PRINTED: 07/21/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		i '	ſ ′			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING		COMPLETED	
		15G247	B. WI	NG		06/14/	2021
NAME OF P	ROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ORNWELL DR		
	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		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' DEFICIENCY)	TE	COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC II		DATE
□ 0000							
Bldg							
5	An Emergency Pre	paredness Survey was	E 00	000			ĺ
		diana Department of Health					
	in accordance with	42 CFR 483.475.					
	Survey Date: 06/14	4/2021					
	Facility Number: 0	000769					
	Provider Number:						
	AIM Number: 100						
	At this Emergency	Preparedness survey, Res					
	Care Community A	lternatives SE IN was found					
	not in compliance v	vith Emergency Preparedness					
	_	Iedicare and Medicaid					
		ders and Suppliers, 42 CFR					
	483.475						
	The facility has 8 co	ertified beds. All 8 beds are					
	-	aid. At the time of the survey,					
	the census was 7.						
	The requirement at	42 CFR, Subpart 483.475 is					
	NOT MET as evide	-					
	Quality Review on	06/24/21					
E 0009	403.748(a)(4), 41	6.54(a)(4), 418.113(a)(4),					
	441.184(a)(4), 48	2.15(a)(4), 483.475(a)(4),					
Bldg	483.73(a)(4), 484	.102(a)(4), 485.625(a)(4),					
		.727(a)(5), 485.920(a)(4),					
	, , , ,	1.12(a)(4), 494.62(a)(4)					
		al Collaboration Process					
		416.54(a)(4), §418.113(a)					
	(4), §441.184(a)(4						
	(4), §484.102(a)(4	83.73(a)(4), §483.475(a)					
	. ,	485.727(a)(5), §485.920(a)					
	3.00.0=0(0)(1), 3						
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G247	B. WIN	IG		06/14/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		2401 CC	EET ADDRESS, CITY, STATE, ZIP CODE 11 CORNWELL DR FFERSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<u> </u>	ID	DECLIDED OF A LV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(4), §486.360(a)(4 §494.62(a)(4)	ł), §491.12(a)(4),					
	develop and main preparedness plan and updated at lea	lan. The [facility] must tain an emergency n that must be reviewed, ast every 2 years [annually The plan must do the					
	collaboration with and Federal emer officials' efforts to	ess for cooperation and local, tribal, regional, State, gency preparedness maintain an integrated disaster or emergency					
	(4) Include a prood collaboration with and Federal emer officials' efforts to response during a situation. The dialy the local emergen least annually to caware of the dialy event of an emerge Based on record reverse facility failed to enspreparedness plan in cooperation and col regional, State, or Further preparedness official integrated response emergency situation the ICF/IID facility officials and, when in collaborative and	view and interview, the sure the emergency ncluded a process for laboration with local, tribal,	E 000	09	1.The emergency plan policicand procedures will be updated a minimum every 2 years to include a continuity of operation plan which addresses notification of the Indiana State Department Health during a disaster or emergency. 2.The area supervisor and program manager will train all on the updated policies and procedures and the program	d at ns ion nt of	07/14/2021

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	OF CORRECTION OF CORRECTION 15G247	(X2) MULTIPLE CO A. BUILDING B. WING	· ·		
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) deficient practice could affect all occupants. Findings include: During record review with the Residential Manager on 06/14/2021 between 11:00 a.m. and 1:15 p.m., the facility provided a document titled "Res Care Emergency/Disaster Preparedness Manual" as documentation of their Emergency Preparedness Plan. No documentation could be located ensuring the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Based on interview at the time of record review, the Residential Manager acknowledged the lack of information and could provide no further documentation. This deficiency was reviewed with the Residential Manager during the Exit Conference held on 06/14/2021.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3. The emergency plan polici and procedures will be update include a continuity of operation plan which addresses notificated of the Indiana State Department Health during a disaster or emergency. 4. The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledged where it is kept in the home are all its content. Upon visiting a home, the Program Manager of the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5. Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Managers, AED, and Area Supervisors will complete more site reviews of each location and document any issues/findings the site review. Site Review where the review of each location and document any issues/findings the site review. Site Review where the review of each location and document any issues/findings the site review. Site Review where the review of each location and document any issues/findings the site review. Site Review where the review of each location and document any issues/findings the site review. Site Review where the review of each location and document any issues/findings the site review. Site Review where the review of each location and document any issues/findings the site review of each location and document any issues/findings the site review. Site Review where the review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and the process and program Managers and program Managers and p	es d to ons ion nt of ed ess of nd will ne e	
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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG	COI	ATE SURVEY MPLETED 114/2021		
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP	CODE		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN	2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE	
				The persons responsi the, Program Manage Supervisor, and Resid Manager	r, Area		
E 0015 Bldg	(1), 482.15(b)(1), 4(1), 485.625(b)(1) Subsistence Need §403.748(b)(1), §441.184(b)(1), §445.625(b)(1) [(b) Policies and p must develop and preparedness polibased on the eme paragraph (a) of the assessment at pasection, and the coparagraph (c) of the and procedures mupdated every 2 y facilities]. At a minimum and the coparagraph (c) and procedures mupdated every 2 y facilities].	460.84(b)(1), §482.15(b), §483.475(b)(1), rocedures. [Facilities] implement emergency cies and procedures, rgency plan set forth in					
	staff and patients shelter in place, in the following: (i) Food, water, me supplies (ii) Alternate source the following: (A) Temperatures and safety and for storage of provision (B) Emergency lig						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING		COMPL	ETED
		15G247	B. W	NG		06/14/	2021
NAME OF D	DOWNER OF CLIPPLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			2401 C	ORNWELL DR		
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	systems. (D) Sewage and w	vaste disposal.					
	*[For Inpatient Hos (iii):] Policies and p (6) The following a for hospice-operationly. The policies address the follow (iii) The provision of hospice employees they evacuate or a but are not limited (A) Food, water, m pharmaceutical sur (B) Alternate source the following: (1) Temperatures and safety and for storage of provision (2) Emergency light (3) Fire detection, systems. (C) Sewage and we Based on record reversal facility failed to ensi- policies and procedure.	spice at §418.113(b)(6) procedures. are additional requirements ted inpatient care facilities and procedures must ring: of subsistence needs for as and patients, whether shelter in place, include, to the following: nedical, and applies. ces of energy to maintain to protect patient health the safe and sanitary ons. hting. extinguishing, and alarm waste disposal. riew and interview, the sure emergency preparedness ures include at a minimum,	E 00	015	1.The administrator will ensu the emergency plan policies ar procedures addresses the	nd	07/14/2021
	and clients, whether	f subsistence needs for staff they evacuate or shelter in			provision of subsistence needs staff and clients, whether they	s for	
	_	are not limited to the			evacuate or shelter in place,		
	• ,,	water, medical, and			including but not limited to the	iool	
	could affect all occu	plies. This deficient practice			following: (i) Food, water, med and pharmaceutical supplies.		
	could affect all occi	ipanis.			Alternate sources of energy to	` '	
	Findings include:				maintain – (A) Temperatures to protect resident health and saf)	
		view and interview on			and for the safe and sanitary		
		n 11:00 a.m. and 1:15 p.m.			storage of provisions; (B)		
	with the Residential	- · · · · ·			Emergency lighting; (C) Fire		
	emergency prepared	lness plan did not address			detection, extinguishing, and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	ETED
		15G247	B. W	ING		06/14/	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			ORNWELL DR		
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		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 OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	aceutical supplies in the event			alarm systems; and (D) Sewa	•	
	of all risks identifie				and waste disposal in accorda	nce	
	Preparedness Plan.				with 42 CFR 483.475(b)(1).		
		ord review with the RM was			2.The area supervisor and		
		the policy and procedures for			program manager will train all		
		aceutical supplies for			on the policies and procedures		
	emergency conditio	ns.			and the program overview will		
					placed in the Emergency Disa	ster	
		s reviewed with the RM during			Preparedness Manual for		
	the Exit Conference	e held on 06/14/2021.			reference as needed.		
					3.The corrective action will b	e	
					monitored and reviewed for		
					effectiveness at a minimum		
					bi-annual		
					4.The Area Supervisor will		
					ensure the EPP is updated		
					annually and all staff are trained		
					on the Emergency Preparedne		
					Manual and have knowledge of		
					where it is kept in the home ar		
					all its content. Upon visiting a		
					home, the Program Manager \	WIII	
					review the Emergency		
					Preparedness Manual and		
					document the visit on the Hom	ie	
					Visitor Sign In form located in		
					each home. 5.Monitoring of Corrective		
					Action: A member of the Site		
					Review Team, consisting of th	۵	
					QA department, Program	•	
					Managers, QIDP-D's, Nurse		
					Manager, AED, and Area		
					Supervisors will complete mor	nthly	
					site reviews of each location a	-	
					document any issues/findings		
					the site review. Site Review w		
					be reviewed by each Area		
					Supervisor and Program Mana	ager	
					for that home and follow-up as		
					that home and lonew up do	•	

