| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 15G175 | A. BUILDING -- B. WING | 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| RES CARE COMMUNITY ALTERNATIVES SE IN | 3607 MIDDLE RD 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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.<br><br>Survey Date: 02/15/2024<br><br>Facility Number: 000709<br>Provider Number: 15G175<br>AIM Number: 100243190<br><br>At this Emergency Preparedness survey, Res Care Community Alternatives Services Inc was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475.<br><br>The facility has 7 certified beds. At the time of the survey, the census was 6.<br><br>Quality Review completed on 02/21/24 | E 0000 | | |
| E 0015<br><br>Bldg. -- | 403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1)<br>Subsistence Needs for Staff and Patients<br>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Mark Slaughter | AED | 03/04/2024 |

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

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| | section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting. | | | |

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| | (3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review and interview on 02/15/2024 between 10:15 AM and 1:45 PM with the Area Supervisor and Maintenance Manager, the emergency plan did not address sewage and waste disposal. Based on interview at the time of record review, the Maintenance Manager stated they would use a plumber for any sewage problems and they use the city waste disposal, but agreed there was no written documentation of the information. | E 0015 | 1.The administrator will ensure the emergency plan policies and procedures addresses the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, including but not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain – (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1).<br>2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>**Persons Responsible:** Program Manager, Area Supervisor, and DSL, DSP, ResCare Maintenance. | 03/05/2024 |

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| E 0030<br><br>Bldg. -- | 403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1)<br>Names and Contact Information<br>§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).<br><br>[(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]<br><br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians<br>(iv) Other [facilities].<br>(v) Volunteers.<br><br>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians<br>(iv) Other [hospitals and CAHs]. | | | |

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| | (v) Volunteers.<br><br>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Next of kin, guardian, or custodian.<br>(iv) Other RNHCIs.<br>(v) Volunteers.<br><br>*[For ASCs at §416.45(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For Hospices at §418.113(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Hospice employees.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Other hospices.<br><br>*[For HHAs at §484.102(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the | | | |

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| | following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For OPOs at §486.360(c):] The communication plan must include all of the following:<br>(2) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Volunteers.<br>(iv) Other OPOs.<br>(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).<br>Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review on 02/15/2024 between 10:15 AM and 1:45 PM with the Area Supervisor and Maintenance Manager, the emergency preparedness communication plan did not include contact information for contracted entities. Based on interview at the time of record review, the Maintenance Manager stated he does most of the maintenance for the home and anything he cannot | E 0030 | 1.The administrator will ensure the emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses a) contact information for other ICF's and b) client physicians.<br>2.The area supervisor and program manager will train all staff on the policies and procedures updates and the updates will be placed in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.This information is located in section 3 of the Emergency Disaster Preparedness Manual<br>4.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual | 03/05/2024 |

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| | do is contracted out, but agreed the facility no longer uses Aramark and Koorsen's contact information was not in their communication plan. | | 5.The Executive Director will review and approve the continuity of operations plan the quality assurance manager and program manger will ensure the most current continuity of operations is in the Emergency Preparedness Manual.<br><br>**Persons Responsible:** Program Manager, Area Supervisor, and DSL, DSP, ResCare Maintenance. | |
| E 0037<br><br>Bldg. -- | 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)<br>EP Training Program<br>§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).<br><br>*[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:]<br>(1) Training program. The [facility] must do all of the following:<br>(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. | | | |

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| | (ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(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.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(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 and others.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(i) Initial training in emergency preparedness | | | |

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| | policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and | | | |

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| | existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(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 systems and signals and firefighting equipment.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, | | | |

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| | 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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[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 CMHC must provide emergency preparedness training at least every 2 years.<br>Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of the training; (iv) | E 0037 | 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 in accordance with CFR 483.475(d) | 03/05/2024 |

