

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G324	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2023
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 4516 W WALDEN DR MUNCIE, IN 47304		
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 08/15/23</p> <p>Facility Number: 000842 Provider Number: 15G324 AIM Number: 100243860</p> <p>At this Emergency Preparedness survey, Voca Corporation of Indiana was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 8 certified beds. All beds are certified for Medicaid. At the time of the survey, the census was 8.</p> <p>Quality Review completed on 08/21/23</p> <p>42 CFR, Subpart 483.475 is NOT MET as evidenced by:</p>	E 0000		
E 0037 Bldg. --	<p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1),</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Daniel Fields

Executive Director

09/02/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>§491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out 			

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	<p>the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of 			

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	<p>emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):] (1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include</p>			

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	<p>instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of</p>			

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	<p>emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Site Supervisor on 08/15/23 at 01:30 a.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of records review, the Site Supervisor did not know if staff were trained on the EPP, and stated no documentation for staff training could not be found during the survey.</p> <p>The findings were reviewed with the Site Supervisor during the exit conference.</p>	E 0037	<p>E0037- EP Training program The area Supervisor has been trained that staff will be trained on the EPP yearly during a staff meeting, training and a test will be given. Documentation will be in the EPP under the training tab. The EP plan will be reviewed at least 2 times per year by the Program Manager and/or Quality Manager to ensure that it has been reviewed, updated, training has occurred, and documentation is in place.</p>	09/08/2023

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E 0039 Bldg. --	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> (i) Participate in a full-scale exercise that is community-based every 2 years; or <ul style="list-style-type: none"> (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or <ul style="list-style-type: none"> (B) If the [facility] 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 community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least 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: <ul style="list-style-type: none"> (A) A second full-scale exercise that is 			

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	<p>community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or a facility based</p>			

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	<p>functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that 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.</p>			

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	<p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills,</p>			

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	<p>tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. <p>(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:</p> <ul style="list-style-type: none"> (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise</p>			(X5) COMPLETION DATE

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	<p>the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: <ul style="list-style-type: none"> (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 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 [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. 			

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	<p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: <ul style="list-style-type: none"> (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the</p>			

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	<p>following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise</p>			

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	<p>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 required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCl must conduct exercises to test the emergency plan. The RNHCl must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCl's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCl's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not</p>	E 0039	<p>E039 EP Training Program</p> <p>The Quality Assurance Manager will monitor compliance through review of the documentation of any emergency event within the building. These would include but not limited to power failures,</p>	09/15/2023

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	<p>accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Site Supervisor on 08/15/23 at 01:35 p.m., the following was not available for review:</p> <ul style="list-style-type: none"> a) No documentation of an annual full-scale exercise that is community-based, a facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency. b) No documentation of an additional annual 		<p>natural disasters, missing clients, infectious diseases, fires, and COVID. Results of these will be filed and reviewed at each quarterly event. If any recommendations will be reviewed updated to any emergency plan.</p>	

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K 0000 Bldg. 01	<p>exercise of choice: a second full-scale exercise that is community-based, a facility-based functional exercise, a mock disaster drill, a tabletop exercise, or a workshop.</p> <p>Based on interview at the time of records review, the Site Supervisor stated the documentation for a community-based exercise or actual event could not be found and documentation of a second exercise of choice could not be found.</p> <p>This finding was reviewed with the Site Supervisor during the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 08/15/2023</p> <p>Facility Number: 000842 Provider Number: 15G324 AIM Number: 100243860</p> <p>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.</p> <p>This one story facility was fully sprinklered. This facility has a fire alarm system with hard wired smoke detectors in client sleeping rooms, the corridors, and common living areas with heat detection in the attic. The facility has a capacity of</p>	K 0000		