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	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	15G247	B. WING		06/14/2021
	130247			00/14/2021
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR	
RES CAF	RE COMMUNITY ALTERNATIVES SE IN		RSONVILLE, IN 47130	
			I	(V5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	·		necessary to correct all issues	S
			The persons responsible will the, Program Manager, Area	De
			Supervisor, and Residential	
			Manager	
E 0018	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)			
Bldg	(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2),			
Blug	485.920(b)(1), 486.360(b)(1), 494.62(b)(1)			
	Procedures for Tracking of Staff and			
	Patients			
	§403.748(b)(2), §416.54(b)(1), §418.113(b)			
	(6)(ii) and (v), §441.184(b)(2), §460.84(b)			
	(2), §482.15(b)(2), §483.73(b)(2),			
	§483.475(b)(2), §485.625(b)(2), §485.920(b) (1), §486.360(b)(1), §494.62(b)(1).			
	(1), 3 100.000(0)(1), 3 10 1.02(0)(1).			
	[(b) Policies and procedures. The [facilities]			
	must develop and implement emergency			
	preparedness policies and procedures,			
	based on the emergency plan set forth in paragraph (a) of this section, risk			
	assessment at paragraph (a)(1) of this			
	section, and the communication plan at			
	paragraph (c) of this section. The policies			
	and procedures must be reviewed and			
	updated at least every 2 years [annually for			
	LTC facilities]. At a minimum, the policies			
	and procedures must address the following:]			
	[(2) or (1)] A system to track the location of			
	on-duty staff and sheltered patients in the			
	[facility's] care during an emergency. If			
	on-duty staff and sheltered patients are			
	relocated during the emergency, the [facility]			
	must document the specific name and location of the receiving facility or other			
	location of the receiving lacility of other			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	ľ í	UILDING	NSTRUCTION	(X3) DATE COMPI 06/14	LETED
	PROVIDER OR SUPPLIER	TERNATIVES SE IN		2401 C	ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR RSONVILLE, IN 47130	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	at §460.84(b):] Po A system to track and sheltered resi ICF/IID or PACE] emergency. If onresidents are relocemergency, the [PPACE] must docu and location of the location. *[For Inpatient Hospolicies and procedii) Safe evacuation includes consideranceds of evacueetransportation; ide location(s) and priof communication assistance. (v) A system to tracemployees' on-dutithe hospice's care the on-duty employers care the on-duty employer relocated durithospice must docu and location of the location. *[For CMHCs at § procedures. (2) Sa CMHC, which incluand treatment need responsibilities; traced evacuation location locat	Ds at §483.475(b), PACE licies and procedures. (2) the location of on-duty staff dents in the [PRTF's, LTC, care during and after an duty staff and sheltered cated during the PRTF's, LTC, ICF/IID or ment the specific name a receiving facility or other spice at §418.113(b)(6):]					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING		COMPL	ETED
		15G247	B. W	NG		06/14/	2021
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ORNWELL DR		
	RE COMMUNITY A	LTERNATIVES SE IN		JEFFERSONVILLE, IN 47130			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	external sources o	or assistance.					
	*[For OPOs at § 4	86.360(b):] Policies and					
		system of medical					
	1 '	at preserves potential and					
	actual donor infor						
		otential and actual donor					
	1	ecures and maintains the					
	availability of reco						
	*[For FCDD at \$ 4	04 69/h) J. Daliaina and					
		.94.62(b):] Policies and afe evacuation from the					
	dialysis facility, wh						
	1	nd needs of the patients.					
		view and interview, the	FO	110	1.The administrator will ensu	ıro	07/14/2021
		sure emergency preparedness	E 0	J18	the emergency plan policies a		07/14/2021
	1	ures include a system to track			procedures addresses the	iu	
	1	uty staff and sheltered clients			tracking of staff and clients,		
		ity's care during and after an			whether they evacuate or shel	tor	
		uty staff and sheltered clients			in place. Including the	lei	
		the emergency, the ICF/IID			consideration of care and		
		nent the specific name and			treatment needs of evacuees,	etaff	
		iving facility or other			responsibilities; transportation		
		nce with 42 CFR 483.475(b)			identification of evacuation	•	
		practice could affect all			locations; and primary and me	ans	
	occupants.				of communication with externa		
	1				assistance.		
	Findings include:				2.The area supervisor and		
					program manager will train all	staff	
	Based on record rev	view on 06/14/2021 between			on the policies and procedures		
	at 11:00 a.m. and 1:	15 p.m. with the Residential			and the program overview will		
		e was nothing in the			placed in the Emergency Disa		
	Emergency Prepare	dness policy which addressed			Preparedness Manual for		
	a system to track the	e whereabouts of staff and			reference as needed.		
	clients during an en	nergency. Based on interview			3.The corrective action will b	е	
		ord review, the RM was not			monitored and reviewed for		
	able to describe the	policy and procedures for			effectiveness at a minimum		
		emergency. The RM			bi-annual		
	_	there was no written policy			4.The Area Supervisor will		
	and procedure whic	h addressed the tracking of			ensure the EPP is updated		

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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				
		15G247	B. WI	NG		06/14/	2021
NAME OF F	DROLUDED OD CLIDDLIEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE			2401 C	ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	staff and clients.				annually and all staff are traine		
					on the Emergency Preparedne		
		ewed with the RM during the			Manual and have knowledge of		
	Exit Conference he	ld on 06/14/2021.			where it is kept in the home ar	ıd	
					all its content. Upon visiting a		
					home, the Program Manager v	VIII	
					review the Emergency Preparedness Manual and		
					document the visit on the Hom	ıe.	
					Visitor Sign In form located in	. =	
					each home.		
					5.Monitoring of Corrective		
					Action: A member of the Site		
					Review Team, consisting of th	е	
					QA department, Program		
					Managers, QIDP-D's, Nurse		
					Manager, AED, and Area		
					Supervisors will complete mor	•	
					site reviews of each location a		
					document any issues/findings		
					the site review. Site Review was be reviewed by each Area	/III	
					Supervisor and Program Mana	nar	
					for that home and follow-up as	_	
					necessary to correct all issues		
					,		
					The persons responsible will b		
					the, Program Manager, Area	C	
					Supervisor, and Residential		
					Manager		
					ĺ		
E 0020	403.748(b)(3), 41	6.54(b)(2), 418.113(b)(6)	İ				
		, 482.15(b)(3), 483.475(b)					
Bldg		485.625(b)(3), 485.68(b)					
	1 ' ''	, 485.920(b)(2), 491.12(b)					
	(1), 494.62(b)(2)						
		and Primary/Alt. Comm.					
		416.54(b)(2), §418.113(b)					
	(0)(11), 9441.184(b 	b)(3), §460.84(b)(3),					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMI	E SURVEY PLETED 4/2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	2401 (ADDRESS, CITY, STATE, ZIP CO CORNWELL DR ERSONVILLE, IN 47130	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	(3), §485.68(b)(1)	33.73(b)(3), §483.475(b) , §485.625(b)(3), 485.920(b)(2), §491.12(b)				
	must develop and preparedness poli based on the eme paragraph (a) of the assessment at paragraph (c) of the and procedures mupdated at least etal LTC facilities]. At and procedures mupdated at least etal LTC facilities]. At and procedures mupdated at least etal LTC facilities], which indicate and treatment responsibilities; tradefer evacuation local alternate means desternal sources of the state of evacuation for the state of	ragraph (a)(1) of this ommunication plan at his section. The policies must be reviewed and very 2 years [annually for a minimum, the policies must address the following:] Safe evacuation from the cludes consideration of the needs of evacuees; staff ansportation; identification with of assistance. 403.748(b)(3) and ASCs 5403.748(b)(3) and ASCs 650 750 750 751 751 752 753 753 753 754 755				
		485.68(b)(1), Clinics, encies, OPT/Speech at				

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i ') DATE SURVEY
	COMPLETED
15G247 B. WING	06/14/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2401 CORNWELL DR	
RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES 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
§485.727(b)(1), and ESRD Facilities at	
§494.62(b)(2):]	
Safe evacuation from the [CORF; Clinics,	
Rehabilitation Agencies, and Public Health	
Agencies as Providers of Outpatient Physical	
Therapy and Speech-Language Pathology	
Services; and ESRD Facilities], which includes staff responsibilities, and needs of	
the patients.	
the patients.	
* [For RHCs/FQHCs at §491.12(b)(1):] Safe	
evacuation from the RHC/FQHC, which	
includes appropriate placement of exit signs;	
staff responsibilities and needs of the	
patients.	
Based on record review and interview, the E 0020 1. The emergency plan policies	07/14/2021
facility failed to ensure emergency preparedness and procedures will be updated to	0
policies and procedures include information for include a continuity of operations	
safe evacuation from the ICF/IID facility, which plan which addresses safe	
includes consideration of care and treatment evacuation of from the ICF/IID	
needs of evacuees; staff responsibilities; facility and includes consideration	۱
transportation; identification of evacuation of care and treatment needs of	
location(s); and primary and alternate means of evacuees; staff responsibilities;	
communication with external sources of transportation; identification of	
assistance in accordance with 42 CFR evacuation location(s); and	
483.475(b)(3). This deficient practice could primary and alternate means of communication with external	
affect all occupants. communication with external sources of assistance.	
Findings include: 2.The area supervisor and	
program manager will train all sta	ıff
Based on review of Emergency Preparedness on the updated policies and	
Plan entitled: "Res Care Emergency/Disaster procedures and the program	
Preparedness Manual" with the Residential overview will be placed in the	
Manager (RM) during record review from 11:00 Emergency Disaster	
a.m. to 1:15 p.m. on 06/14/2021, the plan to Preparedness Manual for	
address safe evacuation was incomplete. The reference as needed.	
facilities documentation of the medical needs of 3.The corrective action will be	
4 of the 7 residents was missing from the binder. monitored and reviewed for	
Based on interview at the time of record review, effectiveness at a minimum	
the RM stated these sheets maintained the bi-annual	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		15G247	B. W	'ING		06/14/	2021
	PROVIDER OR SUPPLIER			2401 C	ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR		
RES CAF	RE COMMUNITY AL	TERNATIVES SE IN		JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		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 OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	information that wo	uld be sent with a resident if					
		e was determined. The RM			The persons responsible will be	е	
	•	the sheets for all of the			the, Program Manager, Area		
		ere not in the binder at the			Supervisor, and Residential		
	time of record revie	w.			Manager		
	l -	reviewed with the RM during held on 06/14/2021.					
E 0023	403.748(b)(5), 416	6.54(b)(4), 418.113(b)(3),					ı
	, , , ,	2.15(b)(5), 483.475(b)(5),					
Bldg	, , , ,	102(b)(4), 485.625(b)(5),					
	485.68(b)(3), 485.	727(b)(3), 485.920(b)(4),					
	486.360(b)(2), 491	1.12(b)(3), 494.62(b)(4)					
	Policies/Procedure	es for Medical					
	Documentation						
	- ,,,,	416.54(b)(4), §418.113(b)					
	(3), §441.184(b)(5	, - , , ,					
	. , , , -	33.73(b)(5), §483.475(b)					
	(5), §484.102(b)(4	, - , , ,					
	. , , , -	185.727(b)(3), §485.920(b)					
	(4), §486.360(b)(2), 9491.12(b)(3),					
	§494.62(b)(4).						
	(b) Policies and p	rocedures. The [facilities]					
	-, ,	implement emergency					
	•	cies and procedures,					
		rgency plan set forth in					
	paragraph (a) of th						
		agraph (a)(1) of this					
	section, and the co	ommunication plan at					
	paragraph (c) of th	is section. The policies					
	·	ust be reviewed and					
	•	very 2 years [annually for					
	_	a minimum, the policies					
	and procedures m	ust address the following:]					
	[/5] -= /0\ /4\ /0\;)					
		A system of medical					
	uocumentation tha	at preserves patient					

