STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  05/20/2024			TED	
	PROVIDER OR SUPPLIE		8307	r address, city, state, zip cod CASTLETON BLVD NAPOLIS, IN 46256		
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION
TAG E 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY		DATE
Bldg	Preparedness Surv	risit (PSR) to the Emergency ey conducted on 02/21/24 was ndiana Department of Health in 2 CFR 483.475.	E 0000			
	Survey Date: 05/2	0/24				
	Facility Number: Provider Number: AIM Number: 20	15G814				
	Indiana Inc was fo Emergency Prepar	ey, Voca Corporation of und not in compliance with edness Requirements for cicaid Participating Providers				
		certified beds. All 8 beds are raid. At the time of the survey,				
	Quality Review co	mpleted on 05/20/24				
	The requirement at NOT MET as evid	t 42 CFR, Subpart 483.475 is enced by:				
E 0039 Bldg	441.184(d)(2), 484 483.73(d)(2), 485 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requist S416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), §	6.54(d)(2), 418.113(d)(2), 62.15(d)(2), 483.475(d)(2), 6.102(d)(2), 485.625(d)(2), 6.727(d)(2), 485.920(d)(2), 61.12(d)(2), 494.62(d)(2) irements 618.113(d)(2), §441.184(d)(2), 628.15(d)(2), §483.73(d)(2), 6484.102(d)(2), §485.68(d)(2), 6485.727(d)(2), §485.920(d)				
LABORATOR	LY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE		(X6) DATE

Bob Morris QIDP Manager 05/24/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin

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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		<u></u>	COMPLI 05/20/	
IDIANA	8307 CA	ASTLETON BLVD		
ATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)
Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
SC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
§494.62(d)(2).				
.54, CORFs at §485.68, as" under §485.727, D, RHCs/FQHCs at D Facilities at §494.62]: cility] must conduct e emergency plan ty] must do all of the				
ull-scale exercise that is very 2 years; or unity-based exercise is duct a facility-based every 2 years; or y] experiences an actual e emergency that requires ergency plan, the [facility] aging in its next required r individual, facility-based following the onset of the tional exercise at least existe the year the full-scale are under paragraph (d)(2) conducted, that may mited to the following: ale exercise that is r individual, facility-based or drill; or cise or workshop that is not includes a group narrated, mergency scenario, and a sements, directed				
Tay Sign (1900) Cooking I Alide Ve early the son air or	ATEMENT OF DEFICIENCIE  MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION  494.62(d)(2).  54, CORFs at §485.68, s" under §485.727, 0, RHCs/FQHCs at Facilities at §494.62]:  fility] must conduct emergency plan y] must do all of the  Ill-scale exercise that is very 2 years; or inity-based exercise is fuct a facility-based every 2 years; or y] experiences an actual e emergency that requires ergency plan, the [facility] aging in its next required r individual, facility-based following the onset of the  tional exercise at least site the year the full-scale e under paragraph (d)(2) conducted, that may nited to the following: ale exercise that is r individual, facility-based or drill; or ise or workshop that is nd includes a group narrated, nergency scenario, and a	ATEMENT OF DEFICIENCIE  MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION  A94.62(d)(2).  54, CORFs at §485.68, s" under §485.727, 0, RHCs/FQHCs at Facilities at §494.62]:  Sility] must conduct The emergency plan The emergency plan The emergency plan The emergency plan The emergency of the emergency that requires ergency plan, the [facility] The emergency plan, the [facility] The emergency plan, the facility-based every 2 years; or The emergency plan, the facility-based encounty of the emergency plan, the facility-based encounty of the emergency plan, the facility-based following the onset of the emergency plan, the facility-based following the onset of the emergency plan, the facility-based following the onset of the emergency plan, the facility-based following the onset of the emergency plan, the facility-based following the onset of the emergency plan, the facility-based following the onset of the emergency plan, the facility-based following the onset of the emergency plan, the facility-based for drill; or is or workshop that is an individual, facility-based for drill; or is or workshop that is and includes a group marrated, mergency scenario, and a ments, directed fred questions designed	ATEMENT OF DEFICIENCIE  'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION  494.62(d)(2).  54, CORFs at §485.68, s' under §485.727, 0, RHCs/FQHCs at 'Facilities at §494.62]:  iility] must conduct emergency plan y] must do all of the  Ill-scale exercise that is very 2 years; or inity-based every 2 years; or y] experiences an actual e emergency that requires ergency plan, the [facility] aging in its next required r individual, facility-based ollowing the onset of the tional exercise at least site the year the full-scale e under paragraph (d)(2) conducted, that may inited to the following: ale exercise that is r individual, facility-based or drill; or ise or workshop that is not includes a group narrated, nergency scenario, and a ments, directed red questions designed	DIANA  ATEMENT OF DEFICIENCIE  WINTS BE PRECEDED BY FULL SCIDENTIFYING INFORMATION  494.62(d)(2).  54, CORFs at \$485.68, s' under \$485.727, 0, RHCs/FCHCs at 1-Facilities at \$494.62]:  ### William of the information in the

