PRINTED: 07/09/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED	
15G194		B. WING		06/25/2024	
		115 ST	ONEGATE	<u> </u>	
SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
conducted by the In accordance with 42 Survey Date: 06/2 Facility Number: 0 Provider Number: 100 At this Emergency Community Altern compliance with E Requirements for N Participating Provi 483.475. The facility has eig time of the survey,	ndiana Department of Health in 2 CFR 483.475. 5/24 000724 15G194 0243320 Preparedness survey, Res Care atives SE IN was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR tht total certified beds. At the the census was six.	E 0000			
conducted by the In accordance with 42 Survey Date: 06/2 Facility Number: 0 Provider Number: AIM Number: 100 At this Life Safety	ndiana Department of Health in 2 CFR 483.470(j). 5/24 000724 15G194 0243320 Code survey, Res Care	K 0000			
	An Emergency Pre conducted by the fr accordance with 42 Survey Date: 06/2 At this Life Safety Code conducted by the If accordance with 42 Survey Date: 06/2 Facility Number: 100 At this Emergency Community Altern compliance with E Requirements for N Participating Provi 483.475. The facility has eig time of the survey, Quality Review co	OF CORRECTION IDENTIFICATION NUMBER 15G194 PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 06/25/24 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CC OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 15G194 STREET . STREET . 'ROVIDER OR SUPPLIER STREET . I15 ST BEDFC SUMMARY STATEMENT OF DEFICIENCIE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. E 0000 Survey Date: 06/25/24 Facility Number: 100243320 E 0000 At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found in compliance with Emergency Preparedness survey, Res Care Community Alternatives SE IN was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. K 0000 Conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). K 0000 K 0000 Survey Date: 06/25/24 K 0000 K 0000 K 0000 K 0000 A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). K 0000 K 0000 K 0000 K 0000 <	TO DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER A BUILDING	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Patrick O'Heran QAM 07/05/2024

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

000724

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 06/25/2024 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 facility was sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, sleeping rooms, common living areas & heat detection in the unused attic. The facility has a capacity of eight and had a census of six 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 .80. Quality Review completed on 06/28/24 K S353 **NFPA 101** Sprinkler System - Maintenance and Testing Bldg. 02 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Event ID: 6Z3R21 Facility ID: 000724 Page 2 of 6 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

07/09/2024

PRINTED:

FORM APPROVED

PRINTED: 07/09/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING		(X3) DATE SURVEY COMPLETED 06/25/2024	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	115 S	t address, city, state, zip STONEGATE FORD, IN 47421	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	inspected, tested accordance with NFPA 25: 1. Control valve 25, section 13.3.1 2. Gauges insp section 13.2.71). 3. Alarm device (NFPA 25, section 4. Alarm device (NFPA 25, section 5. Valve supervise semiannually (NF 6. Visible sprind ((NFPA 25, section 7. Visible pipe in 25, section 5.2.2) 8. Visible pipe in (NFPA 25, section 9. Buildings inso freezing weather filled piping (NFP 10. A represent response sprinkle (NFPA 25, section 11. A represent sprinklers are test section 5.3.1.1.1 12. Antifreeze se (NFPA 25, section 13. Control valve their full range arr annually (NFPA 25 14. Operating se lubricated annual 13.3.4). 15. Dry pipe sy unheated portion	ected monthly (NFPA 25, es inspected quarterly n 5.2.6). es tested semiannually n 5.3.3). visory switches tested FPA 25, section 13.3.3.5). (lers inspected annually on 5.2.1). nspected annually (NFPA). nangers inspected annually n 5.2.3). pected annually prior to for adequate heat for water A 25, section 5.2.5). tative sample of fast ers are tested at 20 years n 5.3.1.1.1.2). tative sample of dry pendant ted at 10 years (NFPA 25, 5). solutions are tested annually				

PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 06/25/2024 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 115 STONEGATE **RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. B. Show who provided the service. C. Note the source of the water supply for the automatic sprinkler system. (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the K S353 07/25/2024 To correct the deficient practice facility failed to ensure 1 of 1 sprinkler system was the third quarter dated 9-6-23 and tested and/or inspected in accordance with NFPA fourth quarter dated 11-2-24 25. NFPA 25, Section 5.2.5 states, waterflow alarm sprinkler inspections will be and supervisory alarm devices shall be inspected submitted with the submission of quarterly to verify that they are free of physical the POC. The sprinkler gauge is damage. An inspection is defined as a visual scheduled to be replaced 7-12-24 examination of a system or a portion thereof to by the service provider. All staff verify that it appears to be in operating condition responsible for the maintenance of and is free of physical damage. Section 5.3.3.2 the home will be re-trained to states vane-type and pressure switch-type water ensure all documentation from flow alarm devices shall be tested semiannually. A service providers is obtained and test is defined as a procedure used to determine available for review. as well as the operational status of a component or system re-trained on ensuring all by conducting periodic physical checks, such as deficiencies noted are scheduled waterflow tests, fire pump tests, alarm tests, and for repair timely. Additional trip tests of dry pipe, deluge, or preaction valves. monitoring will be achieved by the This deficient practice could affect all clients and AS completing an LSC checklist staff. monthly to ensure all LSC features are in working condition and Findings include: documentation is in place. Based on record review with the Qualified Intellectual Disabilities Professional (QIDP) on 06/25/24 at 11:31 a.m., there was no third quarter (July, August, and September) or fourth quarter 6Z3R21

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 000724

If continuation sheet

Page 4 of 6

FORM APPROVED

07/09/2024

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 06/25/2024 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (October, November, and December) inspections or semiannual testing of 2023 for the water flow alarm device available for review. The last inspection available for review was dated 05/13/23. Based on an interview at the time of record review, the QIDP confirmed there was no other sprinkler inspection documents that could be located as of the time of this survey. 2) Based on record review, observation and interview; the facility failed to ensure 1 of 2 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all clients and staff in the facility. Findings include: Based on review of Koorsen Fire & Security "Systems Service" documentation dated 02/06/24 with the Qualified Intellectual Disabilities Professional (QIDP) during record review at 11:38 a.m. on 06/25/24, the date of sprinkler system gauge installation was documented as 2/2019 and the documentation listed it as: "FAILED - Gauge is over 5 years old and needs to be replaced". Based on observations with the QIDP during a tour of the facility at 1:38 p.m., the gauge had a date of manufacture listed on it as 2019 and a date written on the gauge of 2-2019. Based on interview at the time of the observation, the QIDP acknowledged documentation of sprinkler system Event ID: 6Z3R21 Facility ID: 000724 Page 5 of 6 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

PRINTED:

07/09/2024

PRINTED: 07/09/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED		
		15G194	B. WING		06/25/2024		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421			
RES CAP	RES CARE COMMUNITY ALTERNATIVES SE IN						
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
	gauge replacement of	or recalibration was not					
	available for review	and one of the two sprinkler					
	system gauges was	more than five years old.					

6Z3R21 Facility ID: 000724