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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 06/14/2021				
		15G247	B. WI	NG		06/14/	/2021
NAME OF P	PROVIDER OR SUPPLIEF	- :			ADDRESS, CITY, STATE, ZIP CODE		
DE0.045		L TERMATIN (FO. OF IN)			ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTI			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		cts confidentiality of patient ecures and maintains					
	availability of reco						
	availability of 1000	143.					
	*[For RNHCIs at §	3403.748(b):] Policies and					
	procedures. (5) A	system of care					
		at does the following:					
	(i) Preserves patie						
	(ii) Protects confid	lentiality of patient					
	information.						
	(iii) Secures and maintains the availability of records.						
	Tocords.						
	*[For OPOs at §48	36.360(b):] Policies and					
	procedures. (2) A	system of medical					
		at preserves potential and					
	actual donor infor	· ·					
		otential and actual donor					
	availability of reco	ecures and maintains the					
		view and interview, the	E 00)23	1.The emergency plan polici	es	07/14/2021
		sure emergency preparedness)23	and procedures will be update		07/14/2021
	1	ures include a system of			include a continuity of operation		
	medical documenta	tion that preserves client			plan which addresses a syster	n of	
		ts confidentiality of client			medical documentation of fron		
		cures and maintains the			the ICF/IID facility and include	S	
	· ·	ds in accordance with 42 . This deficient practice			consideration of maintaining protection of confidentiality of		
	could affect all occi	-			patient information and secure	,c	
		приши.			and maintains availability of		
	Findings include:				records.		
	-				2.The area supervisor and		
	_	e emergency preparedness			program manager will train all	staff	
		06/14/2021 between 11:00			on the updated policies and		
		with the Residential Manager			procedures and the program		
		nd procedures which include I documentation that			overview will be placed in the Emergency Disaster		
	preserves client info				Preparedness Manual for		
	1 ~	lient information, and secures			reference as needed.		
	1	vailability of records was			3.The corrective action will b	е	
		-	1		1		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/14/2021			
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
E 0031	time of record revie documentation was	Based on interview at the w, the RM stated that available for review.		monitored and reviewed for effectiveness at a minimum bi-annual 4. The Area Supervisor will ensure the EPP is updated annually and all staff are train on the Emergency Preparedn Manual and have knowledge where it is kept in the home a all its content. Upon visiting a home, the Program Manager review the Emergency Preparedness Manual and document the visit on the Hor Visitor Sign In form located in each home. 5. Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete mosite reviews of each location adocument any issues/findings the site review. Site Review we be reviewed by each Area Supervisor and Program Manafor that home and follow-up as necessary to correct all issues. The persons responsible will the, Program Manager, Area Supervisor, and Residential Manager	ess of nd i will ne ne nthly and on vill ager s s.			
E 0031	441.184(c)(2), 482	1.54(c)(2), 418.113(c)(2), 2.15(c)(2), 483.475(c)(2), 102(c)(2), 485.625(c)(2),						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		l í	UILDING	nstruction 	COMPI 06/14	LETED		
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
TAG	485.68(c)(2), 485.486.360(c)(2), 499. Emergency Official §403.748(c)(2), §44(2), §441.184(c)(2) §482.15(c)(2), §48(2), §484.102(c)(2), §485.625(c)(2). [(c) The [facility] man emergency prepare local laws and must least every 2 yes facilities]. The consinclude all of the formal control of the following of the fo	727(c)(2), 485.920(c)(2), 1.12(c)(2), 494.62(c)(2) als Contact Information 416.54(c)(2), §418.113(c), §460.84(c)(2), 33.73(c)(2), §483.475(c), §485.68(c)(2), 485.727(c)(2), §485.920(c), §491.12(c)(2), 4991.12(c)(2),		TAG	DEFICIENCY		DATE	
	(iii) The State Lice	ensing and Certification						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/14/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Agency. Based on record reversal facility failed to ensure preparedness commented for sharing emergency plan that is appropriate with representatives in ad 483.475(c)(8). This affect all occupants Findings include: During review of the documentation on 0 a.m. and 1:15 p.m. vinformation for conthrough the gateway from the contact list information for the from the written English	tunication plan includes a information from the to the facility has determined clients and their families or ecordance with 42 CFR deficient practice could to the emergency preparedness of 6/14/2021 between 11:00 with the Residential Manager, tacting the State of Indiana by and email were missing to the RM agreed that contact State of Indiana was missing the energency Plan.	E 00	031	1.The administrator will ensure the emergency plan policies a procedures will be updated to include a continuity of operation plan which includes how to communicate with Indiana Protection and Advocacy Services (IPAS). 2.The area supervisor and program manager will train all on the continuity of operations plan and the plan will be presented the Emergency Disaster Preparedness Manual for reference as needed. 3.This information is located section 3 of the Emergency Disaster Preparedness Manual 4.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 5.The Executive Director will review and approve the continuity of operations plan and how to communicate with Indiana Protection and Advocacy Services. The quality assuran manager and program mange ensure the most current continuity of operations and how to communicate with Indiana Protection and Advocacy Services is in the Emergency Preparedness Manual.	staff sent in lal coe	07/14/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/14/2021			
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
E 0032 Bldg	441.184(c)(3), 482 483.73(c)(3), 484. 485.68(c)(3), 485. 486.360(c)(3), 491 Primary/Alternate §403.748(c)(3), §4 (3), §441.184(c)(3) §482.15(c)(3), §48 (3), §484.102(c)(3) §485.625(c)(3), §4 (3), §486.360(c)(3) §494.62(c)(3). [(c) The [facility] m an emergency pre plan that complies local laws and mu at least every 2 ye	33.73(c)(3), §483.475(c)), §485.68(c)(3), le85.727(c)(3), §485.920(c)), §491.12(c)(3), sust develop and maintain paredness communication with Federal, State and st be reviewed and updated ars [annually for LTC nmunication plan must					
	*[For ICF/IIDs at § and alternate mea the ICF/IID's staff, regional, and local agencies. Based on record rev facility failed to ens preparedness comm Primary and alterna with the following: Federal, State, tribal	tribal, regional, and local gement agencies. 483.475(c):] (3) Primary ns for communicating with Federal, State, tribal, emergency management iew and interview, the ure the emergency unication plan includes (3) te means for communicating (i) ICF/IID facility's staff (ii)	E 0032	1.The method of communication using both a primary and alter means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies will be place in the EPP by the Programatical states.	nate		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETEI	
		15G247	B. WING		06/14/202	1
			STREET	ADDRESS, CITY, STATE, ZIP CO	DE	
NAME OF F	PROVIDER OR SUPPLIEF	₹		CORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		RSONVILLE, IN 47130		
(X4) ID	CHMMADV	TATEMENT OF DEFICIENCIES	ID	<u> </u>	1	(V5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRE	CTION CO	(X5) MPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
1710		75(c)(3). This deficient	1710	Manager.		DATE
	practice could affect			Managor.		
	practice could arrec	et an occupants.		1.All staff will be traine	d on the	
	Finding Include:			method of communicating		
	i manig merade.			both a primary and alter		
	Based on record rev	view of the Emergency		means of communicating		
		on 04/14/2021 between		ICF/IID staff, Federal, St	•	
	_	5 p.m., the facility was to		regional, and local emer		
	listen to the radio for			managements agencies		
	emergencies. Based on interview with the					
Residential Manger (RM) on 06/14/2021				1.Area Supervisor will	ensure	
between 11:00 a.m. and 1:15 p.m., the RM was				the EPP includes a copy	the	
	not sure where the radio was, if it had charged			method of communicating	g using	
	batteries, and when	it was tested. The RM		both a primary and alter	nate	
	acknowledged that	the EP required a radio and		means of communicating	g with	
		re if there was one in proper		ICF/IID staff, Federal, State,		
	working order in th	e house.		regional, and local emer		
				managements agencies		
		s reviewed with the RM during				
	the Exit Conference	e held on 06/14/2021.		1.The Area Supervisor		
				ensure the EPP is updat		
				annually and all staff are		
				on the Emergency Prepa		
				Manual and have knowled	_	
				where it is kept in the ho all its content. Upon visi		
				home, the Program Man	•	
				review the Emergency	agei wiii	
				Preparedness Manual a	nd	
				document the visit on the		
				Visitor Sign In form locat		
				each home.		
				1.Monitoring of Correc	tive	
				Action: A member of the		
				Review Team, consisting	g of the	
				QA department, Progran	n	
				Managers, QIDP-D's, No	ırse	
				Manager, AED, and Are	а	
				Supervisors will complet	e monthly	
	I		I		1	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G247		(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG	(X3) DATE COMPI 06/14	LETED		
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	G CROSS-REFERENCED TO THE AF	OULD BE PPROPRIATE	(X5) COMPLETION DATE	
				site reviews of each loc document any issues/fit the site review. Site Re be reviewed by each Ar Supervisor and Prograr for that home and follow necessary to correct all	ndings on eview will rea n Manager v-up as		
				The persons responsible the, Program Manager, Supervisor, and Reside Manager	Area		
E 0034 Bldg	441.184(c)(7), 482 483.73(c)(7), 484. 485.68(c)(5), 485. 491.12(c)(5), 494. Information on Occ §403.748(c)(7), §46 (7) §441.184(c)(7), §46 (7), §484.102(c)(6) §485.68(c)(5), §48 (7), §485.920(c)(7) §494.62(c)(7). [(c) The [facility] m an emergency pre plan that complies local laws and must least every 2 ye facilities]. The cor include all of the formation about needs, and its abil	cupancy/Needs .16.54(c)(7), §418.113(c) , §482.15(c)(7), .3.73(c)(7), §483.475(c) .5), §485.68(c)(5), .5.727(c)(5), §485.625(c) .), §491.12(c)(5), ust develop and maintain paredness communication with Federal, State and st be reviewed and updated ars [annually for LTC munication plan must ollowing:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		(X2) MULTI A. BUILDI B. WING	PLE CONSTRUCTION ING	COMPL	(X3) DATE SURVEY COMPLETED 06/14/2021		
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) d Center, or designee.	ID PREI TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION DATE	
	*[For ASCs at 416 providing informat and its ability to provide authority having justice ability failed to ensure preparedness commens of providing ICF/IID facility's of ability to provide as having jurisdiction ability to provide as	.54(c)]: (7) A means of ion about the ASC's needs, ovide assistance, to the irisdiction, the Incident, or designee. spice at §418.113(c):] (7) ing information about the toccupancy, needs, and e assistance, to the irisdiction, the Incident, or designee. The iew and interview, the incident with the emergency unication plan includes a information about the incident, or designee, incident plan includes a information about the incident command in accordance with 42 CFR deficient practice could	E 0034	1.The administrator will ethe emergency plan policies procedures will be updated include a method to share occupancy needs and ability provide assistance to the Alexandrate Having Jurisdiction. 2.The area supervisor and program manager will ensure policies and procedures up including a method to share occupancy needs and ability provide assistance to the Alexandrate Having Jurisdiction is present the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action we monitored and reviewed for effectiveness at a minimum bi-annually. 4.The Area Supervisor we ensure the EPP is updated annually and all staff are training the Emergency Prepared Manual and have knowledged.	s and to ty to ty	07/14/2021	