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K S211 Bldg. 01	<p>8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of .8</p> <p>Quality Review completed on 08/21/23</p> <p>NFPA 101 Means of Egress - General Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 Based on observation and interview, the facility failed to ensure 4 of 5 designated means of egress are continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation and interview on 08/15/23 between 12:50 p.m. and 01:10 p.m. with the Site Supervisor (SS):</p> <ol style="list-style-type: none"> 1. A mop bucket was obstructing the path of egress from the front door exit out of the facility. 2. Two loveseats in the Living Room had a pathway of about 12 inches between them were obstructing the path of egress to the front door. 3. A clothes hamper and curtains were obstructing the path of exit egress from #1 clients sleeping room. 4. The kitchen curtains obstructed the patio door exit egress. 	K S211	KS211 Means of Egress The Area Supervisor and QIDP will conduct at least 2 weekly observations to review all areas of egress, this will include all hallways and ensure no exit doors are blocked. A member of management team (Program Manager, Nurse Manager, Quality Team) will complete a site review monthly to include ensuring that all pathways are clear for egress. The curtains on the door have been addressed to allow egress, and the loveseat has been adjusted in the home to allow egress out the door. The hampers have been placed in central locations to allow access to all egress doors.	09/15/2023

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K S222 Bldg. 01	<p>5. A clothes hamper by the laundry room in the hall to the side exit was obstructing the path of exit egress.</p> <p>Based on interview at the time of the observation, the Site Supervisor (SS) acknowledged that the above mentioned items blocked the path of egress.</p> <p>These findings were reviewed with the SS at the exit conference.</p> <p>NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15.</p>			

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K S300 Bldg. 01	<p>33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)</p> <p>Based on observation and interview; the facility failed to ensure 1 of 8 clients' sleeping room closet doors can be readily opened from the inside if locked. LSC 33.2.2.5.3 states every closet door latch shall be readily opened from the inside. This deficient practice affects 2 of 8 clients.</p> <p>Findings include:</p> <p>Based on observation with the Site Supervisor (SS) at 12:50 p.m., the closet doors in client sleeping rooms #1, had two latches on the outside of the door that could be locked allowing someone to be locked inside the closet with no means of escape. Based on interview at the time of the observation, the SS agreed the closet doors could be locked and could not be opened from the inside when locked.</p> <p>The finding was reviewed with the SS during the exit conference.</p>	K S222	<p>KS222- Egress Doors</p> <p>Maintenance has been notified and will replace the doors or remove the latch on the closet doors in #1 room to ensure door is not able to be locked inside the room. QIDP and AS will each complete at least 2 weekly observations to ensure that there are no locked doors in the home and that all doors are able to be locked from the outside. A member of the management team(Program Manager, Nurse Manager, Quality team) will complete a site review monthly to include ensuring that there is no doors able to be locked from outside preventing someone to be locked in room.</p>	09/15/2023
	<p>NFPA 101</p> <p>Protection - Other</p> <p>Protection - Other</p> <p>2012 EXISTING</p> <p>List in the REMARKS section any LSC Section 33.2.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on observation and interview, the facility failed to ensure the fire extinguisher in the kitchen was protected in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4 requires that portable fire extinguishers types</p>	K S300	<p>KS300- Protection-Other</p> <p>The Area Supervisor has been trained that the fire extinguishers must be inspected monthly. QIDP and AS will each complete at</p>	09/15/2023

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K S341 Bldg. 01	<p>shall be (1) secured on a hanger (2) in the bracket supplied by the manufacturer (3) in a listed bracket approved for such purpose (4) in cabinets or wall recesses. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Site Supervisor (SS) on 08/15/23 at 01:00 p.m., a fire extinguisher was sitting on the floor unsupported in the kitchen. Based on interview at the time of observation, the SS agreed a fire extinguisher was sitting on the floor unsupported in the kitchen.</p> <p>The finding was reviewed with the SS during the exit conference.</p> <p>NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels were protected. LSC 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, Section 10.10.1 states a</p>	K S341	<p>least 2 weekly observations to include checking the fire extinguishers for a monthly inspection. A member of the management team (Program Director, Nurse Manager, Quality team) will complete a site review monthly to include ensuring that Fire extinguishers have been inspected. The Fire Extinguishers have been secured in locations that are easily accessible for use.</p> <p>KS341- Fire Alarm System All staff have will be trained on ensuring that the key to the panel is out and it is locked at all times. The Area Supervisor and QIDP will each complete at least 2 weekly observations to include checking to ensure the Fire Alarm system is always locked and secured. A member of management team</p>	09/15/2023

