PRINTED: 07/29/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES X1) PROVIDE AND PLAN OF CORRECTION IDENTIFICATION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMPLETED 07/12/2024	
NAME OF PROVIDER				8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
TAG REG	ACH 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
conductory accords and accords and accords acc	cted on 05/20 redness Surve cted by the In lance with 42 red Date: 07/12 redness Survey redness rednes	to the Emergency y, Voca Corporation of and not in compliance with dness Requirements for caid Participating Providers FR 483.475.  ertified beds. All 8 beds are aid. At the time of the survey,  mpleted on 07/15/24  42 CFR, Subpart 483.475 is enced by: 6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2),	E 00	000			
486.36 EP Te §416.9 §460.8 §483.4	60(d)(2), 49 esting Requi 54(d)(2), §4 84(d)(2), §4 475(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),			TITLE		(X6) DATE

(X6) DATE

**Bob Morris** QIDP Manager 07/26/2024

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

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	<del></del>	COMPL	LETED
		15G814	B. W	ING		07/12	/2024
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R		8307 C	ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	§485.625(d)(2), § (2), §491.12(d)(2)	485.727(d)(2), §485.920(d) ), §494.62(d)(2).					
	*IFor ASCs at 84°	16.54, CORFs at §485.68,					
	OPO, "Organizations" under §485.727,						
		920, RHCs/FQHCs at					
	_	RD Facilities at §494.62]:					
	(2) Testing. The [	facility] must conduct					
	exercises to test t	he emergency plan					
	annually. The [fac	cility] must do all of the					
	following:						
	(i) Dortiningto in a	full cools eversion that is					
		full-scale exercise that is I every 2 years; or					
	1	nevery 2 years, or munity-based exercise is					
	1 ' '	onduct a facility-based					
		e every 2 years; or					
		ility] experiences an actual					
	. , , -	ade emergency that requires					
		mergency plan, the [facility]					
		ngaging in its next required					
		l or individual, facility-based					
	functional exercis	e following the onset of the					
	actual event.	-					
	(ii) Conduct an ac	lditional exercise at least					
	every 2 years, op	posite the year the full-scale					
	or functional exer	cise under paragraph (d)(2)					
	1 ' '	s conducted, that may					
		limited to the following:					
	` '	scale exercise that is					
	-	l or individual, facility-based					
	functional exercis						
	(B) A mock disast						
		ercise or workshop that is					
	-	and includes a group					
	discussion using						
	I	emergency scenario, and a					
	-	atements, directed					
	I messages, or pre	pared guestions designed	1		1		1

PRINTED: 07/29/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	ľ	LDING	NSTRUCTION	(X3) DATE COMPL 07/12	ETED
	PROVIDER OR SUPPLIES			8307 CA	DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD	•	
VOCA C	ORPORATION OF	Indiana		INDIANA	APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION DATE
IAU	to challenge an er (iii) Analyze the [famaintain documer exercises, and en the [facility's] eme *[For Hospices at (2) Testing for hothe patient's home conduct exercises plan at least annut the following: (i) Participate in a community based (A) When a commaccessible, conduct exercises plan at least annut the following: (i) Participate in a community based functional exercised functional emergency exempt from engascale community-facility-based functional exercised fun	mergency plan. acility's] response to and acility's] response to and actation of all drills, tabletop argency events, and revise argency plan, as needed.  418.113(d):] aspices that provide care in a. The hospice must a to test the emergency ally. The hospice must do a full-scale exercise that is a every 2 years; or anuity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or alency that requires activation plan, the hospital is aging in its next required full based exercise or individual actional exercise following the agency event. additional exercise every 2 are year the full-scale or a under paragraph (d)(2)(i) conducted, that may limited to the following: ascale exercise that is a or a facility based a; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed		IAU			DATE
	to challenge an er	nergency plan.					

