PRINTED:	07/23/2024
FORM API	PROVED

OMB NO. 0938-039

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 07/02/2024 15G745 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16611 SIMA GRAY RD HENRYVILLE, IN 47126 **RES CARE SOUTHEAST INDIANA** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 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 0018 403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), Bldg. --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 SIGNATU	RE TITLE	(X6) DATE
Tracy Callahan	Program Manager	07/17/2024

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. MAN SERVICES FORM APPROVED AID SERVICES OMB NO. 0938-039 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745 X2 MULTIPLE CONSTRUCTION A. BUILDING -- X3) DATE SURVEY COMPLETED 07/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD 16611 SIMA GRAY RD

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>
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STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

RES CA	RE SOUTHEAST INDIANA	HENRY	/VILLE, 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) COMPLETIO DATE
	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			
	(2) of (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.			
	<ul> <li>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.</li> <li>(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.</li> <li>(v) A system to track the location of hospice</li> </ul>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 15G745 B. WING 07/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16611 SIMA GRAY RD HENRYVILLE, IN 47126 **RES CARE SOUTHEAST INDIANA** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 E 0018 1.The administrator will ensure 07/19/2024 failed to ensure emergency preparedness policies the emergency plan policies and and procedures include a system to track the procedures addresses the tracking location of on-duty staff and sheltered clients in of staff and clients, whether they the ICF/IID facility's care during and after an evacuate or shelter in place. emergency. If on-duty staff and sheltered clients Including the consideration of care are relocated during the emergency, the ICF/IID and treatment needs of evacuees, facility must document the specific name and staff responsibilities; location of the receiving facility or other location transportation; identification of in accordance with 42 CFR 483.475(b)(2). This evacuation locations; and primary deficient practice could affect all occupants. and means of communication with Event ID: HXPR21 Facility ID: 011663 Page 3 of 12 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

07/23/2024

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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G745			X3) DATE SURVEY COMPLETED 07/02/2024
	PROVIDER OR SUPPLIE		16611	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD	
RES CA	1			YVILLE, IN 47126	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIC DATE
	Findings include: Based on review of plan on 07/02/202 PM with the Area Maintenance Dire regarding a policy was available for n time of record rev she was not aware was able to find a This finding was n	of the emergency preparedness 4 between 10:30 AM and 1:00 Supervisor and the ctor, no documentation on tracking of staff and clients review. Based on interview at the iew, the Area Supervisor stated of where the policy was but blank client tracking chart. reviewed with the Area e Maintenance Director at the		external assistance. 2. The area supervisor and program manager will train all so on the policies and proceduress and the program overview will be placed in the Emergency Disas 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 Preparedne Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager w 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 mont site reviews of each location ar document any issues/findings of the site review. Site Review wi be reviewed by each Area Supervisor and Program Manag for that home and follow-up as necessary to correct all issues.	staff be ster e ed ss f d vill e e thly nd on ill ger

	ARTMENT OF HEALTH AND HUMAN SERVICES FERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-039		
	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G745	A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 07/02/2024		
	PROVIDER OR SUPPLIEI			16611 S	ddress, city, state, zip cod IMA GRAY RD /ILLE, IN 47126			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE	
					<b>Persons Responsible</b> : Prog Manager, Area Supervisor, a Residential Manager			
E 0035 Bldg	483.475(c)(8), 48 LTC and ICF/IID 3 §483.73(c)(8); §4	Sharing Plan with Patients						
	maintain an emer communication pl Federal, State an reviewed and upd	es at §483.73(c):] ity must develop and gency preparedness an that complies with d local laws and must be lated at least annually. The an must include all of the						
	emergency prepa plan that complies local laws and mu at least every 2 ye	§483.475(c):] nust develop and maintain an redness communication s with Federal, State and ust be reviewed and updated ears. The communication all of the following:]						
	emergency plan, determined is app clients] and their f	sharing information from the that the facility has propriate, with residents [or families or representatives.						
	failed to ensure the communication pla information from th facility has determinand their families of	view and interview, the facility emergency preparedness n includes a method for sharing ne emergency plan that the ned is appropriate with clients or representatives in accordance 75(c)(8). This deficient practice upants.	E 003	.5	1 The administrator will e the emergency plan policies a procedures will be shared wit patient's and guardians durin annual meetings. The Emerg Plan will be made available for review at request of patients guardians. 2 The administrator will e	and h g ency or and	07/19/202	
	Findings include:			the emergency plan policies a				