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K S346 Bldg. 01	<p>means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Site Supervisor (SS) on 08/15/23 at 01:20 p.m., the fire control panel located in the kitchen was in a cabinet but the door to the cabinet was unlocked and had the key in the lock. This condition does not protect the fire alarm system against unauthorized use. Based on interview at the time of observations, the SS agreed the cabinet door to the fire control panel was not properly secured because the key was in the lock of the unlocked door. The SS did lock the panel and remove the key.</p> <p>The finding was reviewed with the SS during the exit conference.</p> <p>NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy</p>	K S346	<p>(Program Manager, Nurse Manager, Quality Team) will complete a site review monthly to include ensuring that the Fire Alarm System is locked.</p>	09/15/2023

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K S354 Bldg. 01	<p>for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Site Supervisor (SS) on 08/15/23 at 11:35 a.m., there were two fire watch plans, one of which stated to contact the Marion Fire Department in the event of implementing a fire watch instead of contacting the local fire department. Based on interview during the record review, the SS acknowledged the fire watch documentation included contacting the Marion Fire Department in the event of implementing a fire watch instead of contacting the local fire department.</p> <p>The finding was reviewed with the SS during exit conference.</p> <p>NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 2 correct written policies in</p>	K S354	<p>they contact the local fire department. All emergency plans including Fire Watch to be conducted when a system failure and ensure the local fire department is contacted. Quality team will be have all the plans updated to ensure proper local department contacted. A member of management team (Program Manager, Nurse Manager, Quality Team) will complete a site review monthly ensuring that all policies are updated in the home</p>	09/15/2023

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K S511	<p>the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on records review with the Site Supervisor (SS) on 08/15/23 at 11:35 a.m., there were two fire watch plans, one of which stated to contact the Marion Fire Department in the event of implementing a fire watch. Based on interview during the record review, the SS acknowledged the fire watch documentation included contacting the Marion Fire Department in the event of implementing a fire watch instead of contacting the local Fire Department.</p> <p>The finding was reviewed with the SS during exit conference.</p> <p>NFPA 101 Utilities - Gas and Electric</p>		<p>Extinguishers for the home and will do monthly audits of all Fire Extinguishers of the home and send to the Quality Assurance Manager for review. All staff will be trained on how to follow fire watch procedures to ensure compliance.</p>	

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Bldg. 01	<p>Utilities - Gas and Electric</p> <p>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code.</p> <p>32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw.</p> <p>NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 clients in the Med Room area.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Site Supervisor on 08/15/23 at 01:05 p.m. a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Med Room. Based on interview at the time of observation, the SS acknowledged a power strip was supplying power to high power draw equipment.</p> <p>This finding was reviewed with the SS at the exit conference.</p>	K S511	<p>K0511- Utilities Gas/Electric-</p> <p>The Quality Assurance and Program Manager and Maintenance Tech will conduct monthly audits of all outlets and covers to ensure equipment is plugged into correct adaptor. The audits will be sent to Quality to review and address with Maintenance Tech and or if required a vendor.</p>	09/15/2023
K S712 Bldg. 01	<p>NFPA 101</p> <p>Fire Drills</p> <p>Fire Drills</p> <p>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:</p> <p>a. Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>b. Ensure that all personnel on all shifts are</p>			

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	<p>familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>2. The facility must:</p> <ul style="list-style-type: none"> a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. <p>3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>42 CFR 483.470(i)</p> <p>Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 3 of 12 shifts. This deficient practice affects all staff and clients.</p> <p>Findings include:</p> <p>Based on records review with the Site Supervisor (SS) on 08/15/23 at 12:15 p.m., there was no documentation of any shift fire drills in the fourth quarter for 2022.</p> <p>Based on interview at the time of record review, the SS stated they could not provide documentation of any of the missing fire drills.</p> <p>Findings were discussed with the SS at the exit</p>	K S712	<p>K0712 Fire Drills</p> <p>A Fire Drill Schedule has been provided to the home to assure variance in days and times of fire drills. The Fire Drill schedule will assure that at minimum, 1 drill is held per shift each quarter across all three shifts. Client will be fully evacuated at each drill unless it is deemed unsafe to do so to assure the minimum standard is met. All staff will be trained on the fire alarm system, how to conduct a drill and how to complete the fire drill documentation. This documentation will be stored for a full calendar year at the home. The Quality Assurance Manager will communicate with the Area</p>	09/15/2023

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	conference.			supervisor of the home to assure that fire drills are held under varied conditions included but not limited to blocked exits, lights turned off, nighttime, daytime and failed alarm drills. The documentation of the fire drills will be reviewed by the Quality Assurance Manager during the monthly site reviews.