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Event ID:

9H7B23 Facility ID: 010453

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	E SURVEY PLETED 2/2024
	PROVIDER OR SUPPLIEF		8307 C	ADDRESS, CITY, STATE, ZIP C CASTLETON BLVD NAPOLIS, 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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	care directly. The exercises to test to per year. The hose (i) Participate in a state that is community (A) When a community (A) When a community-based functional exercise emergency exempt from engatull-scale community-based functional exercise emergency event. (ii) Conduct an act that may include, following:  (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop extenditation that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the hospice's emergency semester exercises, and emergency semester exercises, and emergency semester exercises, and emergency semester exercises emergency semester exercises, and emergency semester exercises, and emergency semester exercises emergency semester exercises, and emergency semester exercises exercises emergency semester exercises emergency semester exercises emergency semester exercises emergency exercises exer	nunity-based exercise is not act an annual individual extional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the editional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem end messages, or prepared ed to challenge an espice's response to and mation of all drills, tabletop nergency events and revise ergency plan, as needed.				
	§482.15(d), CAHs	l41.184(d), Hospitals at s at §485.625(d):] PRTF, Hospital, CAH] must				

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Event ID:

9H7B23 Fac

Facility ID: 010453

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		15G814	B. W	ING		07/12/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA			APOLIS, IN 46256		
				111517111	711 0210, 117 10200		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the	<del>-</del>					
	(i) Participate in an annual full-scale exercise						
	that is community						
	, ,	nunity-based exercise is not					
		ct an annual individual,					
		tional exercise; or					
		Hospital, CAH] experiences					
		or man-made emergency					
	-	ation of the emergency is exempt from engaging in					
		ull-scale community based					
		ty-based functional exercise					
		et of the emergency event.					
	_	an [additional] annual					
	, ,	at may include, but is not					
	limited to the follow						
		scale exercise that is					
	community-based						
	-	ctional exercise; or					
		ock disaster drill; or					
	, ,	exercise or workshop that					
	, ,	or and includes a group					
	discussion, using	<b>.</b>					
		emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an er	·					
	_	he [facility's] response to					
	and maintain docu	umentation of all drills,					
	tabletop exercises	s, and emergency events					
	and revise the [fac	cility's] emergency plan, as					
	needed.						
	*[For PACE at §46	· · -					
		ACE organization must					
		to test the emergency					
	plan at least annu	-					
	organization must	do the following:					

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Event ID:

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814		UILDING	NSTRUCTION	(X3) DATE COMPI 07/12	
	ROVIDER OR SUPPLIEF		Ī	8307 CA	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
	(i) Participate in a that is community (A) When a commaccessible, conducted facility-based functions (B) If the PACE experience or man-made emeractivation of the experience of the emeractivation of the experience of the emeractivation of the	an annual full-scale exercise a-based; or nunity-based exercise is not act an annual individual, ctional exercise; or experiences an actual natural ergency that requires amergency plan, the PACE agaging in its next required anity based or individual, ctional exercise following the agency event. An additional exercise every and include, and include, and include, and includes a group an anarrated, emergency scenario, and a antenents, directed pared questions designed antenents designed antene					

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Event ID:

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION  IG	COM	TE SURVEY  MPLETED  12/2024
	OF PROVIDER OR SUPPLIES  CORPORATION OF		830	EET ADDRESS, CITY, STATE, ZIP 07 CASTLETON BLVD DIANAPOLIS, IN 46256	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE	RRECTION SHOULD BE APPROPRIATE	(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 (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 following: (2) Testing. The I exercises to test to twice per year. The following: (i) Participate in a that is community (A) When a community (A) When a community	nunity-based exercise is not act an annual individual, ctional exercise.  cility] facility experiences an annual man-made emergency that an of the emergency plan, the empt from engaging its next ale community-based or abased functional exercise at of the emergency event.  dditional annual exercise but is not limited to the exercise that is a or an individual, facility exercise; or exercise or workshop that is includes a group a narrated, emergency scenario, and a extements, directed pared questions designed mergency 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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Event ID:

9H7B23

Facility ID: 010453

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814		UILDING	NSTRUCTION	(X3) DATE COMPL 07/12	ETED
	PROVIDER OR SUPPLIEI			8307 CA	DDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIL	DATE
	facility-based fund	ctional exercise; or.					
	(B) If the ICF/IID	experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
		ngaging in its next required					
		nity-based or individual,					
		ctional exercise following the					
	onset of the emer						
	' '	Iditional annual exercise but is not limited to the					
		but is not innited 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						
	` '	ercise or workshop that is					
		and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	atements, directed					
	messages, or pre	pared questions designed					
	to challenge an e						
		CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	   *[For HHAs at §48	84.102]					
		e HHA must conduct					
	exercises to test t	he emergency plan at					
	least annually. Th	e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						
	, ,	community-based exercise					
		conduct an annual					
		based functional exercise					
	every 2 years; or.						
	1 1	A experiences an actual					
	natural or man-ma	ade emergency that requires					

