requires         emergency plan, the [facility]         ngaging in its next required         d or individual, facility-based         se following the onset of the         dditional exercise at least         oposite the year the full-scale         rcise under paragraph (d)(2)         is conducted, that may         t limited to the following:         -scale exercise that is         d or individual, facility-based         se; or         ter drill; or      <	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	clinically-relevant	emergency scenario, and a				

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULT A. BUILD B. WING		STRUCTION	C	(X3) DATE SURVEY COMPLETED 02/06/2023	
NAME OF	PROVIDER OR SUPPLIE	R			DRESS, CITY, STATE, ZIP CO STLETON BLVD	)		
VOCA C	ORPORATION OF	INDIANA			POLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRE	CTION	(X5)	
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TAG		R LSC IDENTIFYING INFORMATION	T.	4G	DEFICIENCY)		DATE	
		atements, directed						
		epared questions designed						
	to challenge an e							
		facility's] response to and						
		ntation of all drills, tabletop						
		mergency events, and revise						
	the [facility's] emo	ergency plan, as needed.						
	*[For Hospices a							
	., .	ospices that provide care in						
		e. The hospice must						
		s to test the emergency						
		ually. The hospice must do						
	the following:							
		a full-scale exercise that is						
	-	d every 2 years; or						
		nunity based exercise is not						
		uct an individual facility						
		exercise every 2 years; or						
		experiences a natural or						
		gency that requires activation						
		/ plan, the hospital is						
		aging in its next required full -based exercise or individual						
		ctional exercise following the						
	onset of the eme	idditional exercise every 2						
		he year the full-scale or						
		se under paragraph (d)(2)(i)						
		conducted, that may						
		t limited to the following:						
		I-scale exercise that is						
		d or a facility based						
	functional exercise	-						
	(B) A mock disas							
	( )	kercise or workshop that is						
		r and includes a group						
	discussion using	- ·						
	-	t emergency scenario, and a						
	set of problem st							

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED 02/06/2023	
	PROVIDER OR SUPPLIE		830	EET ADDRESS, CITY, STATE, ZIP 7 CASTLETON BLVD IANAPOLIS, IN 46256	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO DATE	
	messages, or pre to challenge an e	epared questions designed emergency plan.					
	care directly. The exercises to test per year. The ho (i) Participate in that is communit (A) When a commu- accessible, cond facility-based fur (B) If the hospice man-made emer of the emergency exempt from eng full-scale commu- functional exercise emergency even (ii) Conduct an a that may include following: (A) A second full community-base functional exercise (B) A mock disa (C) A tabletop e facilitator that incousing a narrated emergency scen statements, direc questions design emergency plan. (iii) Analyze the maintain docume exercises, and e	munity-based exercise is not uct an annual individual actional exercise; or e experiences a natural or gency that requires activation y plan, the hospice is aging in its next required unity based or facility-based se following the onset of the t. additional annual exercise , but is not limited to the I-scale exercise that is d or a facility based se; or ster drill; or xercise or workshop led by a cludes a group discussion , clinically-relevant ario, and a set of problem cted messages, or prepared ted to challenge an hospice's response to and entation of all drills, tabletop mergency events and revise					
		ergency plan, as needed. 441.184(d), Hospitals at					
	TFOR PRETS all S	441.184(d), Hospitais at					

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 02/06/2023 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 §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. \*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency XQ4922 Event ID: Facility ID: 010453 Page 11 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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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 02/06/2023 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, XQ4922 Event ID: Facility ID: 010453 Page 12 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CC A. BUILDING B. WING	COMPLET	(X3) DATE SURVEY COMPLETED 02/06/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
VOCA C	ORPORATION OF	INDIANA		ASTLETON BLVD IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE OPRIATE	OMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	that is communit (A) When a communit accessible, cond facility-based fun (B) If the [LTC fa actual natural or requires activation LTC facility is ex- required a full-sc individual, facility following the ons (ii) Conduct an a that may include following: (A) A second ful community-base based functional (B) A mock disa (C) A tabletop ex- led by a facilitato discussion, using clinically-relevan set of problem st messages, or pre- to challenge an et (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 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 02/06/2023 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 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. \*[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. XQ4922 Event ID: Facility ID: 010453 Page 14 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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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 02/06/2023 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 XQ4922 Event ID: Facility ID: 010453 Page 15 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/06/2023	
	PROVIDER OR SUPPLIE		8307	T ADDRESS, CITY, STATE, ZIP COD CASTLETON BLVD ANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	requires activation OPO is exempt of required testing a of the emergency (ii) Analyze the O maintain docume exercises, and en- the [RNHCI's and needed. *[ RNCHIs at §40 (d)(2) Testing. The exercises to test RNHCI must do f (i) Conduct a paper at least annually. group discussion narrated, clinicall scenario, and a se directed messag designed to chall (ii) Analyze the F maintain docume exercises, and en- the RNHCI's emergency plan on emergency plan, the engaging in a com facility-based full-	OPO's response to and entation of all tabletop mergency events, and revise d OPO's] emergency plan, as 03.748]: ne RNHCI must conduct the emergency plan. The	E 0039	CORRECTION: The [facility] must conduct exercises to test the emerge plan at least annually. Speci the agency's Quality Assuran Department has submitted a formal request to the Indiana Metropolitan Police Department/Department of Homeland Security Commun Emergency Response Team (CERT) to conduct an initial talk" disaster exercise, with bi-annual exercises thereafted	rically, nce polis ity 'table	03/08/202