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G247	A. BUILDING B. WING	DNSTRUCTION	COMPLETED 06/14/2021	
RES CAF	•	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				where it is kept in the home an all its content. Upon visiting a home, the Program Manager view the Emergency Preparedness Manual and document the visit on the Hom Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete mor site reviews of each location a document any issues/findings the site review. Site Review who he reviewed by each Area Supervisor and Program Manafor that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	will ne e nthly and on vill ager s	
E 0035 Bldg	483.475(c)(8), 48: LTC and ICF/IID \$ §483.73(c)(8); §4:	Sharing Plan with Patients				
	maintain an emer communication pl Federal, State and reviewed and upd	es at §483.73(c):] ty must develop and gency preparedness an that complies with d local laws and must be ated at least annually. The an must include all of the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/14/2021			
	PROVIDER OR SUPPLIEF	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	*[For ICF/IIDs at § [(c) The ICF/IID m an emergency preplan that complies local laws and must least every 2 yellow plan must include (8) A method for sthe emergency pladetermined is apportional control of the emergency pladetermined is apportional and their for the emergency plan that is appropriate with representatives in an 483.475(c)(8). This affect all occupants Findings Include: Based on record reverse preparedness Planta (RM) on 06/14/202 1:15 p.m., there is a addressing the method from the plan with the families. Based on record review, the FePP did not include information.	ust develop and maintain paredness communication with Federal, State and st be reviewed and updated ears. The communication all of the following:] haring information from an, that the facility has ropriate, with residents [or amilies or representatives. Fiew and interview, the ure the emergency unication plan includes a information from the the facility has determined elients and their families or recordance with 42 CFR a deficient practice could	E 0035	1.The administrator will ensithe emergency plan policies a procedures will be shared wit patient's and guardians during annual meetings. The Emerge Plan will be made available for review at request of patients a guardians. 2.The administrator will ensithe emergency plan policies a procedures will be shared wit patient's and guardians during annual meetings. The Emerge Plan will be made available for review at request of patients a guardians. 1.The QIDP, Area Supervis and Program Manager will enthe emergency plan policies a procedures is shared with patient's and guardians during annual meetings. 2.The Program Manager, and Area Supervisor will ensure a copy of the Emergency Preparedness Manual is available for the emergency will ensure a copy of the Emergency Preparedness Manual is available.	and h g ency or and ure and h g ency or and h g ency or and or sure and g and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15G247	B. WING		06/14/2021
RES CAI	SUMMARY S (EACH DEFICIEN	LTERNATIVES SE IN TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	STREET A 2401 C JEFFEN ID PREFIX	ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR RSONVILLE, IN 47130 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
E 0037 Bldg	403.748(d)(1), 41 441.184(d)(1), 48 483.73(d)(1), 484		TAG	onsite and at ResCare Jeffersonville main office for patient and guardian review. T Area Supervisor will ensure st have knowledge of where the Emergency Preparedness Ma is kept in the home and all its content updated. Upon visiting home, the Program Manager of review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 3.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete mor site reviews of each location and document any issues/findings the site review. Site Review of the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings the site review of each location and document any issues/findings	The aff nual g a will he e htthly nd on will hager is a second or the control of

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì	ULTIPLE CO UILDING	onstruction 	(X3) DATE COMPL			
		15G247	B. W	ING		06/14	/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION	
IAU	§403.748(d)(1), §4(1), §441.184(d)(1), §482.15(d)(1), §48(1), §484.102(d)(1), §485.625(d)(1), §485.625(d)(1), §486.360(d)(1) *[For RNCHIs at § §416.54, Hospitals §483.475, HHAs a "Organizations" ur §486.360, RHC/Fe (1) Training prograll of the following (i) Initial training ir policies and proce existing staff, indivunder arrangemer consistent with the (ii) Provide emerg training at least ex (iii) Maintain documpreparedness train (iv) Demonstrate semergency proced (v) If the emergen and procedures at the [facility] must dupdated policies at The hospice must (i) Initial training ir policies and proceexisting hospice existing hospice exproviding services consistent with the (ii) Demonstrate semergency procedures are emergency procedures are emergency procedures are providing services consistent with the (ii) Demonstrate semergency procedures are emergency procedures are providing services consistent with the (iii) Demonstrate semergency procedures are emergency procedures are providing services consistent with the (iii) Demonstrate semergency procedures are emergency procedures are provided procedures are providing services consistent with the (iii) Demonstrate semergency procedures are provided procedures are providing services consistent with the (iii) Demonstrate semergency procedures are provided proce	33.73(d)(1), §483.475(d)), §485.68(d)(1), 485.727(d)(1), §485.920(d)), §491.12(d)(1). 403.748, ASCs at s at §482.15, ICF/IIDs at at §484.102, nder §485.727, OPOs at QHCs at §491.12:] am. The [facility] must do : a emergency preparedness adures to all new and viduals providing services at, and volunteers, eir expected roles. ency preparedness very 2 years. mentation of all emergency ning. staff knowledge of dures. cy preparedness policies re significantly updated, conduct training on the and procedures. §418.113(d):] (1) Training, do all of the following: a emergency preparedness adures to all new and mployees, and individuals under arrangement, eir expected roles. taff knowledge of tures to all new and mployees, and individuals under arrangement, eir expected roles. taff knowledge of		TAG	DETALENCITY AND ADDRESS OF THE PARTY OF THE		DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ′		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	UILDING		COMPI	
		15G247	B. W	ING		06/14	/2021
NAME OF F	ROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	ROVIDER OR SOLVEIE			2401 C	ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	3	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	RIATE	DATE
	training at least ev	very 2 years.					
	-	eview and rehearse its					
	, ,	redness plan with hospice					
		ling nonemployee staff),					
		asis placed on carrying out					
		ecessary to protect patients					
	and others.						
	(v) Maintain docui	mentation of all emergency					
	preparedness trai						
	(vi) If the emerger	ncy preparedness policies					
	and procedures a	re significantly updated,					
	the hospice must	conduct training on the					
	updated policies a	and					
	procedures.						
	-	l41.184(d):] (1) Training					
		TF must do all of the					
	following:						
		n emergency preparedness					
		edures to all new and					
	•	viduals providing services					
	_	nt, and volunteers,					
		eir expected roles.					
	, ,	ning, provide emergency					
		ning every 2 years.					
		staff knowledge of					
	emergency proce	mentation of all emergency					
	` '						
	preparedness trai	cy preparedness policies					
	` '	re significantly updated,					
	•	onduct training on the					
	updated policies a	-					
	Spaces policios c	p. 000 dai 00.					
	*[For PACE at \$46	60.84(d):] (1) The PACE					
	-	do all of the following:					
	-	n emergency preparedness					
	``	edures to all new and					
		viduals providing on-site					
	•	rangement, contractors,					
		· , ,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			1 ′		DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMP	
		15G247	B. W	ING		06/14	/2021
NAME OF E	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
NAME OF I	ROVIDER OR SOLITER			2401 C	ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	participants, and \	volunteers, consistent with					
	their expected role	es.					
	(ii) Provide emerg	ency preparedness					
	training at least ev	very 2 years.					
	(iii) Demonstrate s	staff knowledge of					
	1	dures, including informing					
		at to do, where to go, and					
		n case of an emergency.					
	` '	mentation of all training.					
	. , ,	ncy preparedness policies					
		re significantly updated,					
		onduct training on the					
	updated policies a	and procedures.					
	*IFor LTC Facilitie	es at §483.73(d):] (1)					
	-	. The LTC facility must do					
	all of the following	-					
	ı	n emergency preparedness					
		edures to all new and					
	1 '	viduals providing services					
	_	nt, and volunteers,					
	consistent with the						
		ency preparedness					
	training at least ar	nnually.					
	(iii) Maintain docu	mentation of all emergency					
	preparedness trai	ning.					
	(iv) Demonstrate s	staff knowledge of					
	emergency proce	dures.					
	tr= 00== :=	405 00(I) 1(4) T :::					
		485.68(d):](1) Training.					
		do all of the following:					
		raining in emergency icies and procedures to all					
	l	staff, individuals providing					
	_	rangement, and volunteers,					
		eir expected roles.					
		ency preparedness					
	training at least ev						
		mentation of the training.					
		staff knowledge of					
	` '	3					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		1 ′		INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPI	
		15G247	B. W	ING		06/14	/2021
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF I	KOVIDEK OK SOIT EIEF			2401 C	ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	emergency proced	dures. All new personnel					
		and assigned specific					
		garding the CORF's					
		within 2 weeks of their first					
		ning program must include					
		ocation and use of alarm					
	systems and signa	als and firefighting					
	equipment.						
	(v) If the emerge	ncy preparedness policies					
	and procedures a	re significantly updated,					
	the CORF must co	onduct training on the					
	updated policies a	and procedures.					
		35.625(d):] (1) Training					
		H must do all of the					
	following:						
	.,	n emergency preparedness					
		edures, including prompt					
	reporting and exti						
	•	nere necessary, evacuation					
		nnel, and guests, fire					
	•	poperation with firefighting					
		orities, to all new and					
	•	viduals providing services					
	-	nt, and volunteers,					
		eir expected roles. ency preparedness					
	training at least e	• • •					
		mentation of the training.					
	(iv) Demonstrate	_					
	emergency proced	_					
		ncy preparedness policies					
	, ,	re significantly updated,					
	·	nduct training on the					
	updated policies a	<u> </u>					
	'	•					
	*[For CMHCs at §	485.920(d):] (1) Training.					
	The CMHC must p	provide initial training in					
		redness policies and					
	procedures to all r	new and existing staff,					
	l		1				I

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING		COMPI	LETED
		15G247	B. W	ING	_	06/14	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			ORNWELL DR		
		LTERNATIVES SE IN	JEFFERSONVILLE, IN 47130				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	individuals providi	· ·					
	•	volunteers, consistent with					
	their expected roles, and maintain						
		the training. The CMHC					
		staff knowledge of					
	CMHC must provi	dures. Thereafter, the					
	· ·	ning at least every 2 years.					
	•	view and interview, the	E 0	027	1.The administrator will ensi	ıre	07/14/2021
	facility failed to ens		LEU	03/	the emergency plan policies a		0//14/2021
	-	am (EPP) training and testing			procedures initial training in		
		training program. The ICF/IID			emergency preparedness poli	cies	
		of the following: (i) Initial			and procedures to all new and		
	-	cy preparedness policies and			existing staff, annual emerger		
		w and existing staff,			training, documentation of the	•	
	-	ng services under arrangement,			training and staff demonstration		
	_	sistent with their expected			knowledge of the emergency		
	roles; (ii) Provide en	mergency preparedness			procedures is completed and		
	training at least ever	ry two years; (iii) Maintain			present in the EPP manual. T	he	
	documentation of al	ll emergency preparedness			ResCare "On The Job" training	g	
	training; (iv) Demon	nstrate staff knowledge of			checklist will be updated to inc	clude	
		res; (v) If the emergency			initial training in emergency		
		es and procedures are			preparedness of all new		
		d, the facility must conduct			employees. The annual traini	ng	
		ated policies and procedures			requirements list will also be		
		42 CFR 483.475(d) (1). This			updated to include the training	g of	
	deficient practice co	ould affect all occupants.			all existing employees.		
	TO 11 T 1 1				2.The residential manager, a		
	Findings Include:				supervisor and program mana	•	
	Dagad on massed	riory of the Training Dragger			will provide initial training to al		
		view of the Training Program yeen 11:00 a.m. and 1:15			new staff and the ResCare tra will provide annual training to	ııı l e i	
		ential Manager (RM), there is			existing staff. Testing results	will	
	_	of training for new employees			be available to demonstrate s		
		on of biannual training for			knowledge of emergency	11	
	staff in the documen	_			procedures. The training and		
					testing documentation will be		
	This deficiency was	s reviewed with the RM during			present in the Emergency		
	•	e held on 06/14/2021.			Disaster Preparedness		
					Manual/HR personnel files for		
1	i		1		I		1

