

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

PRINTED: 01/25/2024

FORM APPROVED

OMB NO. 0938-039

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|------------------------|---|---------------|---|----------------------|
| E 0000 Bldg. -- | <p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 12/20/23</p> <p>Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760</p> <p>At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475.</p> <p>The facility has 8 certified beds. At the time of the survey, the census was 8.</p> <p>Quality Review completed on 01/02/24</p> <p>The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:</p> | E 0000 | | |
| E 0037 Bldg. -- | <p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> | | | |

| | | |
|---|-------|------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| Mark Slaughter | AED | 01/23/2024 |

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

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients</p> | | | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | <p>and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | <p>participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--|---|--------|--|------------|
| | <p>CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure staff received training in regards to emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual-Ewing Lane" documentation dated 05/18/22 with the Program Director during record review from 1:40 p.m. to 2:50 p.m. on 12/20/23, documentation of staff training on the emergency preparedness plan within the most recent two year period was not available for review. Based on interview at the time of record review, the Program Director stated staff training documentation on emergency preparedness policies and procedures within the most recent two year period was not available for review at the time of the survey.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> | E 0037 | <p>E 037 EP Training Program:</p> <p>1.The administrator will ensure the emergency plan policies and procedures initial training in emergency preparedness policies and procedures to all new and existing staff, annual emergency training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed and present in the EPP manual. The ResCare "On The Job" training checklist will be updated to include initial training in emergency preparedness of all new employees. The annual training requirements list will also be updated to include the training of all existing employees.</p> <p>2.The residential manager, area supervisor and program manager will provide initial training to all new staff and the ResCare trainer will provide annual training to existing staff. Testing results will be available to demonstrate staff knowledge of emergency procedures. The training and testing documentation will be present in the Emergency Disaster Preparedness Manual/HR personnel files for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present.</p> | 01/31/2024 |
|--|---|--------|--|------------|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|---|----------------------------|
| E 0039 Bldg. -- | <p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the</p> | | <p>The safety committee will review and update annually as needed.</p> <p>3. This information is located in section 22 of the Emergency Disaster Preparedness Manual</p> <p>4. The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of emergency preparedness training</p> <p>DATE OF COMPLETION: January 31, 2024</p> <p>Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
|--------------------------|--|---------------------|--|----------------------------|

| | | | | |
|--|--|--|--|--|
| | <p>following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do</p> | | | |
|--|--|--|--|--|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--|--|--|--|--|
| | <p>the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or</p> | | | |
|--|--|--|--|--|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | <p>man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|--|----------------------------|
|--------------------------|---|---------------------|--|----------------------------|

| | | | | |
|--|---|--|--|--|
| | <p>plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the</p> | | | |
|--|---|--|--|--|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|--|----------------------------|
| | <p>onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p> (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p> (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p> (A) A second full-scale exercise that is</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|--|----------------------------|
| | <p>community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
|--------------------|---|---------------|---|----------------------|

| | | | | |
|--|---|--------|---|------------|
| | <p>exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of the following: (i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared</p> | E 0039 | <p>E 039 EP Training Requirements:</p> <p>1 The administrator will ensure the participation in a full-scale community based exercise and a table top exercise is present in the EPP manual.</p> <p>2 A full scale community based drill The Great Shake out on Thursday the 19th of October 2023 a second tabletop exercise will be completed on January 30, 2024.</p> <p>3 The area supervisor and program manager will ensure documentation of the table top exercise and the community based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review and update</p> | 01/31/2024 |
|--|---|--------|---|------------|

