	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	f /	JILDING	NSTRUCTION	(X3) DATE ( COMPL 02/21/	ETED
NAME OF P	ROVIDER OR SUPPLIER				ASTLETON BLVD		
VOCA CO	ORPORATION OF I	NDIANA			APOLIS, IN 46256		
(X4) ID	SUMMARY S	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	TE	COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
□ 0000							
Bldg	conducted by the In accordance with 42  Survey Date: 02/21  Facility Number: 0  Provider Number: 2014  At this Emergency I  Corporation of India compliance with En  Requirements for M	/24 10453 15G814	E 00	000			
E 0039 Bldg	certified for Medica the census was 8.  Quality Review con The requirement at NOT MET as evide  403.748(d)(2), 416 441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 497 EP Testing Requir §416.54(d)(2), §47 §460.84(d)(2), §48 §483.475(d)(2), §48	42 CFR, Subpart 483.475 is need by:  6.54(d)(2), 418.113(d)(2),  2.15(d)(2), 483.475(d)(2),  102(d)(2), 485.625(d)(2),  727(d)(2), 485.920(d)(2),  1.12(d)(2), 494.62(d)(2)  rements  18.113(d)(2), §441.184(d)(2),  32.15(d)(2), §483.73(d)(2),  484.102(d)(2), §485.68(d)(2),					
	(2), §491.12(d)(2),						
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	3	TITLE		(X6) DATE

Bob Morris QIDP Manager 03/07/2024

Any define exercisement ending with an asterick (\*) denotes a deficency which the institution may be excused from correcting providing it is determined.

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.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	l í	JILDING	NSTRUCTION	(X3) DATE COMPI 02/21	LETED
	PROVIDER OR SUPPLIER			8307 CA	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, 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 APPROPI DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
TAG	*[For ASCs at §44* OPO, "Organization CMHCs at §485.9 §491.12, and ESF (2) Testing. The [for exercises to test to annually. The [for following:  (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the [factional exercises (B) If the exercise activation of the exercise is exempt from endomonity-based functional exercise actual event.  (ii) Conduct an additional exercise actual event.  (ii) Conduct an additional exercise actual event.  (ii) Conduct an additional exercise (b) A second full-second functional exercise (C) A tabletop exercise (C) A tabletop exercise (C) A tabletop exercise (C)	16.54, CORFs at §485.68, ons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]:  Facility] must conduct the emergency plan illity] must do all of the full-scale exercise that is every 2 years; or munity-based exercise is induct a facility-based every 2 years; or every 2 years; or lility] experiences an actual ade emergency that requires mergency plan, the [facility] agaging in its next required or individual, facility-based e following the onset of the ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based e; or er drill; or ercise or workshop that is and includes a group		TAG	DEFICIENCY		DATE
	set of problem sta messages, or pre to challenge an er	pared questions designed					

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	OF CORRECTION	IDENTIFICATION NUMBER  15G814	A. BUII B. WIN	DING		COMPL 02/21/	ETED
	PROVIDER OR SUPPLIER			8307 CA	DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	exercises, and em the [facility's] eme *[For Hospices at (2) Testing for ho	spices that provide care in					
	conduct exercises plan at least annu the following:	e. The hospice must to test the emergency ally. The hospice must do					
	(A) When a comm accessible, condu based functional e (B) If the hospice man-made emerg	nunity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation					
	exempt from enga scale community-l facility-based fund onset of the emer	plan, the hospital is aging in its next required full based exercise or individual etional exercise following the gency event.					
	years, opposite th functional exercise of this section is c include, but is not	e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: scale exercise that is					
	functional exercise (B) A mock disas (C) A tabletop exe	•					
	discussion using a clinically-relevant set of problem sta	a narrated, emergency scenario, and a tements, directed pared questions designed					
	-	spices that provide inpatient					

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OM	ИВ NO. 0938-039	
	ENT OF DEFICIENCIES  N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	JILDING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  02/21/2024	
	PROVIDER OR SUPPLIE		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
VOCA C (X4) ID PREFIX TAG	summary (EACH DEFICIE REGULATORY O care directly. The exercises to test per year. The ho (i) Participate in that is community (A) When a community-based functional exercise man-made emergency exempt from eng full-scale community-scale community-based (ii) Conduct an authat may include, following: (A) A second full community-based functional exercise functional exercise functional exercise (B) A mock disast (C) A tabletop exercises	r STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION The hospice must conduct the emergency plan twice respice must do the following: an annual full-scale exercise r-based; or munity-based exercise is not fuct an annual individual ctional exercise; or experiences a natural or gency that requires activation r plan, the hospice is aging in its next required finity based or facility-based first following the onset of the first diditional annual exercise but is not limited to the first scale exercise that is d or a facility based first; or	INDIAN  ID  PREFIX  TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRE DEFICIENCY)	D BE	(X5) COMPLETION DATE
	emergency scena statements, direct questions design emergency plan. (iii) Analyze the maintain docume exercises, and er the hospice's em  *[For PRFTs at § §482.15(d), CAH (2) Testing. The	clinically-relevant ario, and a set of problem sted messages, or prepared ed to challenge an chospice's response to and entation of all drills, tabletop mergency events and revise ergency plan, as needed.  441.184(d), Hospitals at s at §485.625(d):] PRTF, Hospital, CAH] must s to test the emergency				