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/14/2021	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP CODE CORNWELL DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
E 0039 Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 491 EP Testing Requir §416.54(d)(2), §41 (2), §460.84(d)(2), §483.73(d)(2), §48 (2), §485.68(d)(2), §485.727(d)(2), §4 (2), §494.62(d)(2). *[For ASCs at §41 OPO, "Organization CMHCs at §485.93 §491.12, and ESR (2) Testing. The [faction of the content of the conten	8.113(d)(2), §441.184(d) §482.15(d)(2), 83.475(d)(2), §484.102(d) §485.625(d)(2), 85.920(d)(2), §491.12(d)		reference as needed. The associate executive director w review the training documenta to ensure it has been complete and is present. The safety committee will review and upd annually as needed. 3. This information is located section 22 of the Emergency Disaster Preparedness Manual The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	tion ed ate in	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		ì		NSTRUCTION	, ,	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING			PLETED
		15G247	B. W	ING		06/14	4/2021
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	3	
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>		2401 C	ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROLUBERG WALLOF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI	D BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	JPRIATE	DATE
	community-based	every 2 years; or					
	(A) When a comn	nunity-based exercise is					
	not accessible, co	nduct a facility-based					
	functional exercise	e every 2 years; or					
	(B) If the [faci	lity] experiences an actual					
	natural or man-ma	nde emergency that					
	requires activation	of the emergency plan,					
		mpt from engaging in its					
	next required com	munity-based or individual,					
	· ·	tional exercise following					
	the onset of the a						
	` '	ditional exercise at least					
	every 2 years, opp	_					
		onal exercise under					
	paragraph (d)(2)(i						
		ay include, but is not ·					
	limited to the follow	_					
	, ,	scale exercise that is					
		or individual, facility-based					
	functional exercise						
	(B) A mock disast	er drill, or ercise or workshop that is					
	1 ' '	and includes a group					
	discussion using a						
	ı	emergency scenario, and					
	I	tatements, directed					
		pared questions designed					
	to challenge an er						
]	acility's] response to and					
	1 ' '	ntation of all drills, tabletop					
		ergency events, and revise					
		rgency plan, as needed.					
	*[For Hospices at	418.113(d):]					
	l ' '	spices that provide care in					
		e. The hospice must					
		to test the emergency plan					
	1	The hospice must do the					
	following:						
	(i) Participate in a	full-scale exercise that is					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /		DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPI	
		15G247	B. W	ING		06/14	/2021
NAME OF E	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF I	ROVIDER OR SOLI EIEF			2401 C	ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	3	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
	community based	*	1				
		nunity based exercise is not					
	l ` '	ct an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
	1 ' '	ency that requires					
	· ·	mergency plan, the hospital					
		gaging in its next required					
	I	nity-based exercise or					
	individual facility-b	pased functional exercise					
	following the onse	et of the emergency event.					
	(ii) Conduct an ad	dditional exercise every 2					
	years, opposite th	e year the full-scale or					
	functional exercise	e under paragraph (d)(2)(i)					
		onducted, that may					
		limited to the following:					
	1 ' '	scale exercise that is					
	1 -	or a facility based					
	functional exercise						
	(B) A mock disas						
		ercise or workshop that is					
	1	and includes a group					
	discussion using a						
		emergency scenario, and					
		tatements, directed					
		pared questions designed					
	to challenge an er	nergency plan.					
	(3) Testing for hos	spices that provide inpatient					
	, ,	hospice must conduct					
	I	he emergency plan twice					
		spice must do the following:					
	1 ' '	an annual full-scale					
		ommunity-based; or					
		nunity-based exercise is					
	1 ' '	nduct an annual individual					
		ctional exercise; or					
	1	experiences a natural or					
		ency that requires					
		mergency plan, the					
							1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			· /		INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		15G247	B. W	ING		06/14/	/2021
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF	C		2401 C	ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(V4) ID	CLIMOMADAZ C	TATEMENT OF DEFICIENCIES	1	ID.	·		(7/5)
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
		t from engaging in its next					
		community based or					
	1	tional exercise following					
	the onset of the e	- ·					
	1 ' '	dditional annual exercise					
	· ·	but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
		or a facility based					
	functional exercise	•					
	(B) A mock disas	-					
		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.						
	1 ' '	ospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	the nospice's eme	ergency plan, as needed.					
	*(C-" DDCT4 0 4	144 404/d) Haaritala at					
	§482.15(d), CAHs	141.184(d), Hospitals at					
	\ ''	. , ,					
	' '	PRTF, Hospital, CAH] must					
		to test the emergency planne [PRTF, Hospital, CAH]					
	must do the follow	an annual full-scale					
		ommunity-based; or					
		nunity-based, or					
	1 ' '	nduct an annual individual,					
		ctional exercise; or					
	(B) If the [PRTF, I						
	. , -	ctual natural or man-made					
		equires activation of the					
		the [facility] is exempt from					
		xt required full-scale					
		vriednijen inii-scale					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G247	A. BUILDING B. WING		COMPL 06/14/	ETED
NAME OF P	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE	•	
RES CAF	RE COMMUNITY AL	TERNATIVES SE IN		CORNWELL DR ERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	functional exercise emergency event. (ii) Conduct a	or individual, facility-based following the onset of the				
	limited to the follow	scale exercise that is or individual, a				
	(B) A mod (C) A tabletop is led by a facilitate discussion, using a	ck disaster drill; or exercise or workshop that or and includes a group				
	a set of problem st messages, or prep to challenge an en	atements, directed pared questions designed nergency plan.				
	and maintain docu tabletop exercises	ne [facility's] response to mentation of all drills, and emergency events ility's] emergency plan, as				
	conduct exercises at least annually. I must do the follow (i) Participate in a exercise that is con (A) When a common not accessible, con facility-based funct (B) If the PACE ex	ACE organization must to test the emergency plan The PACE organization ing: n annual full-scale mmunity-based; or unity-based exercise is nduct an annual individual,				
	requires activation the PACE is exem required full-scale individual, facility-b	of the emergency plan, pt from engaging in its next community based or pased functional exercise t of the emergency event.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 06/14/2021				
		100241				00/14/	∠U∠ I
NAME OF F	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
DEC CAE		LTERNATIVES SE INI		1	ORNWELL DR		
KES CAR	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	` '	in 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	_					
		scale exercise that is					
		or individual, a facility					
	based functional e	-					
	(B) A mock disas	ter drill; or					
		ercise or workshop that is					
	•	and includes a group					
	discussion, using						
		emergency scenario, and					
		statements, directed pared questions designed					
	to challenge an er						
	-	PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
	*[For LTC Facilitie	- ' ' -					
	, , -	ity] must conduct exercises					
	•	ency plan at least twice per announced staff drills					
		ncy procedures. The [LTC					
		ust do the following:					
	•	an annual full-scale					
	exercise that is co	ommunity-based; or					
	(A) When a comm	nunity-based exercise is					
	· ·	onduct an annual individual,					
	facility-based fund						
	, , _	ility] facility experiences					
		or man-made emergency					
	•	ation of the emergency lity is exempt from					
		required a full-scale					
		or individual, facility-based					
	-	e following the onset of the					
	emergency event.	_					
	emergency event.		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		l í	JILDING	NSTRUCTION	(X3) DATE COMPI 06/14	LETED	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	<u> </u>	2401 C	ODDRESS, CITY, STATE, ZIP CODE ORNWELL DR RSONVILLE, IN 47130	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	(ii) Conduct an act that may include, I following: (A) A second full-community-based based functional et (B) A mock disast (C) A tabletop excled by a facilitator discussion, using clinically-relevant a set of problem s messages, or prepto challenge an er (iii) Analyze the [Li response to and mall drills, tabletop events, and revise emergency plan, at (2) Testing. The IC exercises to test the twice per year. The following: (i) Participate in an that is community-(A) When a community-(A) When a community-(A) When a community-(B) If the ICF/IID is exercised function of the ICF/IID is exercised full-sindividual, facility-following the onse (ii) Conduct an additional community-ICP/IID is exercised full-sindividual, facility-following the onse (iii) Conduct an additional community-ICP/IID is exercised full-sindividual, facility-ICP/IID is exercised full-sindividual, facility-ICP/ICP/ICP/ICP/ICP/ICP/ICP/ICP/ICP/ICP/	Iditional annual exercise out is not limited to the scale exercise that is or an individual, facility exercise; or ere drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and tatements, directed oared questions designed energency plan. TC facility] facility's naintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed. 483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the en annual full-scale exercise					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247			r í	UILDING	NSTRUCTION		LETED L/2021	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	community-based facility-based facility-based functions (B) A mock disaste (C) A tabletop exelled by a facilitator discussion, using clinically-relevant a set of problem s messages, or preproceed to challenge an erection of the ICF/IID's emerection of th	tional exercise; or er drill; or roise or workshop that is and includes a group a narrated, emergency scenario, and tatements, directed pared questions designed pergency plan. EF/IID's response to and station of all drills, tabletop pergency events, and revise gency plan, as needed. EHAA must conduct the emergency plan at the HHA must do the full-scale exercise that is gor or o						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		15G247	B. W	ING		06/14/	2021
NAME OF F	DOLUDED OD GUDDU IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		2401 C	ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	community-based						
	facility-based func						
	l ' '	saster 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						
	· ·						
	to challenge an er	pared questions designed					
		HA's response to and					
	. , ,	ntation of all drills, tabletop					
		nergency events, and revise					
	· ·	ency plan, as needed.					
	and this to omorgo	mey plan, as nesasa.					
	*[For OPOs at §48	36.360]					
	(d)(2) Testing. The	e OPO must conduct					
	exercises to test the	ne emergency plan. The					
	OPO must do the	following:					
	(i) Conduct a pape	er-based, tabletop exercise					
	or workshop at lea	ast annually. A tabletop					
	I	a facilitator and includes a					
		using a narrated, clinically					
		cy scenario, and a set of					
		ts, directed messages, or					
		is designed to challenge an					
		f the OPO experiences an					
		nan-made emergency that					
	· ·	of the emergency plan,					
		ot from engaging in its next kercise following the onset					
	of the emergency	<u> </u>					
		PO's response to and					
	1 ' '	ntation of all tabletop					
		nergency events, and revise					
		OPO's] emergency plan,					
	as needed.	c. c of omorganoy plant,					
	*[RNCHIs at §403	3.748]:					
		e RNHCI must conduct					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER:		JILDING		COMPL	
		15G247	B. W	ING		06/14/	2021
RES CA	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	exercises to test to RNHCI must do the (i) Conduct a paper at least annually. It is group discussion to narrated, clinically scenario, and a set directed message designed to challed (ii) Analyze the RI maintain document exercises, and enter the RNHCI's eme Based on record rest facility failed to contotest the emergency years. The facility failed to contotest the emergency years. The facility for counting the COVI emergency that requivalent existing EPP. The If following: (ii) Conduct an addinctude, but is not lated as A second full-sear community-based of functional exercises. A mock disaster c. A tabletop exercise facilitator that incompared the problem statement prepared questions emergency plan. (iii) Analyze the IC and maintain docume exercises, and emergency in the ICF/IID facility's end accordance with 42 accor	he emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a y-relevant emergency et of problem statements, es, or prepared questions enge an emergency plan. NHCl's response to and natation of all tabletop nergency events, and revise regency plan, as needed. view and interview, the nature an additional exercises by plan at least every two had documentation of D pandemic as an actual uired activation of the CF/IID facility must do the ditional exercise that may imited to the following: ale exercise that is or an individual, facility-based drill; or ise or workshop that is led by sludes a group discussion led	E 00		1.The administrator will ensuthe emergency plan policies a procedures includes the participation in a full-scale community based exercise antable top exercise in accordantable top exercise in the EPP manual. 2.To meet the requirements the Emergency/Disaster Preparedness training, the factorist to the same months other simulatable drills are completed (January admils are completed (January admils are completed (January admils are completed (January admils). 3.The Program Manager and Area Supervisor will ensure facility will conduct at least the full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually 4.Area Supervisor will ensure facility will form is sent to the Program Manager for review and follow-up. Program	nd d a ce for illity e a cted ted and d the wo	07/14/2021