| | | | | | |
|---|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | | X3) DATE SURVEY COMPLETED 12/20/2023 |
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | | | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K 0000 Bldg. 01 | <p>questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual-Ewing Lane" documentation dated 05/18/22 with the Program Director during record review from 1:40 p.m. to 2:50 p.m. on 12/20/23, documentation for at least two exercises conducted within the most recent twelve month period to test the emergency plan using the emergency procedures was not available for review. Based on interview at the time of record review, the Program Director stated the facility just completed an emergency preparedness exercise but agreed the facility has not documented a community based disaster drill, mock drill, workshop or conducted a tabletop exercise within the most recent twelve month period and agreed testing documentation was not available for review at the time of the survey.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> | K 0000 | <p>annually as needed.</p> <p>4 This information is located in section 22 of the Emergency Disaster Preparedness Manual</p> <p>5 Dated Documentation will be provided showing the completion of a tabletop exercise</p> <p>6 The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of conducting an annual community based exercise and maintaining documentation.</p> <p>7 All supervisory staff responsible for maintaining drills will be retrained to ensure each group home is completing the drills per LSC. Ongoing monitoring will be achieved by the Quality Assurance Department maintaining a tracking spreadsheet to ensure all drills are completed per the calendar.</p> <p>Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Quality Assurance.</p> <p>DATE OF COMPLETION: January 31, 2024</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--------------------|---|--|--|--|
| K S100 Bldg. 01 | <p>Survey Date: 12/20/23</p> <p>Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760</p> <p>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.</p> <p>This one story facility was determined to be fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, common living areas and all client sleeping rooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.3.</p> <p>Quality Review completed on 01/02/24</p> <p>NFPA 101 General Requirements - Other 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.</p> | | | |
|--------------------|---|--|--|--|