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Event ID:

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	NI OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER  15G814	A. BUII B. WIN	LDING		COMPL 05/20/	ETED
	PROVIDER OR SUPPLIEF			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	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	(iii) Analyze the [farmaintain documer exercises, and enter the [facility's] emeth [facil	acility's] response to and natation of all drills, tabletop nergency events, and revise rgency plan, as needed.  418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual stional exercise following the gency event. Inditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed					

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Event ID:

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	ILDING	<del>-</del>	COMPL	
		15G814	B. WI	NG		05/20/	2024
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					ASTLETON BLVD		
VOCA CO	ORPORATION OF	INDIANA		INDIANAPOLIS, IN 46256			
(X4) ID		STATEMENT OF DEFICIENCIE	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	` ·	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	, ,	spices that provide inpatient					
		hospice must conduct he emergency plan twice					
		spice must do the following:					
		an annual full-scale exercise					
	that is community-						
	_	nunity-based exercise is not					
	, ,	ict an annual individual					
	facility-based fund						
	-	experiences a natural or					
	man-made emerg	ency that requires activation					
	of the emergency	plan, the hospice is					
	exempt from enga	aging in its next required					
	full-scale commun	nity based or facility-based					
	functional exercise	e following the onset of the					
	emergency event.						
		dditional annual exercise					
	that may include,	but is not limited to the					
	following:						
		scale exercise that is					
	community-based	-					
	functional exercise						
	(B) A mock disast						
	` '	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,						
	• •	rio, and a set of problem					
		ed messages, or prepared					
	questions designe	ed to challenge an					
	emergency plan.	ospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		ergency plan, as needed.					
	and nospide a cine	ngonoy pian, ao noodod.					
	_	l41.184(d), Hospitals at					
	§482.15(d), CAHs	. , ,					
	. ,	PRTF, Hospital, CAH] must					
	i conquet exercises	to test the emergency	1				1

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814			r í	JILDING	NSTRUCTION	(X3) DATE COMPI 05/20	LETED
	PROVIDER OR SUPPLIEF			8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
VOO/10				II VDI/ (I V	711 0210, 111 40200		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	plan twice per year CAH] must do the (i) Participate in a that is community (A) When a commaccessible, condufacility-based function (B) If the [PRTF, Han actual natural of that requires active plan, the [facility] its next required from individual, facility following the onse (ii) Conduct a exercise or and the limited to the following the onse (iii) Conduct a exercise or and the limited to the following the onse (B) A mon (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem state messages, or preton challenge an erection (iii) Analyze the and maintain docutableton exercises and revise the [factorial factorial f	ar. The [PRTF, Hospital, following: an annual full-scale exercise abased; or aunity-based exercise is not an annual individual, ational exercise; or alospital, CAH] experiences or man-made emergency ation of the emergency ation of the emergency sexempt from engaging in all-scale community based ty-based functional exercise at of the emergency event. In an [additional] annual at may include, but is not wing: scale exercise that is or individual, a ational exercise; or ack disaster drill; or a exercise or workshop that or and includes a group an anarrated, emergency scenario, and a tements, directed pared questions designed mergency plan. The [facility's] response to a tementation of all drills, and emergency events collity's] emergency plan, as					