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	,		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G247	A. BU B. WI	ILDING NG		COMPL: 06/14/	
		130241	D. W1			00/14/	ZUZ I
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN	_		RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	Findings include: Based on record rev "Emergency/Disaste documentation with (RM) between 11:0 06/14/2021, docum- additional exercise of Emergency Prepare for review. Based of review with the RM EPP did not include actual activation do COVID. The RM a	er Preparedness Manual" I the Residential Manager 0 a.m. to 1:15 p.m. on entation of biannual or activation of the dness Plan was not available on interview during record I, it was determined that the e scheduled testing or an cumentation other than for agreed with this assessment.		TAG	Manager will forward Mock D to the QA department for review and filing. 5.A community based full scale drill has been schedule with local emergency responders and will be conducted on April 9, 2019. 6.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete more site reviews of each location and document any issues/findings the site review. Site Review will be reviewed by each Area Supervisor and Program Manager that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	ed ethly nd on vill ager	DATE
K 0000							
Bldg. 01		1/2021 00769 15G247	K 00	000			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		A. BUILDING B. WING	Onstruction 01	COMPLETED 06/14/2021
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	At this Life Safety Code survey, RES CARE Community Alternatives SE IN was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building is not protected by automatic sprinklers. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has a capacity of 8 and had a census of 7 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 0.7. Quality Review on 06/24/21			
K S100	NFPA 101 General Requirements - Other			
Bldg. 01	General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General 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. 1. Based on observation and interview, the facility failed to ensure 3 of 3 portable fire extinguishers located in the facility were inspected at least monthly and the inspections were documented including the date and initials	K S100	1.ResCare Maintenance will conduct monthly inspections of facility fire extinguishers. Documented test dates will be	f all

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/14/2021		
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	•	2401 C	ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
TAG	of the person perfor 33.1.1.3 states the p General, shall apply existing LSC feature as fire extinguishers removed. NFPA 10 Fire Extinguishers, states fire extinguish manually or by mean monitoring device/s 30-day intervals. Winspections are condinspection was performing to recorded. Where m conducted, records be kept on a tag or lextinguisher, on an maintained on file, or Records shall be kept the last 12 monthly performed. This deall clients, staff and Findings include: Based on observation from 1:15 p.m. Residential Manage downstairs portable affixed inspection a lacked monthly inspections was not to do and no one ha monthly inspections.	ming the inspection. LSC rovisions of Chapter 4, 2. LSC 4.6.12.3 requires es obvious to the public, such 3, to be either maintained or 4, the Standard for Portable 2010 Edition, Section 7.2.1.2 thers shall be inspected either ins of an electronic ystem at a minimum of there monthly manual ducted, the date the manual formed and the initials of the he inspection shall be anual inspections are for manual inspections are for manual inspections shall abel attached to the fire inspection checklist for by an electronic method. For the demonstrating that at least inspections have been ficient practice could affect visitors. On on 06/14/2021 during the to 2:00 p.m. with the r., the kitchen, front door, and fire extinguishers had an and maintenance tag and sections for the months since the device in March 2021. The time of observation, the ager indicated the monthly something she had training disease hired to provided 3.		TAG	onsite and with maintenance manager for review. 2.The AED met with ResCa Maintenance Manager on Jun 25, 2021 to ensure monthly checks are being performed. 3.The Facility will conduct random monthly inspections being the Residential Manager, Area Supervisor or Program Managet or ensure documentation of Fi Extinguisher Inspections are being completed as required a available for review. If documentation is not available Program Manager, Area Supervisor or Residential Manager will contact Aramark (844)- RESCARE and create service order and follow up to ensure completion within 5 da 4.The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of inspecting Fire Extinguishers maintaining proper documentation. 5.Random Monthly site visit be conducted by the manager team to verify the inspecting Fire Extinguishers and maintaining proper documentation. 6.The Administrator will ensite the portable fire extinguisher located in the cabinet under the kitchen sink is inspected annualong with all portable fire extinguisher in the facility.	re e y a ger re and e the s will ment cire y ure	DATE
	This deficiency was	reviewed with the RM during			7.Concerning annual		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		15G247	B. W			06/14/	
		1.002				00, 1.1,	
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					ORNWELL DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the Exit Conference	e held on 06/14/2021.			maintenance of Fire Extinguis	her	
					The Associate Executive Dire	ctor	
	Based on observ	ration and interview, the			contacted Eric Grey with Koor	sen	
	facility failed to ens	sure 3 of 3 interior			Fire and Security on June 25,		
	emergency lights w	ere tested and the records of			2021 to schedule annual		
	the testing maintain	ed. LSC 33. 1.1.3 states the			maintenance for all the facilitie	es	
	provisions of Chapter 4, General, shall apply.				Fire Extinguisher. The Scope	of	
	LSC 4.6.12.3 states existing life safety features				work has been updated to ens	sure	
	obvious to the public, if not required by the				the inclusion of annual		
	Code, shall either be maintained or removed.				maintenance for portable fire		
	LSC 7.9.3.1.1 testing of required emergency				extinguishers and required		
	lighting systems shall be permitted to be				documentation. The Program		
	conducted as follows:				Manager, Area Supervisor and	d	
	(3) Functional testing shall be conducted				Direct Support Lead have bee	n	
		mum of 1 ½ hours if the			in-serviced on the requiremen	t	
	emergency lighting	is battery powered.			and if a deficiency is noted the	9	
	(5) Written records	of visual inspections and			Program Manager, Area		
	tests shall be kept b	y the owner for inspection			Supervisor or Direct Support I	_ead	
	for the authority has	ving jurisdiction.			will contact (844) ResCare to		
	This deficient pract	ice could affect all occupants			create a service order. The		
	if the facility were i	required to evacuate in an			Associate Executive Director		
	emergency during a	loss of normal power.			contacted Aramark Services o	n	
					June 25, 2021 the Facilities		
	Findings include:				maintenance vendor to ensure	e the	
					scope of work for Koorsen Fire	е	
	Based on record rev	view of the Monthly Fire &			and Security included the ann	ual	
	Safety Checks with	the Residential Manager on			maintenance of portable fire		
	06/14/2021 between	n 1:15 p.m. and 2:15 p.m.,			extinguishers and required		
	the records do not d	locument a 90-minute test of			documentation will be made		
	the emergency light	ting in the last twelve months.			available for review.		
	The documentation	does not include an inventory			8.The Facility will ensure int	erior	
	specifying the locat	ion or defining characteristic			emergency lights are tested,		
		ghting fixtures. Based on			maintained, and records of tes	sting	
	observations during	the facility tour with the RM			are maintained.		
	between 1:15 p.m.	and 2:15 p.m. there were			9.The Facility will ensure int	erior	
	_	gency lights observed in the			emergency lights are tested a		
	three hallways. No	ne of the devices had an			minimum of 3 weeks and a		
	I	ast 90-minute test. Based on			maximum of 5 weeks for no le	ess	
		RM at the time of record			than 30 seconds, records of te	est	
		cumentation of written			will be maintained by the facili		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
ANDILAN	15G247	B. WING	<u>01</u>	06/14/2021
	130247			00/14/2021
NAME OF P	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	
RES CAF	RE COMMUNITY ALTERNATIVES SE IN		ORNWELL DR RSONVILLE, IN 47130	
			1	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE
1710	records of an annual functional test were	1710	10.The facility will ensure a	Dille
	available for review. Based on interview at the		functional test is conducted	
	time of record review, the Group Home Manager		annually for a minimum of 1 $\frac{1}{2}$	
	acknowledged there was no written record of an		hour for all battery powered	
	annual test regarding the battery-operated		interior emergency lights, reco	rds
	emergency lights.		of the test will be maintained b	у
			the facility.	
	This deficiency was reviewed with the RM during		11.The Program Manager wil	II
	the Exit Conference held on 06/14/2021.		schedule a service order with	
			Koorsen Fire and Security to	27
			repair or replace the emergend light	-y
			l light	
			Persons Responsible: Progra	ım
			Manager, Area Supervisor, an	d
			Residential Manager, DSP,	
			Koorsen Fire and Security.	
IX 0000	NEDA 404			
K S222	NFPA 101			
Bldg. 01	Egress Doors Egress Doors			
Diag. 01	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.			