| | | | | | |
|---|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/20/2023 |
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K S222 | <p>Based on observation and interview, the facility failed to ensure 1 of 2 smoke barrier doors which were arranged to self close or automatic close with fire alarm system activation would resist the passage of smoke. LSC Section 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC Section 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Program Director during a tour of the facility from 2:50 p.m. to 3:15 p.m. on 12/20/23, the smoke barrier door in the living room was held in the fully open position with a wall mounted magnetic hold open device set to release with fire alarm system activation and was equipped with a latching mechanism to latch the door into the door frame but the door failed to fully self close and latch into the door frame when tested to close multiple times. The latching mechanism failed to protrude into the latching plate on the door frame when tested to close multiple times. Based on interview at the time of the observations, the Program Director agreed the smoke barrier door failed to fully self close and latch into the door frame when tested to close multiple times.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>NFPA 101 Egress Doors</p> | K S100 | <p>K0100 General Requirements - Other:</p> <p>1. The Area Supervisor will in-service the facility staff on ensuring smoke barrier doors remain free of and obstacle that will prevent the smoke barrier door from closing.</p> <p>2. ResCare Maintenance will adjust closing and latching mechanism to ensure self-close door latches to door frame.</p> <p>3. Random monthly site reviews will be conducted by a member of ResCare's Administrative Team to ensure smoke barrier doors remain free from obstacles that would prevent them from closing properly, and doors latch to frame as required.</p> <p>Persons Responsible: Program Manager, Area Supervisor, and Residential Manager, DSP</p> | 01/15/2024 | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|----------|---|--------|--|------------|
| Bldg. 01 | <p>Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii) Based on observation and interview, the facility failed to ensure 4 of 8 client bedroom doors and 2 of 3 bathroom doors were arranged such that staff can rescue clients in an emergency if the doors become locked. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on observations with the Program Director during a tour of the facility from 2:50 p.m. to 3:15</p> | K S222 | <p>1. The Program Manager will ensure all bathroom and bedroom doors allow opening from the outside during an emergency when locked. New door knobs that do not require a special tool or key will be installed by ResCare Maintenance by January 31, 2024.</p> <p>2. Program manager will inspect installed door knobs to ensure the standard is met. Residential</p> | 01/31/2024 |
|----------|---|--------|--|------------|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| K S345 Bldg. 01 | <p>p.m. on 12/20/23, 4 of 8 client bedroom doors and 2 of 3 bathroom doors each had an operable lock on the door which required a key to unlock from the corridor side of the door. Each door had a thumb twist release device on the the room side of the door but no key was available to unlock the door from the corridor side of the door. Based on interview at the time of the observations, the Program Director agreed keys were not available to unlock each door from the corridor side of the door.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70,</p> | K S345 | <p>Manager with inspect operation of installed door knobs monthly to ensure correct operation. Area Supervisor and Program Manager will conduct periodic inspections.</p> <p>Persons Responsible: Program Manager, Area Supervisor, and Residential Manager, DSP. ResCare Maintenance Manager.</p> <p>1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2.The administrator will ensure smoke sensitivity testing and</p> | 01/31/2024 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | <p>National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Program Director from 1:40 p.m. to 2:50 p.m. on 12/20/23, fire alarm system inspection and testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Program Director agreed fire alarm system inspection and testing documentation for the most recent twelve month was not available for review.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:</p> <ul style="list-style-type: none"> a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) | | <p>documentation is available from fire alarm system inspection is completed Koorsen Fire and Security and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion.</p> <p>Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Program Director from 1:40 p.m. to 2:50 p.m. on 12/20/23, documentation of a visual semi-annual fire alarm system inspection within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Program Director stated fire alarm system inspection documentation was not available for review and agreed documentation for a semi-annual visual fire alarm system inspection within the most recent twelve month period was not available for review.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>3. Based on record review and interview, the facility failed to ensure all facility smoke detectors were within their listed and marked sensitivity range. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and 14.4.5.3.2 states every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|--|----------------------------|