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| | Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review on 02/15/2024 between 10:15 AM and 1:45 PM with the Area Supervisor and Maintenance Manager, no documentation for initial training for new hires or testing for new hires or ongoing staff was available for review. Based on interview at the time of record review, the Area Manager stated she did not have access to any facility systems due to being new and she was not aware of where testing for ongoing staff was located. | | (1) and present in the EPP manual.<br>2.The area supervisor and program manager will provide initial training to all existing staff and new staff and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>**Persons Responsible:** Program Manager, Area Supervisor, and DSL, DSP, ResCare Maintenance. | |
| K 0000<br><br>Bldg. 02 | A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).<br><br>Survey Date: 02/15/2024<br><br>Facility Number: 000709<br>Provider Number: 15G175<br>AIM Number: 100243190<br><br>At this Life Safety Code survey, Res Care Community Alternatives Services Inc. 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), | K 0000 | | |

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| | 15G175 | A. BUILDING 02<br>B. WING | 02/15/2024 |

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| RES CARE COMMUNITY ALTERNATIVES SE IN | 3607 MIDDLE RD<br>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 |
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| | Chapter 33, Existing Residential Board and Care Occupancies.<br><br>This two story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and in all living areas. The facility has heat detectors installed in the attic. The facility has a capacity of 7 and had a census of 6 at the time of this survey.<br><br>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 4.32.<br><br>Quality Review completed on 02/21/24 | | | |
| K S100<br><br>Bldg. 02 | NFPA 101<br>General Requirements - Other<br>General Requirements - Other<br>2012 EXISTING<br>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.<br>Based on observation and interview, the facility failed to ensure 3 of 3 interior emergency lights were tested and the records of the testing maintained. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows:<br>(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 | K S100 | 1 The Facility will ensure interior emergency lights are tested, maintained, and records of testing are maintained.<br>2 The Facility will ensure interior emergency lights are tested at a minimum of 3 weeks and a maximum of 5 weeks for no less than 30 seconds, records of test will be maintained by the facility.<br>3 The facility will ensure a | 03/05/2024 |

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| | weeks between tests, for not less than 30 seconds.<br>(2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction.<br>(3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered.<br>(4) The emergency lighting equipment shall be fully operational for the duration of the test.<br>(5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction.<br>This deficient practice could affect all occupants if the facility were required to evacuate in an emergency during a loss of normal power.<br><br>Findings include:<br><br>Based on record review on 02/15/2024 between 10:15 AM and 1:45 PM with the Maintenance Manager and the Area Supervisor, the "E-Light Summary Inspection Report" from 02/06/2024 did not itemize the number of emergency lights in the facility and did not have the correct total number of emergency lights listed for the annual 90 minute emergency light testing. Based on observation during a tour of the facility, 3 emergency lights were in the building. Additionally, the Life Safety Checklist completed by the Maintenance Manager, which included monthly 30 second emergency light testing, did not itemize the emergency lights. Based on interview at the time of record review, the Maintenance Manager agreed neither of the reports itemized the emergency lights. | | functional test is conducted annually for a minimum of 1 ½ hour for all battery powered interior emergency lights, records of the test will be maintained by the facility.<br>4 The Program Manager met with ResCare Maintenance Manager to ensure monthly checks are being performed.<br>5 Documented test dates will be kept onsite and with maintenance manager for review.<br><br>**Persons Responsible:** Program Manager, Area Supervisor, and DSL, DSP, ResCare Maintenance. | |
| K S168 | NFPA 101<br>Building Construction Type and Height | | | |