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	AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G814  A. BUILDING   B. WING		NSTRUCTION	COMPLETED 05/20/2024		
NAME (	F PROVIDER OR SUPPLIEF	2		DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
VOCA	CORPORATION OF	INDIANA		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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	accessible, condu- facility-based func- (B) If the PACE ex- or man-made eme- activation of the e- is exempt from en- full-scale commun- facility-based func- onset of the emer- (ii) Conduct a 2 years opposite to functional exercise of this section is co- but is not limited to (A) A second full- community-based based functional executional execution executio	nunity-based exercise is not lect an annual individual, etional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required nity based or individual, etional exercise following the gency event.  In additional exercise every the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: escale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a exempt of the exercise that is and includes a group and the exercise of the exercise or workshop that is and includes a group and includes a group and the exercise of the exercise or workshop that is and includes a group and the exercise of the exercise or workshop that is and includes a group and the exercise of the exercise or workshop that is and includes a group and the exercise of the exercise of the exercise of the exercise of the exercises are sent of the exercises are sent of the exercises are sent of the exercise of the following: an annual full-scale exercise or workshop that is an exercise or workshop that is and includes a group an arrated, emergency plan.  PACE's response to and the exercise of the exercises are sent of the exercises of the exercise of the e				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G814		ľ	JILDING	NSTRUCTION	COMPL 05/20	ETED	
NAME (	OF PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD		
VOCA	CORPORATION OF	INDIANA			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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(A) When a commaccessible, condutatively-based functional facility-based functional facility-based functional facility-based functional facility is exercised a full-scalindividual, facility-following the onset (ii) Conduct an activate may include, following:  (A) A second full-community-based based functional formunity-based functional functional functional functional formunity-based functional functi	nunity-based exercise is not act an annual individual, stional exercise.  ility] facility experiences an anan-made emergency that a of the emergency plan, the mpt from engaging its next ale community-based or based functional exercise at of the emergency event. Additional annual exercise but is not limited to the escale exercise that is or an individual, facility exercise; or a ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan.  LTC facility] facility's maintain documentation of exercises, and emergency et he [LTC facility] facility's as needed.  (3483.475(d)]:  CF/IID must conduct the emergency plan at least are ICF/IID must do the					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 05/20/2024			
	PROVIDER OR SUPPLIER		8307 C	ADDRESS, CITY, STATE, ZIP COD CASTLETON BLVD NAPOLIS, IN 46256	
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		BE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	1 ' '	experiences an actual			
		ade emergency that requires			
		mergency plan, the ICF/IID			
	-	gaging in its next required			
		ity-based or individual, tional exercise following the			
	onset of the emerg				
		ditional annual exercise			
	l ` '	but is not limited to the			
	following:				
		scale exercise that is			
	community-based				
	1	tional exercise; or			
	(B) A mock disast				
	(C) A tabletop exe	rcise 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 sta	tements, directed			
		pared questions designed			
	to challenge an er				
	1 ' ' -	F/IID's response to and			
		ntation of all drills, tabletop			
		nergency events, and revise			
	the ICF/IID's emer	gency plan, as needed.			
	*[For HHAs at §48	34.102]			
		e HHA must conduct			
		he emergency plan at			
	1	e HHA must do the			
	following:				
		full-scale exercise that is			
	community-based				
	1 ' '	ommunity-based exercise			
		conduct an annual			
	1	based functional exercise			
	every 2 years; or.	A			
		A experiences an actual			
		ade emergency that requires mergency plan, the HHA is			

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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA  INDIANAPOLIS, IN 46256  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  exempt from engaging in its next required full-scale community-based or individual,  STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE
VOCA CORPORATION OF INDIANA  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION  exempt from engaging in its next required  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETION DATE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CACOON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF COMPLETION DATE  REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)  exempt from engaging in its next required  COMPLETION DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  exempt from engaging in its next required
exempt from engaging in its next required
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 actual natural or man-made emergency that
requires activation of the emergency plan, the
OPO is exempt from engaging in its next