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plan twice per year. The [PRTF, Hospital,

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r /		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	<del></del>	COMPLI	
		15G814	B. WING			02/21/	2024
NAME OF E	PROVIDER OR SUPPLIER	- }			DDRESS, CITY, STATE, ZIP COD		
					ASTLETON BLVD		
VOCA C	ORPORATION OF	Indiana 	IN	NDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	Tz	AG	DEFICIENCY)		DATE
	CAH] must do the						
		nn annual full-scale exercise					
	that is community.	nunity-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 a	an [additional] annual					
	exercise or and th	at may include, but is not					
	limited to the follow	_					
	(A) A second full-	scale exercise that is					
	community-based						
		ctional exercise; or					
	, ,	ock disaster 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						
		he [facility's] response to					
		umentation of all drills,					
	-	s, and emergency events cility's] emergency plan, as					
	needed.	omy of emergency plan, as					
	noodod.						
	*[For PACE at §46	60.84(d):]					
	_	PACE organization must					
	conduct exercises to test the emergency plan at least annually. The PACE						
	organization must	do the following:					
	(i) Participate in a	an annual full-scale exercise					
	that is community.	-based: or					

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION  G <u></u>	COM	e survey pleted 1/2024
	OF PROVIDER OR SUPPLIES		8307	ET ADDRESS, CITY, STATE, ZIP COI 7 CASTLETON BLVD ANAPOLIS, IN 46256	)	
(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 CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPOPER OF TH	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	accessible, condu- facility-based fund (B) If the PACE e or man-made em activation of the e is exempt from er full-scale community-based functional exercise of this section is of but is not limited to (A) A second full- community-based based functional exercise of this section is of but is not limited to (A) A second full- community-based based functional exercise based functional exercise based functional exercise led by a facilitator discussion, using clinically-relevant set of problem star messages, or pre- to challenge an e (iii) Analyze the F maintain docume exercises, and en the PACE's emer  *[For LTC Facilities (2) The [LTC facilities (2) The [LTC facilities (2) The remained in a that is community	the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: -scale exercise that is or individual, a facility exercise; or eter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan.  PACE's response to and intation of all drills, tabletop mergency events and revise gency plan, as needed.  es at §483.73(d):] ity] must conduct exercises ency plan at least twice per lannounced staff drills using locedures. The [LTC facility, the following: an annual full-scale exercise				

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	COM	re survey pleted 21/2024
	OF PROVIDER OR SUPPLIES  CORPORATION OF		8307	T ADDRESS, CITY, STATE, ZIP COI 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 CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE
	accessible, condu- facility-based fund (B) If the [LTC fac- actual natural or requires activation LTC facility is exe- required a full-sca- individual, facility- following the onse (ii) Conduct an arthat may include, following: (A) A second full- community-based based functional of (B) A mock disas (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem sta- messages, or pre to challenge an e (iii) Analyze the [ response to and response to the response t	act an annual individual, ctional exercise. cility] facility experiences an man-made emergency that in of the emergency plan, the empt from engaging its next ale community-based or abased functional exercise et of the emergency event. dditional annual exercise but is not limited to the exercise that is a for an individual, facility exercise; or exercise or workshop that is includes a group a narrated, emergency scenario, and a extements, directed pared questions designed exercises, and emergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed.  S483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY  IPLETED  21/2024
	PROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP CO ASTLETON BLVD APOLIS, IN 46256	OD .	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	activation of the exempt from enfull-scale community-based functions of the emer (ii) Conduct an additivation and that may include, following:  (A) A second full-community-based facility-based functions of the emer (iii) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an er (iii) Analyze the IC maintain documer exercises, and enthe ICF/IID's eme  *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. The following:  (i) Participate in a community-based (A) When a cois not accessible, individual, facility-every 2 years; or.  (B) If the HH natural or man-matactivation of the exercises for the exercises of the exercise	ditional annual exercise but is not limited to the scale exercise that is or an individual, stional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. CF/IID's response to and station of all drills, tabletop mergency events, and revise rgency plan, as needed. 34.102] e HHA must conduct the emergency plan at e HHA must do the full-scale exercise that is				