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Facility ID: 010453

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME O	F PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	•
VOCA	CORPORATION OF	INDIANA		CASTLETON BLVD NAPOLIS, IN 46256	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		emergency plan, the HHA is			
		aging in its next required			
		nity-based or individual,			
		ctional exercise following the			
	onset of the emer	-			
	1 ' '	Iditional exercise every 2			
		ne year the full-scale or			
	of this section is	e under paragraph (d)(2)(i) conducted, that may			
		: limited to the following:			
		I full-scale exercise that is			
	community-based				
	-	ctional exercise; or			
	-	lisaster drill; or			
	, ,	p exercise or workshop that			
	, ,	tor and includes a group			
	discussion, using				
	_	emergency scenario, and a			
		atements, directed			
	messages, or pre	pared questions designed			
	to challenge an e	mergency plan.			
	(iii) Analyze the H	IHA's response to and			
	maintain docume	ntation of all drills, tabletop			
		nergency events, and revise			
	the HHA's emerg	ency plan, as needed.			
	*[For OPOs at §4	<del>-</del>			
		e OPO must conduct			
		the emergency plan. The			
	OPO must do the	•			
		er-based, tabletop exercise			
		ast annually. A tabletop			
		a facilitator and includes a			
		using a narrated, clinically			
	_	cy scenario, and a set of			
		nts, directed messages, or			
		ns designed to challenge an			
		If the OPO experiences an			
		man-made emergency that n of the emergency plan, the			
	i requires activation	n or the entergency plant, the	1	i	I

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DEPARTMENT OF HEALTH AND HUMA	AN SERVICES
CENTERS FOR MEDICARE & MEDICAL	D SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G814	A. BU	A. BUILDING COMP		(X3) DATE : COMPL 07/12/	LETED	
	PROVIDER OR SUPPLIER		•	8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD APOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R. LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
PREFIX TAG	PREGULATORY OF OPO is exempt from required testing exempt from required testing exempt from required testing exempts. Analyze the Office maintain documer exercises, and entitle [RNHCl's and needed.  *[RNCHIS at §400 (d)(2) Testing. The exercises to test to the standard of the conduct at paper at least annually. It is group discussion in narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain documer exercises, and entitle RNHCl's emer Based on record reversible to conduct at emergency plan on emergency procedured all of the following exercise that is compositioned.	commengaging in its next exercise following the onset event.  PO's response to and intation of all tabletop exercise following:  RNHCI must conduct the emergency plan. The me following:  Portion of all tabletop exercise is a led by a facilitator, using a relevant emergency et of problem statements, is, or prepared questions enge an emergency plan. NHCI's response to and intation of all tabletop exercise regency events, and revise regency plan, as needed.  Portion of all tabletop exercise is a led by a facilitator, using a relevant emergency et of problem statements, is, or prepared questions enge an emergency plan. NHCI's response to and intation of all tabletop exercise is and revise regency plan, as needed.  Portion of all tabletop exercises to test the an annual basis using the res. The ICF/IID facility must ing: (i) participate in a full-scale imunity-based or when a exercise is not accessible, an	E 00	TAG	CORRECTION: The [facility] must conduct exercises to test the emergence plan at least annually. Specific the agency has assigned a risk management specialist from the Quality Assurance Department	cy ally, c	COMPLETION DATE  08/11/2024	
	experiences an actu emergency that requ emergency plan, the engaging in a comn facility-based full-s following the onset conduct an addition	based. If the ICF/IID facility al natural or man-made uires activation of the e ICF/IID facility is exempt from nunity-based or individual, cale exercise for 1 year of the actual event; (ii) al exercise that may include, the following: (A) a second			(the QIDP Manager) to conduct exercise of choice table talk conference, with the provider's Safety Committee. Participants will include ResCare Department Heads, the QIDP and other administrative level management (Program Manager, Quality Assurance Manager, Quality	s S ent		

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Event ID: 9H7B23 Facility ID: 010453