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STATEME	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		15G247	B. W	ING		06/14/	2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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'	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	7.2.1.5.10. Corridor positive latching in are prohibited. Door assemblies required to swing travel shall be instant annually in a 33.2.2.5.1 through CFR 483.470(j)(1) Based on observation failed to ensure 1 of arranged such that the emergency if the ballocked. This deficit occupant of the batter occupant o	on and interview, the facility of 3 bathroom doors were staff can rescue clients in an athroom doors become ent practice could affect the hroom. on with the Residential 06/14/2021 between 1:15 of the door to bathroom #3 was r-operated lock. Based on an ale of the observation, the RM de a key for the lock, one ced. The RM acknowledged operable from the outside	KS	222	1.The administrator submitted work order Aramark for the regof bathroom door 1 of 3, to ensure the door is designed to allow opening from the outside during an emergency when locked. 2.Staff will be in-serviced on daily inspection of all doors us for evacuation and if a deficier is found they are to immediate report any issues to ResCare Maintenance. 3.The Residential Manager with the conduct weekly and if a deficiency is found they are to immediately report any issues ResCare Maintenance. 4.The Management team with conduct monthly inspections for proper function of all doors use for evacuation and if a deficier is found they are to immediate report any issues to ResCare Maintenance. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential	pair sure g the ed ncy ly will to	07/14/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		(X2) MULTIPLE (A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 06/14/2021		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
				Manager, DSP		
K S253	NFPA 101					
K S253 Bldg. 01	Number of Exits - Non-SI Number of Exits - Non-Sleeping Roo 2012 EXISTING (I Every sleeping roo have access to a plocated to provide outside. Where sleeping roa above or below th primary means of stair in accordance stair, a horizontal In addition to the psleeping room shall escape that consistence of the level that is independent.					
	2. It shall be a p adjacent nonlocka and remotely loca means of escape, escape. 3. It shall be an operable from the tools, keys, or speclear opening of n feet. The width shinches. The heigh inches. The botton ot more than 44 Such means of es	assage through an able space, independent of ted from the primary to approved means of outside window or door inside without the use of incial effort that provides a ot less than 5.7 square all be not less than 20 t shall be not less than 24 m of the opening shall be inches above the floor. cape shall be acceptable following criteria are met:				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247 A. BUILDING B. WING D. NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRICEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTION BOATE a. The window shall be within 20 feet of finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an exterior balcony. 4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 36 inches. c. Window well deeper than 43 inches b. D. Providers Provided and the provided with a length and width of not less than 36 inches. c. Window well deeper than 43 inches c. Window well de	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) a. The window shall be within 20 feet of finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an exterior balcony. 4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPI	LETED
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			15G247	B. W	ING		06/14	/2021
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following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches			_					
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be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches								
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feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches		be fully openable.						
36 inches. c. Window well deeper than 43 inches								
c. Window well deeper than 43 inches		_	and width of not less than					
has an approved parmanently affived ladder								
has an approved, permanently affixed ladder			•					
or steps complying with the following:			-					
1. The ladder or steps do not extend								
more than 6 inches into the well.								
2. The ladder or steps are not								
obstructed by the window.								
5. If the sleeping room has a door leading			-					
directly to the outside of the building with		-	-					
access to finished ground level or to a								
stairway that meets the requirements of		1	•					
exterior stairs in 33.2.2.2.2, that means of								
escape shall be considered as meeting all			G					
the escape requirements for the sleeping		1	ements for the sleeping					
room.			manna of account from					
a. A second means of escape from each sleeping room shall not be required			· · · · · · · · · · · · · · · · · · ·					
			•					
where the facility is protected throughout by approved automatic sprinkler system in								
accordance with 33.2.3.5.								
b. Existing approved means of escape		1						
shall be permitted to continue to be used.			•					
33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE S	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 01 COMPL		COMPLE	ETED
		15G247	B. Wl	NG		06/14/2	2021
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R					
DECCVE		LTERNATIVES SE IN			ORNWELL DR RSONVILLE, IN 47130		
KES CAP	RE COMMONTT A	LIERNATIVES SE IN		JEFFER	RSONVILLE, IN 47 130		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY 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
	33.2.2.3.4						
		on and interview, the facility	KS	253	1.The administrator will ensu		12/15/2021
		f 5 clients sleeping rooms			client sleeping rooms maintair		
	-	a secondary means of escape			secondary escape with multip	le	
		33.2.2.3. LSC 33.2.2.3			provisions including windows		
	requires a secondary egress from each sleeping				providing a clear with of eleve	n	
	room with multiple provisions. This deficient				inches when open and an		
	practice could affect at all clients.				unobstructed secondary mear	ns of	
	Tr. Ir. i. I. I				escape in accordance with		
	Findings include:				33.2.2.3.		
					2.The Program Director will		
		on with the Residential			schedule repair/replacement of	of	
	- , ,	06/14/2021 between 1:15			the window with the ResCare		
	p.m. and 2:15 p.m., the following conditions				maintenance coordinator. The		
	were noted:				ResCare maintenance coording		
		not have a second means of			will inspect all windows to ens		
	_	has a single door to the			they meet all criteria for mean		
		nich serves as the primary			escape. The facility manager	Will	
	-	The only other opening from			ensure secondary means of		
		rior window that does not			escape are not blocked with		
		l area requirements to be			furniture.		
		d means of escape. The			3.Five Bedroom windows wi		
		ents are 33-1/4" W x 19-1/4"			replaced to ensure an approve		
		14 SF. The window does not			means of escape. October 15		
	stay in the fully ope	-			2021 and contractor selected	by	
		not have a second means of			November 15, 2021. The		
	_	has a single door to the			replacement windows will be installed before Dec 15, 2021.		
	-	nich serves as the primary			· ·		
	-	The only other opening from rior window that does not			4. The facility will perform	ing	
		I area requirements to be			function check of windows dur monthly drills to ensure windo	-	
	_	d means of escape. The			are operating properly and rep	I	
		ents are 31" W x 21" H for an			any defect through the	JUIL	
	area of 4.52 SF.	Citis aic 31 W A 21 H 101 aii			maintenance request form wh	en	
		not have a second means of			discovered.	C11	
		has a single door to the			aiscovered.		
	_	nich serves as the primary			***** Date this deficiency will h	ne	
	-	The only other opening from			***** Date this deficiency will be complete updated to 15DEC2021		
	-	rior window that does not			****	V21	
		I area requirements to be					
	meet the neight and	area requirements to be					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		A. BUILDING B. WING	<u>01</u>	COMPLETED 06/14/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
RES CARE COMMUNITY ALTERNATIVES SE IN				RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	window measureme area of 4.52 SF. A copartially in front of the Bedroom #4 does not escape. The room hinterior hallway white means of escape. The room is an externate the height and considered a second window measureme an area of 3.71 SF. the fully open positis Bedroom #5 does not escape. The room hinterior hallway white means of escape. The room is an externate the height and considered a second window measureme an area of 3.77 SF. This deficiency was	ot have a second means of as a single door to the ch serves as the primary the only other opening from the only other opening from area requirements to be means of escape. The onts are 31" W x 17-1/4" H for The window does not stay in		Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager	
K S321 Bldg. 01	as, and is in or abute escape or a sleepil by one of the follows. 1. Protection shat fire resistance rations with a self-closing door in accordance.	- Enclosure Prompt) ea that is on the same floor ut, a primary means of ng room shall be protected			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL	DING	01	(X3) DATE COMPL	ETED	
15G247		B. WINC			06/14/	2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN] :	2401 CC	DRNWELL DR SONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	protection, in accordance with 3 solid-bonded wood 2. Automatic spraccordance with 3 enclosure. Areas with approvimantal furnace and cooking and lactassified as hazar of such equipment Standard response permitted for use in accordance with 3 33.2.2.2.4, 33.2.3. Based on observation failed to maintain prestorage areas in accordance with 3 storage areas in accordance with 3 solid-bonded wood 2. Automatic spraccordance with 3 enclosure. Areas with approvimantained furnace and cooking and lactassified as hazar of such equipment Standard response permitted for use in accordance with 3 33.2.2.2.4, 33.2.3. Based on observation failed to maintain prestorage areas in accordedicient practice controlled.	e sprinklers shall be n hazardous areas in 3.2.3.2. 2, 33.2.3.2.5 on and interview, the facility rotection of 1 of 1 basement ordance of 33.2.3.2.5. This buld affect staff only.	K S32		1.The maintenance coordina will coordinate the disposal of hazardous materials in the basement. 2.The Area Supervisor will to staff to dispose of hazardous materials in the basement.		07/14/2021
	Manager (RM) on 0	on with the Residential 16/14/2021 between 1:15 the basement storage room			3.Aramark Maintenance completed the cleanout of the basement area and it has been	า	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01 COMPLETED			ETED		
15G247		B. WING 06/14/2021			2021		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
RES CAE	RE COMMUNITY AI	TERNATIVES SE IN	2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
			-		COCIVILLE, IIV 47 100		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
		ardous area for having fuel			inspected by the Program		
	conditions exceedin	_			Manager to ensure the basem	ent	
	two-family dwelling and the close proximity of fuel-fired equipment. The storage area is not separated from the occupied floor above, the				has been cleaned removing		
					cardboard boxes, old furniture,		
	-	occupied floor above, the , or means of escape. Based			and clothing.		
		ime of observation, the RM			Persons Responsible: Progra	m	
		ignificant fuel conditions,			Manager, Maintenance Manag		
	_	t, and lack of enclosure.			Area Supervisor, Residential	Ci,	
	raci-med equipmen	i, and lack of chelosure.			Manager, DSP		
	This deficiency was	reviewed with the RM during					
	the Exit Conference	held on 06/14/2021.					
K S345	NFPA 101						l
	Fire Alarm System	ı - Testing and					
Bldg. 01	Maintenance						
	Fire Alarm System	n - Testing and					
	Maintenance						
	2012 EXISTING (F	Prompt)					
	-	n is tested and maintained					
		n an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		n and Signaling Code.					
	-	acceptance, maintenance					
	and testing are rea						
	9.7.5, 9.7.7, 9.7.8,						
		riew, observation and	KS	345	1.The administrator will ensu	re	07/14/2021
	interview; the facilit				annual functional testing for		
	document all fire ala	-			initiating devices such as smol		
		schedules for testing			detectors, heat detectors, relea		
		72. LSC Section 33.2.3.4.1 alarm system shall be			devices, and fire alarm boxes i performed by Koorsen Fire and		
		nce with Section 9.6, unless			Security on the fire alarm system		
	-	.2.3.4.1.1 or 33.2.3.4.1.2 are			and that reports of the		
	-	2.6.1.3 states a fire alarm			tests/inspections are available	in	
		life safety shall be installed,			the facility for review.	-	
	-	ed in accordance with the			2.The administrator will ensu	re	
		ents of NFPA 70, National			sensitivity testing of the fire ala		
		IFPA 72, National Fire Alarm			system is completed by Koorse		
		*			l [*]		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/14/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		2401 C	ADDRESS, CITY, STATE, ZIP CODE CORNWELL DR RSONVILLE, IN 47130		
	SUMMARY S (EACH DEFICIEN REGULATORY OR and Signaling Code Section 14.4.5 state in accordance with Table 14.4.5 require appliances, batteries tested at least annua could affect all clies Findings include: Based on record rev p.m. on 06/14/2021 Manager (RM), does semi-annual inspect completed work ore inspection and testif were not available for interview at the tim stated the fire alarm documentation had record review. The documentation of fit testing within the m not available for rev This deficiency was	LTERNATIVES SE IN TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) NFPA 72, 2010 Edition, stesting shall be performed the schedules in Table 14.4.5. es alarm notification s, and initiating devices to be ally. This deficient practice ints, staff, and visitors. Tiew from 11:00 a.m. to 1:15 with the Residential cumentation of annual and tions and testing was a der. The reports of the ing from the service provider for review. Based on the of observation, the RM to system inspection not been sent to the house for RM acknowledged the alarm inspection and toost recent year period was	STREET 2401 C	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRING DEFICIENCY) Fire and Security every alterry year after install and that reprof the tests/inspections are available in the facility for revision forward inspection report the QA Manager for monitoric completion. 3. The Program Manager with meet with a representative of Koorsen Fire and Security, tentative date has been set June 25,2021 pending the status of the COVID-19 response and suspense of none essential travel. The Facility will require schedul required testing and request copies of inspections and testing mailed to the program manager upon completion to the Program Manager at 434 Security PKWY Suite 101 No Albany IN 47150. 4. The Program Manager sp with the Kris Carney from Koorsen Fire and Security effective immediately all sites have an annual functional fire alarm inspection in the Month February and a semiannual falarm visual inspection comp	(X5) COMPLETION DATE nate orts riew. II tts to ng of vill from a for e et t m o 41 ew coke s will e n of ire eleted
				in August. Repair of the device that failed the sensitivity test been scheduled to be comple no later than August 15,2021 Access to the device will be available and that device will tested no later than August 3 2021. Koorsen Fire and Sec	has eted . made be 1,