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION (2	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		15G814	B. WING		02/06/2023	
JAME OF	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP COD		
				ASTLETON BLVD		
VOCAC	CORPORATION OF	INDIANA	INDIAN	IAPOLIS, IN 46256		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	conduct an addition	nal exercise that may include,		Additionally, the ResCare Quality	ty	
	but is not limited to	o 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	up discussion led by a		coordinate with CERT to facilitat	te	
	facilitator, using a	narrated, clinically-relevant		this process. ResCare Facility		
	-	o, and a set of problem		supervisors, the QIDP and		
		d messages, or prepared		administrative level managemer	nt	
		to challenge an emergency		(Operations Managers, Program		
		he ICF/IID facility's response to		Managers, Quality Assurance		
		mentation of all drills, tabletop		Manager, QIDP Manager, Quali	itv	
		rgency events, and revise the		Assurance Coordinators, and	le y	
		mergency plan, as needed in		Nurse Manager) will participate	in	
	-	2 CFR 483.475(d)(2). This		the exercises to assure facility	"	
		ould affect all occupants.		-		
	deficient plactice c	ould affect all occupants.		emergency preparedness		
	Eindings insluder			protocols are consistent with		
	Findings include:			community emergency		
				management practices.		
		f "Emergency/Disaster		The facility will develop		
	-	ual" documentation dated		documentation of the activation	of	
		Maintenance Aide during record		the Emergency Preparedness		
		.m. to 9:40 a.m. on 02/06/22,		Plan during the 2/9/23 high		
		a community based disaster drill		wind/mass power outage event,	by	
		cent twelve month period was		3/8/23. At the time of this		
		view. Based on interview at the		exercise, a "table talk exercise v	vill	
	time of record revi	ew, the Maintenance Aide		be scheduled with local		
		is currently experiencing an		emergency management officia	ls	
		gency due to Covid-19 and		within 6 months of the full-scale		
	Covid-19 policy ar	nd procedures currently in effect		event.		
	for the pandemic a	re stated in the emergency		The QIDP Manager will collabor	rate	
	preparedness docu	mentation but agreed the		with other residential providers t		
	facility has not con	ducted a second community		determine a functional approach		
	based disaster drill	or conducted a tabletop		correct this deficient practice.		
		most recent twelve month		PREVENTION:		
	period and agreed			Members of the Operations Tea	ım	
		s not available for review at the		(comprised of the Executive		
	time of the survey.			Director, Operations Managers,		
	/			Program Managers, Area		
	This finding was re	eviewed with the Maintenance		Supervisors, Quality Assurance		
	Aide during the ex			Manager, QIDP Manager, QIDF		
			1	I manager, QIDF Manager, QIDF	,	

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G814	ì í	JILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 02/06/2023	
	PROVIDER OR SUPPLIE			8307 C	ADDRESS, CITY, STATE, ZIP CC ASTLETON BLVD IAPOLIS, IN 46256	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
K 0000 Bldg. 01	This deficiency wa failed to implement to prevent recurrer	as cited on 12/21/22. The facility t a systemic plan of correction	К 0		Quality Assurance Coor and Nurse Manager) wi incorporate reviews of the emergency preparedness into scheduled twice mod audits to assure all requised components, including the limited to bi-annual community-based disass exercises, are present. Additionally, the agency Committee will review at the plan as needed but than annually. <b>RESPONSIBLE PARTIL</b> Area Supervisor, Direct Lead, Direct Support St Operations Team, Regis Director	II he facility's ss program onthly uired out not ter v Safety nd revise no less ES: QIDP, Support aff,	
	Code Recertification 12/21/22 was cond Department of Heat 483.470(j). Survey Date: 02/00 Facility Number: 02/00 Facility Number: 200 At this PSR survey was found in comp Participation in Med 483.470(j), Life Sat	on Survey conducted on hucted by the Indiana alth in accordance with 42 CFR 6/23 010453 15G814					

PRINTED: 02/22/2023 FORM APPROVED

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FOI	ERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	r í	JILDING	DNSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 02/06/2023	
	PROVIDER OR SUPPLIEI		-	8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION Safety Code (LSC), Chapter 33,		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	This one story build sprinklered. The fa with smoke detection areas. The facility to the fire alarm syst The facility has a co of 8 at the time of t Calculation of the H (E-Score) using NF Approaches to Life facility Prompt with	l Board and Care Occupancies. 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 his survey. Evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the h an E-Score of 0.1. mpleted on 02/06/23					

XQ4922 Facility ID: 010453