| | <p>extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Program Director from 1:40 p.m. to 2:50 p.m. on 12/20/23, smoke detector sensitivity testing documentation within the most recent two year period was not available for review. Based on interview at the time of record review, the Program Director agreed smoke detector sensitivity testing documentation within the most recent two year period was not available for review.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|--|----------------------------|
| K S351 Bldg. 01 | <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with Section 9.6, as modified below. The adequacy of the water supply shall be documented.</p> <p>In Prompt Evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted.</p> <p>Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier.</p> <p>In Prompt Evacuation Capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier.</p> <p>In Prompt Evacuation Capability facilities in</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--|--|--------|---|------------|
| | <p>buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted.</p> <p>Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following:</p> <ol style="list-style-type: none"> 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. <p>33.2.3.5.3, 33.2.3.5.3.1, 33.2.3.5.3.3, 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7</p> <p>1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 attics was fully sprinklered or met 1 or more of 4 exceptions per LSC 33.2.3.5.7.2. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Program Director from 1:40 p.m. to 2:50 p.m. on 12/20/23, fire alarm inspection documentation and sprinkler system inspection documentation for the most recent twelve month period was not available for review.</p> | K S351 | <p>1.The administrator will ensure sprinkler head or sprinkler coverage is provided meets NFPA 13, Section 8.6.3.4, "Minimum Distance between Sprinklers", verifying sprinklers shall be spaced not less than 6 feet on center.</p> <p>2.Bids will be collected by January 31,2024 for reinstallation of sprinkler heads, contractor will be selected by February 15,2024 and installation will be complete</p> | 03/31/2024 |
|--|--|--------|---|------------|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|---|----------------------------|
| | <p>Based on interview at the time of record review, the Program Director agreed fire alarm inspection documentation and sprinkler system inspection documentation for the most recent twelve month period was not available for review. Based on observations with the Program Director during a tour of the facility from 2:50 p.m. to 3:15 p.m. on 12/20/23, access to the attic was not available. Based on interview at the time of the observations, the Program Director agreed it could not be assured the attic was provided with sprinkler coverage or met an exception as allowed by the Life Safety Code.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>2. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 8.6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 4.6.7.5 requires existing life safety features that do not meet the requirements for new buildings, but exceed the requirements for existing buildings shall not be further diminished. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Program Director during a tour of the facility from 2:50 p.m. to 3:15 p.m. on 12/20/23, two of the two ceiling mounted sprinklers installed in 3 of the 8 client bedrooms were installed less than six feet apart. The two sprinklers in TD's bedroom were installed 37</p> | | <p>by March 31, 2024.</p> <p>Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager</p> <p>*****Update 1/23/2023*****</p> <p>1 The Program Manager met with ResCare Maintenance Manage to ensure proper attic access is available for the inspection of Attic Heat Detectors and sprinkler system.</p> <p>2 The maintenance Manager received bids for the installation of additional attic hatches and work will be complete no later than February 15, 2024.</p> <p>3 The program Manager will verify work and report any issue to the AED immediately.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|--|----------------------------|
| K S353 Bldg. 01 | <p>inches apart. The two sprinklers installed in RR's bedroom were installed 53 inches apart. The two sprinklers installed in TT's bedroom were installed 48.5 inches apart. All measurements were made with a measuring tape. Based on interview at the time of the observations, the Program agreed the ceiling mounted sprinklers installed in the three client bedrooms were installed less than six feet of one another.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing 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 Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71).</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|--|----------------------------|
| | <p>3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6).</p> <p>4. Alarm devices tested semiannually (NFPA 25, section 5.3.3).</p> <p>5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5).</p> <p>6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1).</p> <p>7. Visible pipe inspected annually (NFPA 25, section 5.2.2).</p> <p>8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).</p> <p>9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5).</p> <p>10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2).</p> <p>11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15).</p> <p>12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4).</p> <p>13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).</p> <p>14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4).</p> <p>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).</p> <p>A. Date sprinkler system last checked and necessary maintenance provided.</p> <p>_____</p> <p>B. Show who provided the service.</p> <p>_____</p> <p>C. Note the source of the water supply for the automatic sprinkler system.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
|--------------------|---|---------------|---|----------------------|