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED  B. WING 05/20/2024				
		15G814	B. W	ING		05/20/	2024
	PROVIDER OR SUPPLIEF			8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
IAU	required testing exof the emergency (ii) Analyze the OI maintain documer exercises, and em the [RNHCI's and needed.  *[ RNCHIs at §403 (d)(2) Testing. The exercises to test to RNHCI must do the conduct a paper at least annually. It group discussion	xercise following the onset event. PO's response to and nation of all tabletop nergency events, and revise OPO's] emergency plan, as  3.748]: PRINHCI must conduct the emergency plan. The ne following: Per-based, tabletop exercise tabletop exercise is a led by a facilitator, using a		IAU			DATE
	scenario, and a sed directed message designed to challe (ii) Analyze the RI maintain documer exercises, and enthe RNHCI's emergancy plan on emergency plan on emergency procedudo all of the follow exercise that is community-based exindividual, facility-experiences an actue emergency plan, the engaging in a community-based full-sfollowing the onset conduct an addition but is not limited to	et of problem statements, s, or prepared questions enge an emergency plan. WHCl's response to and natation of all tabletop nergency events, and revise regency plan, as needed. View and interview, the facility least two exercises to test the an annual basis using the res. The ICF/IID facility must ing: (i) participate in a full-scale amunity-based or when a exercise is not accessible, an anatural or man-made energe activation of the et ICF/IID facility is exempt from nunity-based or individual, cale exercise for 1 year of the actual event; (ii) all exercise that may include the following: (A) a second that is community-based or	E 00	039	CORRECTION: The [facility] must conduct exercises to test the emergen plan at least annually. Specific the agency has assigned a ris management specialist from ti Quality Assurance Department (the QIDP Manager) to conduct exercise of choice table talk conference, with the provider's Safety Committee. Participant will include ResCare Department Heads, the QIDP and other administrative level managem (Program Manager, Quality Assurance Manager, Quality Assurance Coordinator, and Name of the services of the s	cally, k he ct an s s ent	07/05/2024

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Facility ID: 010453

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G814		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED  B. WING 05/20/2024				
NAME OF I	PROVIDER OR SUPPLIER	<u>.</u>		T ADDRESS, CITY, STATE, ZIP COD	•	
				CASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA	INDIA	ANAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		based. (B) a tabletop exercise		Manager) will participate in t	the	
		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 ne ICF/IID facility's response to		management practices. The		
		nentation of all drills, tabletop		Safety Committee chairpers assure biannual completion		
		gency events, and revise the		these exercises.	OI	
		mergency plan, as needed in		The facility will develop		
		CFR 483.475(d)(2). This		documentation of the activation	tion of	
		ould affect all occupants.		the Emergency Preparedne	•	
	deficient practice ex	said affect aff occupants.		Plan during the 3/14/24 seve		
	Findings include:			weather event, in which the		
	i mamga maraaci			sheltered in place by 6/19/2	,	
	Based on review of	"Emergency/Disaster		"table talk exercise will be		
		al" documentation dated		scheduled within 6 months of	of the	
	_	rgency, Disaster, Evacuation		full-scale event. Specifically		
		es" documentation dated		exercise will occur in conjun		
	07/01/23 with the N	Maintenance Aide during record		with the operation's quarterl	•	
	review from 10:00	a.m. to 11:05 a.m. on 02/21/24,		Safety Committee meeting.		
	documentation of a	community based disaster drill				
	within the most rec	ent twelve month period was		The QIDP Manager, who de	velops	
		view. Based on interview at the		and updates facility Emerge	ncy	
		ew, the Maintenance Aide		Preparedness Planning rece	eived	
	agreed the facility h			additional training from the		
	_	isaster drill or conducted a		corporate risk management	team.	
		ithin the most recent twelve		PREVENTION:		
	_	greed testing documentation		Members of the Operations		
	was not available for	or review at the time of the		(comprised of the Executive		
	survey.			Director, Operations Manag	ers,	
	<b>.</b>			Program Managers, Area		
		at the time of the PSR at 10:05		Supervisors, Quality Assura		
	· ·	ne Maintenance Aide stated the		Manager, QIDP Manager, Q		
	1	ducted a community based		Quality Assurance Coordina	itors,	
		ducted a tabletop exercise		and Nurse Manager) will	:!!4. / .	
		ent twelve month period and		incorporate reviews of the fa		
		mentation was not available		emergency preparedness pr	_	
	for review at the tin	ne of the PSK.		into scheduled monthly audi	•	
I	I		1	assure all required compone	ะแง,	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G814		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  G <u></u>	(X3) DATE SU COMPLET 05/20/20	TED	
	PROVIDER OR SUPPLIER		830	EET ADDRESS, CITY, STATE, ZIP COD 7 CASTLETON BLVD IANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE
	This deficiency was	luring the exit conference.  cited on 02/21/24. The facility a systemic plan of correction		including but not limited to bi-annual community-base disaster exercises, are pre Additionally, the agency S Committee will review and the plan as needed but not than annually.  RESPONSIBLE PARTIES Area Supervisor, Direct St Lead, Direct Support Staff Operations Team, Region Director	ed esent. afety revise less : QIDP, upport	
K 0000 Bldg. 01	Code Recertification 02/21/24 was condu	sit (PSR) to the Life Safety n Survey conducted on cted by the Indiana th in accordance with 42 CFR	K 0000			
	was found not in co for Participation in 483.470(j), Life Saf edition of the Natio (NFPA) 101, Life S Existing Residentia	10453 15G814				
	sprinklered. The fa- with smoke detection	cility has a fire alarm system in corridors and all living has smoke detectors hard wired				