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| Bldg. 02 | Building Construction Type and Height<br>2012 EXISTING (Slow)<br>In Slow Evacuation Capability facilities, the facility shall be housed in a building where the interior is fully sheathed with lath and plaster or other material providing a 15-minute thermal barrier, including all portions of bearing walls, bearing partitions, floor construction, and roofs.<br>All columns, beams, girders, and trusses shall be similarly encased or otherwise shall provide not less than a 1/2-hour fire resistance rating, unless modified by the modified by the following:<br>* Exposed steel or wood columns, girders, and beams (but not joists) located in the basement shall be permitted.<br>* Buildings of Type I, Type II (222), Type II (111), Type III (211), Type IV, Type V (111) construction shall not be required to meet the requirements of 33.2.1.3.2 (See 8.2.1).<br>* Areas protected by approved automatic sprinkler systems in accordance with 33.2.3.5. shall not be required to meet the requirements of 33.2.1.3.2.<br>* Unfinished, unused, and essentially inaccessible loft, attic, or crawl space shall not be required to meet the requirements of 33.2.1.3.2.<br>* Where the facility achieves an E-score of 3 or less using the board and care occupancies evacuation capability determination methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety. The requirements of 33.2.1.3.2 shall not apply.<br>33.2.1.3.2.1 through 33.2.1.3.2.7<br>Based on observation and interview, the facility failed to ensure the facility was fully sheathed to provide a 15-minute thermal barrier. This deficient | K S168 | The Administrator will the repair of the hole in the wall of approximately 2 inches around | 03/15/2024 |

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| | practice could affect all clients, staff and visitors.<br><br>Findings include:<br><br>Based on observation with the Maintenance Manager on 02/15/2024 between 1:45 PM and 2:30 PM, a hole in the wall of approximately 2 inches around was located in Basement Storage Room A. Based on interview at the time of observation, the Maintenance Manager stated the sprinkler had been moved and the hole was not filled in. The Maintenance Manager agreed the hole was approximately 2 inches and the hole did not ensure the facility was fully sheathed to provide a 15-minute thermal barrier. | | located in Basement Storage Room A.<br>The Maintenance Manager will contract the repair and insure materials use provide a 15-minute thermal barrier.<br>The repair will be complete no later than 15 March 2024.<br>The program manager will inspect work and report any issues or delay to the Associate Executive Director immediately.<br>A random monthly site review will be completed by a member of ResCare's Administrative team to ensure compliance.<br><br>Persons Responsible: AED, Maintenance Manager, Program Manager, ResCare Maintenance. Area Supervisor, DSL, DSP | |
| K S321<br><br>Bldg. 02 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>2012 EXISTING (Prompt)<br>Any hazardous area that is on the same floor as, and is in or abut, a primary means of escape or a sleeping room shall be protected by one of the following means:<br>1. Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour.<br>2. Protection shall be automatic sprinkler protection, in accordance with 33.2.3.5, and a smoke partition, in accordance with 8.4 | | | |

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| | located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic closing in accordance with 7.2.1.8.<br>Other hazardous areas shall be protected in accordance with 33.2.3.2.5 by one of the following:<br>1. An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than a 13/4 inch (4.4 cm) thick, solid-bonded wood core construction.<br>2. Automatic sprinkler protection in accordance with 33.2.3.5, regardless of enclosure.<br>Areas with approved, properly installed and maintained furnaces and heating equipment, and cooking and laundry facilities are not classified as hazardous areas solely on basis of such equipment.<br>Standard response sprinklers shall be permitted for use in hazardous areas in accordance with 33.2.3.2.<br>33.2.2.2.4, 33.2.3.2, 33.2.3.2.5 | | | |
| | Based on observation and interview, the facility failed to maintain protection of 1 of 1 main level storage rooms, 1 of 1 pantry, and 1 of 1 garages in accordance with 33.2.3.2.4. This deficient practice could affect staff and all clients.<br><br>Findings include:<br><br>Based on observation with the Maintenance Manager on 02/15/2024 between 1:45 PM and 2:30 PM, the main level storage room, pantry, and garage were being used for storage and was not being treated as a hazardous area as it did not have a self-closing door separating the areas from | K S321 | 1 The Program Manager contacted ResCare Maintenance and scheduled installation of a self-closing device on the garage door.<br>2 The Program Manager will in service the ResCare Maintenance technician on requirements for self-closing devices on areas that are used for storage of combustible items.<br>3 The Program Manager will verify completion and ensure proper installation of a self-closing | 03/05/2024 |