| | | | | |
|--|--|--------|---|------------|
| | <p>(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</p> <p>1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for eleven months of the most recent twelve month period. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all clients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Program Director from 1:40 p.m. to 2:50 p.m. on 12/20/23, quarterly sprinkler inspection documentation performed by a sprinkler system inspection contractor for the most recent twelve month period was not available for review. In addition, monthly sprinkler system gauge and control valve inspection documentation for staff inspections for</p> | K S353 | <p>1.The Program Manager will ensure monthly sprinkler gauge inspections and monthly control valve inspections are conducted by the ResCare maintenance coordinator, documentation will be maintained on site and a copy kept with ResCare Maintenance Manager.</p> <p>1.The program manager will conduct random monthly inspections to ensure monthly and quarterly inspections are being preformed as required.</p> <p>3 The administrator will ensure Fire and Security Contractor conducts quarterly sprinkler inspections and that the reports of the inspections are available in the facility for review and forwarded to the Program Manager for monitoring.</p> <p>Persons Responsible: Program Manager, Maintenance Manager, Area Supervisor, Direct Support Lead, ResCare Maintenance. *****Update 1/23/2023*****</p> <p>1.Bids will be collected by January 31,2024 for reinstallation</p> | 01/31/2024 |
|--|--|--------|---|------------|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| | <p>the most recent twelve month period was also not available for review. Based on interview at the time of record review, the Program Director agreed sprinkler system inspection and testing documentation for the most recent twelve month period was not available for review. Based on observations with the Program Director during a tour of the facility from 2:50 p.m. to 3:15 p.m. on 12/20/23, the facility has a supervised wet sprinkler system. The sprinkler system inspection contractor affixed a hanging tag to the sprinkler system riser indicating sprinkler system gauge and valve inspections were conducted for one month of the most recent twelve month period in February 2023.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>2. Based on record review, observation and interview; the facility failed to document annual testing of the sprinkler system antifreeze solution in accordance with NFPA 25 for the most recent twelve month period. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.4 states the freezing point of solutions in antifreeze systems shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Section 5.3.4.1 states solutions shall be in accordance with Table 5.3.4.1(a) and Table 5.3.4.1(b). Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all clients, staff and visitors.</p> | | <p>of sprinkler heads, contractor will be selected by February 15,2024 and installation will be complete by March 31, 2024.</p> <p>2.The AED contacted Koorsen Fire and security for documentation of antifreeze testing. If documentation is unavailable antifreeze testing will be scheduled with Northside Fire and Security.</p> <p>3.The Maintenance Manager will schedule antifreeze test to be complete no later than March 31, 2024.</p> <p>4.The Maintenance Manger contacted Northside Fire and Security for the installation of 2 missing escutcheon plates no later than February 15, 2024.</p> <p>5.The Maintenance Manager contacted Northside Fire and Security and ordered missing sprinkler heads no fewer than six sprinkler heads will be available. Missing sprinkler heads will be on site no later than February 15, 2024.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|--|----------------------------|
| | <p>Findings include:</p> <p>Based on record review with the Program Director from 1:40 p.m. to 2:50 p.m. on 12/20/23, annual antifreeze testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Program Director agreed annual antifreeze testing documentation for the most recent twelve month period was not available for review. Based on observations with the Program Director during a tour of the facility from 2:50 p.m. to 3:15 p.m. on 12/20/23, the facility has a supervised wet sprinkler system. Documentation affixed to the sprinkler system riser indicated the sprinkler system contained antifreeze. The sprinkler system inspection contractor affixed a hanging tag to the sprinkler system riser indicating sprinkler system water flow alarm, gauge and valve inspections were conducted for one month of the most recent twelve month period in February 2023 but annual antifreeze testing documentation for the most recent twelve month period was not available for review.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>3. Based on observation and interview, the facility failed to ensure 2 of over 10 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect all clients and staff in the facility.</p> <p>Findings include:</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>Based on observations with the Program Director during a tour of the facility from 2:50 p.m. to 3:15 p.m. on 12/20/23, the ceiling mounted sprinkler installed in TD's bedroom closet and the ceiling mounted sprinkler installed in the storage room were each missing its escutcheon which left a two inch opening in the ceiling. Based on interview at the time of the observations, the Program Director agreed the aforementioned sprinkler locations each had a missing escutcheon which left a two inch opening in the ceiling.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>4. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with a minimum of six spare sprinklers in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all clients and staff in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Program Director during a tour of the facility from 2:50 p.m. to 3:15</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| K S511 Bldg. 01 | <p>p.m. on 12/20/23, a total of five spare sprinklers were noted in the spare sprinkler cabinet in the sprinkler riser room. Based on interview at the time of the observations, the Program Director agreed fewer than six spare sprinklers were located on the premises in the spare sprinkler cabinet.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical outlets were protected in 1 of 8 client bedrooms according to Section 33.2.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect one client, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Program Director during a tour of the facility from 2:50 p.m. to 3:15 p.m. on 12/20/23, the wall mounted outlet box for two electrical receptacles near the chest of drawers in TD's bedroom was missing its cover plate. Based on interview at the time of the observations, the Program Director agreed the electrical outlet box in TD's bedroom was missing</p> | K S511 | <p>1 The Program Manager will ensure outlet box of receptacles have cover plates installed by ResCare Maintenance.</p> <p>2 The Program Manager contacted ResCare Maintenance and schedule a service call to ensure cover plates are installed as required.</p> <p>3 ResCare Maintenance will ensure the installation of outlet cover plates as required by NFPA 70, By January 10, 2024.</p> <p>Persons Responsible: Program Manager, ResCare Maintenance.</p> | 01/10/2024 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/20/2023 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|---|---------------------|--|----------------------------|
| K S712 Bldg. 01 | <p>its cover plate.</p> <p>These findings were reviewed with the Program Director during the exit conference.</p> <p>NFPA 101 Fire Drills Fire Drills</p> <p>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:</p> <ul style="list-style-type: none"> a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. <p>2. The facility must:</p> <ul style="list-style-type: none"> a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. <p>3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)</p> <p>Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the first, second and third shifts for 3 of 4 quarters. This deficient practice affects all clients, staff and visitors.</p> | K S712 | 1.All staff at the Facility will be re-trained on conducting fire drills quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills | 01/31/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/20/2023 |
|---|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | | | STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, 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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>Findings include:</p> <p>Based on review of "Emergency Evacuations Drills" documentation with the Program Director during record review from 1:40 p.m. to 2:50 p.m. on 12/20/23, documentation of a fire drill conducted on the first shift in the fourth quarter (October, November, December) 2022, the first quarter (January, February, March) 2023 and the third quarter (July, August, September) 2023 was not available for review. Documentation of a fire drill conducted on the second shift in the first quarter 2023, the second quarter (April, May, June) 2023 and in the third quarter 2023 was also not available for review. In addition, documentation of a fire drill conducted on the third shift in the fourth quarter 2022, the first quarter 2023 and in the third quarter 2023 was also not available for review. Based on interview at the time of record review, the Program Director stated the facility operates three shifts per day, additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the first, second and third shifts in the aforementioned calendar quarters was not available for review.</p> <p>These findings were reviewed with the Program Director and the Home Manager during the exit conference.</p> | | <p>area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff.</p> <p>1. The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date.</p> <p>1. The Residential Manager will submit monthly drills to the QA Department upon completion. The QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required.</p> <p>1. The Area supervisor will ensure drills are completed as required.</p> <p>1. The program manager will conduct random monthly inspections to ensure drills are being completed as required.</p> <p>Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP</p> | | |