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		15G814	B. WI	NG		07/12/	/2024
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					ASTLETON BLVD		
VOCA C	ORPORATION OF	INDIANA		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	full-scale exercise t	hat is community-based or			Assurance Coordinator, and N	lurse	
	individual, facility-	based. (B) a tabletop exercise			Manager) will participate in the	Э	
	that includes a grou	p discussion led by a			exercises to assure facility		
	facilitator, using a r	narrated, clinically-relevant			emergency preparedness		
	emergency scenario, and a set of problem				protocols are consistent with		
	statements, directed messages, or prepared				community emergency		
		to challenge an emergency			management practices. The		
	plan; (iii) analyze the ICF/IID facility's response to				Safety Committee chairpersor	ı will	
	and maintain documentation of all drills, tabletop				assure biannual completion of		
	exercises, and emergency events, and revise the				these exercises.		
	ICF/IID facility's emergency plan, as needed in				The facility will provide		
		CFR 483.475(d)(2). This			documentation of the activation	n of	
	deficient practice could affect all occupants.				the Emergency Preparedness		
	deficient practice could affect an occupants.				Plan during the 3/14/24 severe		
	Findings include:				weather event, in which the fa		
	i manigs metade.				sheltered in place. This	Cility	
	Based on review of	"Emergency/Disaster			documentation will be uploade	ad to	
		al" documentation dated			the IDOH Gateway at the time		
	_	rgency, Disaster, Evacuation			this plan of correction's	: 01	
		es" documentation dated			•	fatı,	
	_	Maintenance Aide during record			submission. The Agency's Sa	-	
		a.m. to 11:05 a.m. on 02/21/24,			Committee conducted a table	laik	
					exercise on 7/24/24.	_	
		community based disaster drill			Documentation of this exercise	е	
		ent twelve month period was			will be uploaded to the IDOH	,	
		view. Based on interview at the			Gateway at the time of this pla	an of	
		ew, the Maintenance Aide			correction's submission.		
	agreed the facility h				PREVENTION:		
	1	lisaster drill or conducted a			Members of the Operations Te	eam	
	_	ithin the most recent twelve			(comprised of the Executive		
	_	greed testing documentation			Director, Operations Manager	s,	
		or review at the time of the			Program Managers, Area		
	survey.				Supervisors, Quality Assurance		
					Manager, QIDP Manager, QID		
		at the time of the PSR at 10:05			Quality Assurance Coordinato	rs,	
		ne Maintenance Aide stated the			and Nurse Manager) will		
	1	ducted a community based			incorporate reviews of the faci	-	
		ducted a tabletop exercise			emergency preparedness pro	gram	
	within the most rec	ent twelve month period and			into scheduled monthly audits	to	
	agreed testing docu	mentation was not available			assure all required componen	ts,	
	for review at the tin	ne of the PSR.	1		including but not limited to		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED		
15G814		B. WI	B. WING			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		NOVIDENCEN AN OF CONDUCTION		(X5)	
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMAT			TAG	DEFICIENCY)	DATE		
	These findings were reviewed with the Maintenance Aide during the exit conference.  This deficiency was cited on 02/21/24. The facility failed to implement a systemic plan of correction to prevent recurrence.				bi-annual community-based disaster exercises, are presen Additionally, the agency Safet Committee will review and rev the plan as needed but no less than annually.  RESPONSIBLE PARTIES: QI Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	y ise s DP,		
K 0000								
Bldg. 01	conducted on 05/20 Recertification Surve conducted by the In accordance with 42 Survey Date: 07/12 Facility Number: 0 Provider Number: AIM Number: 201- At this PSR survey, was found in comple Participation in Med 483.470(j), Life Safedition of the Natio (NFPA) 101, Life Sexisting Residentia This one story build sprinklered. The face	2/24 10453 15G814	K 0	000				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF I		8307 C	ADDRESS, CITY, STATE, ZIP COD ASTLETON BLVD IAPOLIS, IN 46256	(X3) DATE SURVEY COMPLETED 07/12/2024	
PREFIX TAG  (EACH DEFICIENCY REGULATORY OR  to the fire alarm sys The facility has hear attic. The facility has census of 8 at the tin  Calculation of the E (E-Score) using NFI Approaches to Life facility Prompt with	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  to the fire alarm system installed in all bedrooms. The facility has heat detection installed in the attic. 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.  Quality Review completed on 07/15/24		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	

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