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Facility ID: 010453

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>01</u>		01	COMPLETED		
15G814		B. WING 05/20/2024				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		DROVIDEDIS DI ANI OE CODDECTIONI		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG				TAG	DEFICIENCY)	.16	DATE	
K S511 Bldg. 01	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		K S		CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
	NFPA 70, 2011 Edi Requirements states located in branch ci III of Article 210. (crequirements shall be through (F). (A) Grounding Type and 20-ampere bran grounding type. Grounding-type reco	70, National Electrical Code. tion at 406.4 General Installation receptacle outlets shall be reuits in accordance with Part General installation be in accordance with 406.4(A)  e. Receptacles installed on 15- ch circuits shall be of the eptacles shall be installed only ltage class and current for			licensed electrician to repair the electrical receptacles in the laundry room to assure they a properly grounded.  PREVENTION:  Members of the Operations To (comprised of the Executive Director, Operations Manager: Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QID	ne re eam s,		
	which they are rated	l, except as provided in Table			Quality Assurance Coordinato	rs,		

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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	B. WING		05/20/2024		
				STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	₹			ASTLETON BLVD		
VOCA CORPORATION OF INDIANA					APOLIS, IN 46256		
				INDIAN	7.1 OZIO, III 70200		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	210.21(B)(2) and T	* / * /			and Nurse Manager) will		
		unding-type receptacles			incorporate reviews of the fac		
	installed in accorda				electrical outlets into schedule		
		ed. Receptacles and cord			monthly audits to assure they		
	connectors that have equipment grounding				properly grounded.		
		shall have those contacts		RESPONSIBLE PARTIES			
	connected to an equipment grounding conductor.				Area Supervisor, Direct Supp		
	_	eceptacles mounted on portable			Lead, Environmental Services		
	and vehicle-mounted generators in accordance				Staff, Operations Team		
	with 250.34.						
	_	eplacement receptacles as					
	permitted by 406.4						
	· /	ounding. The equipment					
		or contacts of receptacles and					
		all be grounded by connection					
		to the equipment grounding conductor of the					
	circuit supplying the receptacle or cord connector.						
	The branch-circuit wiring method shall include or						
	provide an equipment grounding conductor to						
		nt grounding conductor					
		contacts of the receptacle or cord connector are					
		connected.					
	Informational Note No. 1: See 250.118 for						
	acceptable grounding means.						
	Informational Note No. 2: For extensions of						
	existing branch circuits, see 250.130.						
	This deficient practice could affect one client and						
	staff.						
	Findings include:						
	Findings include:						
	Based on observations with the Maintenance						
	Aide at 10:00 a.m. on 05/20/24, the electrical						
	receptacles in the wall mounted outlet box in the						
	laundry room near the sink were found to have an						
	"open ground" when tested with an Ideal						
	* *						
	Industries UL listed circuit tester testing device.  Based on interview at the time of the						
	observations, the Maintenance Aide stated he						
	replaced the electrical receptacles recently to						1

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER  15G814	A. BUILDING <u>01</u> B. WING		01	COMPLETED 05/20/2024		
		130014	B. W1			03/20/	2024	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 8307 CASTLETON BLVD INDIANAPOLIS, IN 46256				
VOCA CORPORATION OF INDIANA								
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	•	but agreed they still have an						
	open ground. The Maintenance Aide stated he							
	has a service call into an electrician to see why the							
	circuit for the receptacles has an open ground and							
	agreed the testing device showed the aforementioned electrical receptacle location needed repair.							
	These findings were reviewed with the							
	Maintenance Aide d	luring the exit conference.						
	•	cited on 02/21/24. The facility						
	failed to implement	a systemic plan of correction						
	to prevent recurrence	ee.						

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