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| | the rest of the facility. The door from the home to the main level storage room was a solid core door. The door from the main level storage room and the garage and from the garage to pantry were hollow core doors and none of the areas were sprinklered. The pantry housed food storage and the garage housed adult diapers, renovation items, and other combustible materials. The main level storage room housed a significant amount of paperwork, a desk, and office supplies. The Maintenance Manager agreed there was a significant amount of storage in these areas. | | device leading to all areas that are used for storage of combustible items.<br>4 The Area Supervisor will in-service all staff in the facility on operation of self-closing doors and reporting to ResCare Maintenance if issues are found with self-closing door mechanism.<br>5 A random monthly site review will be completed by a member of ResCare's Administrative team to ensure compliance.<br><br>Persons Responsible: Program Manager, ResCare Maintenance. Area Supervisor, DSL, DSP | |
| K S341<br><br>Bldg. 02 | NFPA 101<br>Fire Alarm System - Installation<br>Fire Alarm System - Installation<br>2012 EXISTING (Prompt)<br>A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms.<br>33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2<br>Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm control panels were protected. LSC 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical | K S341 | 1 The administrator will ensue fire control panels remain properly secured.<br>2 The Area Supervisor will in-service staff on ensuring fire control panels remain properly secured | 03/05/2024 |

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| | Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observation during record review with the Maintenance Manager on 02/15/2024 between 10:15 AM and 1:45 PM, the secondary fire panel in the dining room had a key in the lock and was unlocked. This condition does not protect the fire alarm system against unauthorized use. Based on interview at the time of observations, the Maintenance Manager agreed the door to the fire control panel was not properly secured because the key was in the lock of the unlocked door. The Maintenance Manager removed the key from the panel and reported he placed it in the key safe. The Maintenance Manager stated the key had likely been left in the secondary fire panel due to renovations being completed on one of the bathrooms in the facility. | | 3 A random monthly site review will be completed by a member of ResCare's Administrative team to ensure compliance.<br><br>Persons Responsible: Program Manager, ResCare Maintenance. Area Supervisor, DSL, DSP | |
| K S345<br><br>Bldg. 02 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Fire Alarm System - Testing and Maintenance<br>2012 EXISTING (Prompt)<br>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. | | | |

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| | Records of system acceptance, maintenance and testing are readily available.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>1. Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 33.3.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all clients, staff and visitors.<br><br>Findings include:<br><br>Based on observation of the fire alarm control panel on 02/15/2024 at 1:49 PM during a tour of the facility with the Maintenance Manager, the time and date on the fire alarm control panel were incorrect. The display on the main fire alarm control panel indicated the date was 01/30/2018 and the time was 12:26 AM. Based on interview at the time of observation, the Maintenance Manager agreed the date and time were incorrect.<br><br>2. Based on record review, observation 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, 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 at | K S345 | **1** The administrator will ensure annual functional testing for initiating devices such as smoke detectors, heat 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.<br>**2** Reports will be verified for accuracy with Koorsen Fire and Security and ResCare Maintenance.<br>3 The Program Manager contacted a representative from Koorsen Fire and Security to will schedule required testing and request copies of inspections and testing mailed to the program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany IN 47150.<br>4 The Program Manager will ensure access to the device will be made available and that device will be tested no later than April 1, 2024. Koorsen will notify the Program Manger upon completion of all inspections to ensure any deficiencies are properly tracked and repaired. Koorsen will send documentation of all inspections, services and repair to ResCare main office at 4341 Security Parkway STE. 101 New Albany IN | 04/01/2024 |