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		A. BUILDING 01 B. WING		COMPLETED 06/14/2021			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		2401 C	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K S362 Bldg. 01	walls shall meet at * Walls separating minimum 1/2-hour which is considered partitioning is finise and plaster or mat 15-minute thermal * Sleeping room doors, such as the solid-bonded wood other construction stability and fire in * Any vision pan assemblies in according wired glass not extending the separation of the	uction of Walls Prompt) indicated below, corridor Il of the following: ng sleeping rooms have a refire resistance rating, ed to be achieved if the hed on both sides with lath terials providing a I barrier. doors are substantial tose of 1-3/4 inch thick, d-core construction or of equal or greater		was notified of ResCare's "In Scope Services Agreement" the automatically authorizes repair/service of fire systems. Koorsen will notify the Program Manger upon completion of all inspections to ensure any deficiencies are properly track and repaired. Koorsen will ser documentation of all inspections services and repair to ResCarmain office at 4341 Security Parkway STE. 101 New Albart 47150 with in 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required.	m l ed nd ns, e e		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 COMPLETED 15G247 B. WING 06/14/2021	
15G247 B. WING 06/14/2021	
	1
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2401 CORNWELL DR	
RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	MPLETION
	DATE
This requirement shall not apply to corridor walls that are smoke partitions in accordance	
with 8.4 and that are protected by automatic	
sprinklers in accordance with 33.2.3.5 on	
both sides of the wall and door. In such	
instances, there shall be no limitation on the	
type or size of glass panels.	
In Prompt Evacuation facilities, all sleeping	
rooms shall be separated from the escape	
route by smoke partitions in accordance with	
8.2.4.	
Sleeping arrangements that are not located	
in sleeping rooms shall be permitted for nonresident staff members, provided that the	
audibility of the alarm in the sleeping area is	
sufficient to awaken staff that might be	
sleeping.	
In previously approved facilities, where the	
group achieves an E-score of three or less	
using the board and care methodology of	
NFPA 101A, Guide on Alternative	
Approaches to Life Safety, sleeping rooms	
shall be separated from escape routes by	
walls and doors that are smoke resistant. 33.2.3.6	
	/14/2021
failed to ensure 5 of 5 sleeping room doors were Maintenance Manager on June	117/2021
1-3/4 inches thick, solid bonded wood core 25, 2021 to ensure all doors in the	
construction or of other construction of equal or facility meet or exceed LSC	
greater stability and fire integrity. This deficient 8.3.3.1 states openings required	
practice could affect all clients. to have a fire protection rating by	
Table 8.3.4.2 shall be protected	
Findings include: by approved, listed, labeled fire door assemblies and fire window	
Based on observation with the Residential assemblies and their	
Manager (RM) during a tour of the facility accompanying hardware,	
between 1:15 p.m. and 2:15 p.m. on 06/14/2021, including all frames, closing	
the doors of the sleeping rooms were found to be devices, anchorage, and sills in	
6-panel wood doors with panels of a thickness accordance with the requirements	
less than 1-3/4". Based on interview at the time of NFPA 80, Standard for Fire	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/14/2021	
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	of observation, the RM stated that the doors were not new and the only doors that have been used since her arrival at the facility. The RM acknowledged that the 6-panel construction of the wood doors was not 1-3/4" thick, solid bonded wood core construction. This deficiency was reviewed with the RM during the Exit Conference on 06/14/2021.		Doors and Other Opening Protectives, except as otherwi specified in this Code. NFPA 8 Standard for Fire Doors and Other Opening Protectives, 20 Edition, Section 4.8.4.2 states clearance under the bottom of door shall be a maximum of 3/ inch. 2.The AED met with ResCar Maintenance Manager on Jun 25, 2021 to ensure all bedroor doors are at a minimum 1-3/4 inches thick, solid bonded wod core construction or of other construction of equal or greate stability and fire integrity 3.The AED contacted Arama on 6/25/2021 and submitted a work order to have ResCare Maintenance noncompliant do will be removed and compliant doors will be installed by Octo 1, 2021.	eo, 10 the a 4 ee en od er	
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with				

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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	COMPL	ETED
15G247		B. WING 06/14/2021				/2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹					
DEC 041		LTERNATIVES OF IN			ORNWELL DR		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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 INFORMATION)		TAG	DEFICIENCY)	16	DATE
	33.2.3.5.						
		with leaves required to					
		tion of egress travel are					
	_	-					
	inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7						
		on and interview, the facility	KS	262	I 1.The Program Manager will		07/14/2021
		f 5 resident rooms doors had	K 2	303	ensure clients bedroom doors		
					positively latch to the frame.		
	_	losing and positively latched			1'	tor	
		s deficient practice could			2.The maintenance coordina		
	affect 6 occupants.				will ensure all clients bedroom		
	F: 1: 1 1				doors will positively latch as		
	Findings include:				required.		
					3.The Bedroom Door 1 and	4	
		on with the Residential			will be repaired by ResCare		
		06/14/2021 between 1:15			Maintenance before August 1	,	
		the following conditions			2021.		
	were found in the fa	-			4.The Residential Manager		
		room #1 was equipped with a			inspect house weekly to ensur	e	
	_	but the door did not close			bedroom Area Manager will		
		h when released from the			preform random monthly		
	fully open position.				inspections and Program		
	b. The door to Bed	room #4 was equipped with a			Manager will provide quarterly		
	self-closing device,	but the door did not close			inspections to ensure bedroon	n	
	completely and late	h when released from the			doors positively latch to frame	as	
	fully open position.				required.		
	c. The door to Bed	room #5 was equipped with a			5.The Residential Manager v	will	
	self-closing device,	but the door was obstructed			check the all bedroom doors to)	
	from closing by a p	lastic door stop and video			ensure they are not being		
	tapes that are stored	d on the floor near the door.			obstructed from closing.		
	Based on interview	at the time of each			6.Staff will notify ResCare		
		A acknowledged the need for			Maintenance upon discovery o	of	
		ntained self-closing and			any damage that prevents Clie		
	latching.	C			Bedroom Doors from positively		
					latching to the frame as require	•	
	These deficiencies	were reviewed with the RM			by calling 844-ResCare.		
		aference held on 06/14/2021.					
	<i>g</i> ee.						
					Persons Responsible: Prograr	n	
					Manager, Area Supervisor,		
					Residential Manager, DSP.		
					1 100 dontain manager, Dor .		

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AND PLAN OF CORRECTION IDEN		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/14/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		<u> </u>	2401 C	ADDRESS, CITY, STATE, ZIP CODE ORNWELL DR RSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
TAG K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must least quarterly for and under varied of a. Ensure that a trained to perform b. Ensure that a familiar with the ust emergency and diprocedures. 2. The facility must a. Actually evactione drill each year b. Make special evacuation of clier disabilities; c. File a report a drill; d. Investigate all drills, including action; and e. During fire drievacuated to a sarunder the Health (of the Life Safety (3. Facilities must reparagraphs (i) (1)	at hold evacuation drills at each shift of personnel conditions to: Il personnel on all shifts are assigned tasks; Il personnel on all shifts are se of the facility's saster plans and at: uate clients during at least r on each shift; provisions for the nts with physical and evaluation on each I problems with evacuation cidents and take corrective Ils, clients may be fe area in facilities certified Care Occupancies Chapter		TAG	DEFICIENCY)		DATE	
	42 CFR 483.470(i Based on record rev facility failed to cor each shift for each c shifts over the past could affect all clien Findings include:	niew and interview, the aduct fire drills quarterly on calendar quarter and 2 of 3 year. This deficient practice	KS	712	1.All staff at the Facility will be re-trained on conducting fire dequarterly on all shifts. The Residential Manager will review drills to ensure all required drill area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility.	rills w all ls	07/14/2021	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE:	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 COMPL	ETED	
15G247 B. WING 06/14/	06/14/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE OAGA CORNWELL DR		
2401 CORNWELL DR		
RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS 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 SKIGGS AGE PLANCES TO THE 74 THE NUMBER OF THE 74 THE	DATE	
Drill Reports on 06/14/2021 between 11:00 a.m. staff.		
and 1:15 p.m. with the Residential Manager		
(RM), there was no record of a fire drill 1.The Area Supervisor will visit		
conducted on first shift for the first quarter of the home at least monthly to		
the year 2021 and for the first and third shifts for ensure the drills are in the home		
the fourth quarter of 2020. Based on an and up to date.		
interview with the RM at the time of record		
review, there was no other documentation 1.The Residential Manager will		
available for review to indicate the missed drill submit monthly drills to the QA		
had been conducted. Drill records sent Department upon completion. The		
electronically also did not include drills for QA Department will notify the Area		
these three periods. This was verified by the RM Manager and Program manager if		
at the time of record review and acknowledged. the facility has not performed		
monthly drills as required.		
This deficiency was with the RM reviewed during		
the Exit Conference on 06/14/2021. 1.The Area supervisor will		
ensure drills are completed as		
required.		
1.The program manager will		
conduct random monthly		
inspections to ensure drills are		
being completed as required.		
Persons Responsible: Program		
Manager, Area Supervisor,		
Residential Manager, DSP		

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