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	OF CORRECTION	IDENTIFICATION NUMBER  15G814	ľ í	UILDING	NSTRUCTION	COMPL 02/21	LETED
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
VOCA C	ORPORATION OF	INDIANA			ASTLETON BLVD APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		nity-based or individual,		TAG			DATE
		tional exercise following the					
	onset of the emer	_					
		ditional exercise every 2					
	, ,	e year the full-scale or					
	functional exercise	e under paragraph (d)(2)(i)					
	of this section is c	onducted, that may					
	include, but is not	limited to the following:					
	` '	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						
	-	emergency scenario, and a					
	set of problem sta						
	to challenge an er	pared questions designed					
	_	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ency plan, as needed.					
	*[For OPOs at §48	R6 3601					
	_	e OPO must conduct					
		he emergency plan. The					
	OPO must do the	- · · · · · · · · · · · · · · · · · · ·					
		er-based, tabletop exercise					
		ast annually. A tabletop					
	-	a facilitator and includes a					
	group discussion,	using a narrated, clinically					
	relevant emergen	cy scenario, and a set of					
	problem statemen	ts, directed messages, or					
		ns designed to challenge an					
		f the OPO experiences an					
		nan-made emergency that					
	-	n of the emergency plan, the					
		om engaging in its next					
	required testing ex	xercise following the onset					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/21/2024
	PROVIDER OR SUPPLIER		8307	ET ADDRESS, CITY, STATE, ZIP COD CASTLETON BLVD ANAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	maintain document exercises, and enthe [RNHCl's and needed.  *[RNCHIs at §40: (d)(2) Testing. The exercises to test to the state of the exercises to test to the exercises of the exercise of the exercise of the exercise of the exercises, and enthe exercises of the follow exercise that is concommunity-based of all of the follow exercise that is concommunity-based enthe emergency that requency plan, the engaging in a community-based full-sfollowing the onset conduct an addition but is not limited to full-scale exercise to	PO's response to and ntation of all tabletop hergency events, and revise OPO's] emergency plan, as  3.748]: e RNHCI must conduct the emergency plan. The	E 0039	CORRECTION: The [facility] must conduct exercises to test the emerger plan at least annually. Specifithe agency has assigned a rimanagement specialist from Quality Assurance Departme (the QIDP Manager) to conduct exercise of choice table talk conference, with the provider Safety Committee. Participar will include ResCare Department Heads, the QIDP and other administrative level manager (Program Manager, Quality Assurance Manager, Quality Assurance Coordinator, and Manager) will participate in the	ically, sk the nt uct an 's nts nent nent,

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	ORRECTION IDENTIFICATION NUMBER A. BUILDING		(X3) DATE SURVEY  COMPLETED  02/21/2024	
	PROVIDER OR SUPPLIER		8307 0	ADDRESS, CITY, STATE, ZIP COD CASTLETON BLVD NAPOLIS, IN 46256		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG	*	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE	
	_	p discussion led by a		exercises to assure facility		
		narrated, clinically-relevant		emergency preparedness		
		o, and a set of problem		protocols are consistent with		
		l messages, or prepared		community emergency		
		to challenge an emergency		management practices. The		
		ne ICF/IID facility's response to		Safety Committee chairperso		
	and maintain documentation of all drills, tabletop			assure biannual completion o	f	
	exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in			these exercises.		
				The facility will develop		
		CFR 483.475(d)(2). This		documentation of the activation	on of	
	deficient practice co	ould affect all occupants.		the Emergency Preparedness	5	
				Plan during the 11/7/23 mass		
	Findings include:			power outage event, in which	the	
				facility sheltered in place by		
		"Emergency/Disaster		3/16/24. A "table talk exercise	will	
	-	al" documentation dated		be scheduled within 6 months	of	
		rgency, Disaster, Evacuation		the full-scale event.		
	-	es" documentation dated		PREVENTION:		
	07/01/23 with the N	Maintenance Aide during record		Members of the Operations T	eam	
		a.m. to 11:05 a.m. on 02/21/24,		(comprised of the Executive		
	documentation of a	community based disaster drill		Director, Operations Manager	rs,	
		ent twelve month period was		Program Managers, Area		
		view. Based on interview at the		Supervisors, Quality Assuran	ce	
		ew, the Maintenance Aide		Manager, QIDP Manager, QII	OP,	
	agreed the facility h			Quality Assurance Coordinate	ors,	
	-	isaster drill or conducted a		and Nurse Manager) will		
	tabletop exercise w	ithin the most recent twelve		incorporate reviews of the fac	ility's	
	_	greed testing documentation		emergency preparedness pro		
	was not available for	or review at the time of the		into scheduled monthly audits		
	survey.			assure all required componer	its,	
				including but not limited to		
	These findings were			bi-annual community-based		
	Maintenance Aide	during the exit conference.		disaster exercises, are preser		
				Additionally, the agency Safe	-	
				Committee will review and rev		
				the plan as needed but no les	S	
				than annually.		
				RESPONSIBLE PARTIES: Q		
				Area Supervisor, Direct Supp	ort	
				Lead, Direct Support Staff,		