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| | 15(e) states the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with 14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year. Records shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect all clients, staff, and visitors.<br><br>Findings include:<br><br>Based on record review from 10:15 AM to 1:45 PM on 02/15/2024, the "Alarm System Inspection" report from 01/06/2023 documented the facility to have 5 heat detectors, 2 of which were in the attic. "Alarm System Inspection" reports from 02/26/2024 and 08/02/2023 document the facility to have 4 heat detectors, 1 of which was in the attic. The "Alarm System Inspection" report from 02/05/2024 documented the facility to have 3 heat detectors, 0 of which were in the attic. Based on interview at the time of record review, the Maintenance Manager was unsure of the number of heat detectors in the attic. During a tour of the facility from 1:45 PM to 2:30 PM, 1 heat detector was located in the attic. | | 47150 with in 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required.<br>5 | |
| K S353<br><br>Bldg. 02 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>2012 EXISTING (Prompt)<br>NFPA 13 and 13R Systems<br>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 | | | |

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| | 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.<br>NFPA 13D Systems<br>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:<br>1. Control valves inspected monthly (NFPA 25, section 13.3.2).<br>2. Gauges inspected monthly (NFPA 25, section 13.2.71).<br>3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6).<br>4. Alarm devices tested semiannually (NFPA 25, section 5.3.3).<br>5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5).<br>6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1).<br>7. Visible pipe inspected annually (NFPA 25, section 5.2.2).<br>8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).<br>9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5).<br>10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2).<br>11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15).<br>12. Antifreeze solutions are tested annually | | | |

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| RES CARE COMMUNITY ALTERNATIVES SE IN | 3607 MIDDLE RD<br>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 |
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| | (NFPA 25, section 5.3.4).<br>13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).<br>14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4).<br>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).<br>A. Date sprinkler system last checked and necessary maintenance provided.<br>_____<br>B. Show who provided the service.<br>_____<br>C. Note the source of the water supply for the automatic sprinkler system.<br>_____<br>(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.)<br>33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 | | | |
| | Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and | K S353 | 1.The administrator will ensure Koorsen Fire and Security conducts 5 year internal pipe inspections and that the reports of the inspections are available in the facility for review and forwarded to the Program Manager for monitoring not later than April 1, 2024.<br><br>1.The Program Manager will verify the completion of 5 year internal pipe inspection and ensure any deficiencies are scheduled for repair with Koorsen Fire. The Facility will require | 04/01/2024 |

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|---|---|---|---|
| | 15G175 | A. BUILDING 02<br>B. WING | 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| | visitors.<br><br>Findings include:<br><br>Based on record review on 02/15/2024 between 10:15 AM and 1:45 PM, documentation stating the 5 year internal pipe inspection was completed in November 2018. No documentation was provided for a completed 5 year internal pipe inspection for 2023 or 2024. Based on interview at the time of record review, the Maintenance Manager stated a 5 year internal pipe inspection is planned to happen, however nothing is currently scheduled. | | schedule required testing and request copies of inspections and testing mailed to the program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany IN 47150.<br><br>**Persons Responsible:** Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative. | |
| K S712<br><br>Bldg. 02 | NFPA 101<br>Fire Drills<br>Fire Drills<br>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:<br>a. Ensure that all personnel on all shifts are trained to perform assigned tasks;<br>b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.<br>2. The facility must:<br>a. Actually evacuate clients during at least one drill each year on each shift;<br>b. Make special provisions for the evacuation of clients with physical disabilities;<br>c. File a report and evaluation on each drill;<br>d. Investigate all problems with evacuation drills, including accidents and take corrective action; and<br>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. | | | |

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| | 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.<br>42 CFR 483.470(i)<br>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 2 of 4 second shift fire drills during the previous 4 quarters. This deficient practice could affect all clients in the facility.<br><br>Findings include:<br><br>Based on review of the facility's fire drill reports on 02/15/2024 between 10:15 AM and 1:45 PM with the Area Supervisor and Maintenance Manager, no documentation was available for the first and fourth quarters for second shift. Based on interview at the time of record review, the Area Supervisor stated the facility had 2 shifts and she was not aware of any other locations for the fire drill paperwork. | 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 area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff.<br><br>1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date.<br><br>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.<br><br>1.The Area supervisor will ensure drills are completed as required.<br><br>1.The program manager will conduct random monthly inspections to ensure drills are being completed as required.<br><br>**Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP | 03/05/2024 |

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