STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G745	A. BUILDING -- B. WING	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16611 SIMA GRAY RD HENRYVILLE, IN 47126

(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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 07/02/2024 Facility Number: 011663 Provider Number: 15G745 AIM Number: 200902020 At this Emergency Preparedness survey, Res Care Southeast Indiana was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 4 certified beds. At the time of the survey, the census was 4. Quality Review completed on 07/03/24	E 0000		
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracy Callahan	Program Manager	07/17/2024

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice			

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	employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants.	E 0018	1.The administrator will ensure the emergency plan policies and procedures addresses the tracking of staff and clients, whether they evacuate or shelter in place. Including the consideration of care and treatment needs of evacuees, staff responsibilities; transportation; identification of evacuation locations; and primary and means of communication with	07/19/2024

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	Findings include: Based on review of the emergency preparedness plan on 07/02/2024 between 10:30 AM and 1:00 PM with the Area Supervisor and the Maintenance Director, no documentation regarding a policy on tracking of staff and clients was available for review. Based on interview at the time of record review, the Area Supervisor stated she was not aware of where the policy was but was able to find a blank client tracking chart. This finding was reviewed with the Area Supervisor and the Maintenance Director at the exit conference.		external assistance. 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. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual. 4.The Area Supervisor will ensure the EPP is updated annually, and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues.	

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			Persons Responsible: Program Manager, Area Supervisor, and Residential Manager	
E 0035 Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC 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 annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID 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. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include:	E 0035	1 The administrator will ensure the emergency plan policies and procedures will be shared with patient's and guardians during annual meetings. The Emergency Plan will be made available for review at request of patients and guardians. 2 The administrator will ensure the emergency plan policies and	07/19/2024

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	Based on record review on 07/02/2024 between 10:30 AM and 1:00 PM with the Area Supervisor and Maintenance Director, no documentation was provided regarding the facility's method for sharing appropriate emergency preparedness information with clients and family. The Area Supervisor agreed there was no documentation regarding sharing of emergency preparedness information with clients and family available for review and she was unaware of other locations where this information would be located. This finding was reviewed with the Area Supervisor and Maintenance Director at the exit conference.		procedures will be shared with patient's and guardians during annual meetings. The Emergency Plan will be made available for review at request of patients and guardians. 1.The QIDP, Area Supervisor and Program Manager will ensure the emergency plan policies and procedures is shared with patient's and guardians during annual meetings. 2.The Program Manager, and Area Supervisor will ensure a copy of the Emergency Preparedness Manual is available onsite and at ResCare Jeffersonville main office for patient and guardian review. The Area Supervisor will ensure staff have knowledge of where the Emergency Preparedness Manual is kept in the home and all its content updated. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 3.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area	

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			Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. **Persons Responsible:** Program Manager, Area Supervisor, and Residential Manager	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 07/02/2024 Facility Number: 011663 Provider Number: 15G745 AIM Number: 200902020 At this Life Safety Code survey, Res Care Southeast Indiana was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas, and all client sleeping rooms, furthermore, the facility was equipped with heat detection in the attic connected to the fire alarm system. The facility has a capacity of 4 and had a census of 4 at the time of this survey. Calculation of the Evacuation Difficulty Score	K 0000		

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	(E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.16. Quality Review completed on 07/03/24			
K S353 Bldg. 01	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). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually			

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	((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review, observation and	K S353	1.The administrator will ensure	08/16/2024

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	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 clients, staff and visitors. Findings include: Based on record review with the Area Supervisor and the Maintenance Director on 07/02/2024 between 10:30 AM and 1:00 PM, documentation of an internal pipe inspection conducted within the most recent five year period was not available for review. Based on interview at the time of record review, the Maintenance Director agreed documentation of an internal pipe inspection conducted within the most recent five year period was not available for review. This finding was reviewed with the Area Supervisor and Maintenance Director at the exit conference. 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 garage furnace rooms and 1 of 1 offices. NFPA 12, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations.		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. 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 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. Complete no later than 8/16/2024 3 The Maintenance Manager repaired the garage furnace room ceiling to ensure a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations in the ceiling on 7/10/2024. 4 The Maintenance Manager repaired a 3/4 inch penetration in the ceiling around the sprinkler piping and a 12 inch by 3 foot penetration in the ceiling going to the attic was observed around the furnace. Additionally, a penetration around 1 of 2 office sprinkler heads of 1 inch on 7/10/2024. 5 The Maintenance Manager	

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	The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation during a tour of the facility on 07/02/2024 between 1:00 PM and 1:30 PM with the Area Supervisor and the Maintenance Director, a 3/4 inch penetration in the ceiling around the sprinkler piping and a 12 inch by 3 foot penetration in the ceiling going to the attic was observed around the furnace. Additionally, a penetration around 1 of 2 office sprinkler heads of 1 inch was observed. Based on interview at the time of the observations, the Maintenance Director agreed there were present in the aforementioned locations and provided the measurements. The penetration in the office was corrected at the time of observations. This finding was reviewed with the Area Supervisor and the Maintenance Director at the exit conference. 3. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 garages in accordance with 33.2.3.5. NFPA 13, 2010 edition, Section 8.5.5.1, states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Section 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector that prevent the pattern from fully developing. This deficient practice could affect all clients.		removed obstructions to ensure 18 inches of clearance from the ceiling in the garage. 6 The Area Supervisor will in-service staff on storage is in with accordance with 33.2.3.5. NFPA 13, 2010 edition Section 8.5.5.2 and 8.5.5.3 to allow continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector that prevent the pattern from fully developing. 1.A random monthly site review will be completed by a member of ResCare's Administrative team to ensure compliance. Persons Responsible: AED, Maintenance Manager, Program Manager, ResCare Maintenance. Area Supervisor, DSL, DSP	

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	Findings include: Based on observation during a tour of the facility with the Area Supervisor and the Maintenance Director on 07/02/2024 between 1:00 PM and 1:30 PM, storage in the garage was less than 10 inches from the ceiling. Based on interview at the time of observation, the Area Supervisor and the Maintenance Director agreed there was storage in the garage less than 18 inches from the ceiling. The measurement was provided by the Maintenance Director. This finding was reviewed with the Area Supervisor and the Maintenance Director at the exit conference.			