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NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	COMI	E SURVEY PLETED 1/2024
		8307	CASTLETON BLVD	OD	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE IPPROPRIATE	(X5) COMPLETION DATE
			Operations Team, Reg Director	ional	
conducted by the In accordance with 42  Survey Date: 02/21  Facility Number: 0  Provider Number: 201-  At this Life Safety 0 of Indiana was foun Requirements for Pacter Subpart 483.4 the 2012 edition of Association (NFPA Chapter 33, Existing Occupancies.	diana Department of Health in CFR 483.470(j).  /24  10453 15G814 408320  Code survey, Voca Corporation d not in compliance with articipation in Medicaid, 42 70(j), Life Safety from Fire and the National Fire Protection ) 101, Life Safety Code (LSC), g Residential Board and Care	K 0000			
sprinklered. The fa with smoke detection areas. The facility to the fire alarm system The facility has heat attic. The facility has census of 8 at the time. Calculation of the E (E-Score) using NF Approaches to Life facility Prompt with	cility has a fire alarm system on in corridors and all living has smoke detectors hard wired tem installed in all bedrooms. It detection installed in the has a capacity of 8 and had a me of this survey.  Evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the han E-Score of 0.1.				
	PROVIDER OR SUPPLIER ORPORATION OF I SUMMARY: (EACH DEFICIEN REGULATORY OR  A Life Safety Code conducted by the In accordance with 42 Survey Date: 02/21 Facility Number: 0 Provider Number: AIM Number: 2014 At this Life Safety of Indiana was foun Requirements for Pactor of Indiana was f	DENTIFICATION NUMBER 15G814  PROVIDER OR SUPPLIER  ORPORATION OF INDIANA  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).  Survey Date: 02/21/24  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 Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care	DENTIFICATION NUMBER 15G814  ROVIDER OR SUPPLIER  ORPORATION OF INDIANA  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).  Survey Date: 02/21/24  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 Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.  This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has smoke detectors hard wired to the fire alarm system installed in all bedrooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey.  Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.1.	OF CORRECTION IDENTIFICATION NUMBER 15G814  PROVIDER OR SUPPLIER ORPORATION OF INDIANA  SUMMARY STATEMENT OF DEFICIENCIE (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).  Survey Date: 02/21/24  Facility 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 8012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.  This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detectors hard wired to the fire alarm system installed in all bedrooms. The facility has heat detection installed in the attic. The facility has heat detection installed in the attic. The facility has neapacity of 8 and had a census of 8 at the time of this survey.  Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.1.	OF CORRECTION DESTIFICATION NUMBER 15G814  ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j.)  Survey Date: 02/21/24  Facility Number: 010453 Provider Number: 15(8314 ALM 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 Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.  This one story building was determined to be fully sprinklered. The facility has smoke detectors in corridors and all living areas. The facility has smoke detectors hard wired to the fire alarm system with smoke detection in corridors and all living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.  Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an F-Score of 0.1.

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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. building <u>01</u>		01	COMPLETED			
		15G814		ING	_	02/21/	/2024		
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DDOVIDED'S DI AN OE CODDECTION	FION (X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION		
TAG				TAG	DEFICIENCY)		DATE		
K S511  Bldg. 01	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		KS	8307 CASTLETON BLVD INDIANAPOLIS, IN 46256  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		A  nt nal e m to  eam s, ce DP, ors, dility's ed are	03/15/2024		

PRINTED: 03/08/2024 FORM APPROVED 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 <u>01</u>		COMPLETED				
		15G814	B. WING			02/21/2024			
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		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
IAG	(C) Methods of Grogrounding conductor cord connectors shat to the equipment grocircuit supplying the The branch-circuit value provide an equipment which the equipment contacts of the recept connected.  Informational Note acceptable grounding Informational Note existing branch circuit This deficient practicular staff.  Findings include:  Based on observation Aide during a tour of 11:20 a.m. on 02/21 the wall mounted on near the sink were figround" when tested listed circuit tester to interview at the time Maintenance Aide as showed the aforement location needed report of the staff of	unding. The equipment or contacts of receptacles and all be grounded by connection ounding conductor of the exceptacle or cord connector. Wiring method shall include or not grounding conductor to the grounding conductor of the grounding conductor of the exceptacle or cord connector are are all the state of the facility from 11:05 a.m. to all the facili		IAG			DATE		

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