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER 15G745		(X2) MULTIPLE C A. BUILDING B. WING	COMI	(X3) DATE SURVEY COMPLETED <b>07/02/2024</b>	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD		
RES CA	RE SOUTHEAST I	NDIANA	HENR	YVILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETI DATE
	Based on record re 10:30 AM and 1:0 and Maintenance I provided regarding sharing appropriat information with c Supervisor agreed regarding sharing information with c review and she wa where this informat	eview on 07/02/2024 between 0 PM with the Area Supervisor Director, no documentation was g the facility's method for e emergency preparedness dients and family. The Area there was no documentation of emergency preparedness dients and family available for s unaware of other locations ation would be located. eviewed with the Area aintenance Director at the exit		procedures will be shared patient's and guardians d annual meetings. The Em Plan will be made availab review at request of patie guardians. 1.The QIDP, Area Supe and Program Manager wit the emergency plan polic procedures is shared with patient's and guardians d annual meetings. 2.The Program Manage Area Supervisor will ensu of the Emergency Prepar Manual is available onsite ResCare Jeffersonville m for patient and guardian r The Area Supervisor will staff have knowledge of v Emergency Preparedness is kept in the home and a content updated. Upon v home, the Program Mana review the Emergency Preparedness Manual an document the visit on the Visitor Sign In form locate each home. 3.Monitoring of Correcti Action: A member of the S Review Team, consisting QA department, Program Managers, QIDP-D's, Nu Manager, AED, and Area Supervisors will complete site reviews of each locat document any issues/find the site review. Site Revi	uring hergency ble for ints and ervisor ill ensure ies and uring er, and ure a copy edness e and at ain office eview. ensure where the s Manual II its isiting a ager will d Home ed in Site of the rse e monthly ion and lings on iew will	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE COMPI 07/02		
	PROVIDER OR SUPPLIER			16611	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD		
	RE SOUTHEAST IN				YVILLE, IN 47126		1
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	I E	(X5)
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					Supervisor and Program Ma for that home and follow-up necessary to correct all issu <b>Persons Responsible:</b> Pro Manager, Area Supervisor, a Residential Manager	as es. gram	
C 0000							
Bldg. 01	conducted by the Ir accordance with 42 Survey Date: 07/02 Facility Number: 0 Provider Number: 0 Provider Number: 200 At this Life Safety Southeast Indiana v Requirements for P CFR Subpart 483.4 the 2012 edition of Association (NFPA Chapter 33, Existin Occupancies. This one story facil sprinklered. The fa with smoke detection living areas, and all furthermore, the face detection in the atti	2/2024 011663 15G745 902020 Code survey, Res Care vas found in compliance with articipation in Medicaid, 42 70(j), Life Safety from Fire and the National Fire Protection (1) 101, Life Safety Code (LSC), g Residential Board and Care ity was determined to be fully willity has a fire alarm system on in the corridors, common client sleeping rooms, cility was equipped with heat c connected to the fire alarm y has a capacity of 4 and had a	К	000			
	Calculation of the H	Evacuation Difficulty Score					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 15G745 B. WING 07/02/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16611 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE. IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE (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 **NFPA 101** Sprinkler System - Maintenance and Testing Bldg. 01 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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Event ID: HX

HXPR21 Facility ID: 011663

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	TATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER         15G745		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 07/02/2024	
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP ( 1 SIMA GRAY RD	COD		
RES CA	RE SOUTHEAST I	NDIANA		RYVILLE, IN 47126			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	25, section 5.2.2 8. Visible pipe (NFPA 25, section 9. Buildings insist freezing weather filled piping (NFF 10. A represent response sprinklet (NFPA 25, section 11. A represent sprinklers are test section 5.3.1.1.1 12. Antifreeze (NFPA 25, section 13. Control value their full range are annually (NFPA 25, section 13. A). 15. Dry pipe sy unheated portion inspected, tested section 13.4.4). A. Date sprinkler necessary mainter B. Show who pro- C. Note the source automatic sprinkler (Provide in REM, coverage for any automatic sprinkler	Inspected annually (NFPA ). hangers inspected annually in 5.2.3). upected annually prior to for adequate heat for water (A 25, section 5.2.5). tative sample of fast ers are tested at 20 years in 5.3.1.1.1.2). tative sample of dry pendant at 10 years (NFPA 25, 5). solutions are tested annually in 5.3.4). ves are operated through ind returned to normal 25, section 13.3.3.1). stems of OS&Y valves are lly (NFPA 25, section stems extending into s of the building are and maintained (NFPA 25, system last checked and enance provided. vided the service. ce of the water supply for the er system. ARKS information on non-required or partial					
		review, observation and	K S353	1.The administrator	will ensure	08/16/20	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDI						MB NO. 0938-039
STATEME! AND PLAN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 15G745		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 07/02/2024	
	PROVIDER OR SUPPLIE			STREET ADDRESS, C 16611 SIMA GRA HENRYVILLE, IN			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	FFIX (EACH)	ROVIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
	automatic sprinkle	lity failed to ensure 1 of 1 r piping systems was examined		conduct	n Fire and Security ts 5 year internal pi		
	that could cause of	ctions where conditions exist ostructed piping as required by lition, the Standards for the		the insp	ions and that the re pections are availab for review and forwa	le in the	
	Inspection, Testing Water-Based Fire	g and Maintenance of Protection Systems, Section .2.1 states, except as discussed		the Prog monitor	gram Manager for		
	in 14.2.1.1 and 14. and branch line co every 5 years by o the end of one mai toward the end of of inspecting for th	2.1.4, an inspection of piping nditions shall be conducted pening a flushing connection at n and by removing a sprinkler one branch line for the purpose he presence of foreign organic erial. This deficient practice		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		vear d e Coorsen re	
	Findings include:			request testing	t copies of inspectio mailed to the progra	ons and am	
	and the Maintenan between 10:30 AM of an internal pipe the most recent fiv for review. Based record review, the documentation of a	eview with the Area Supervisor ce Director on 07/02/2024 f and 1:00 PM, documentation inspection conducted within e year period was not available on interview at the time of Maintenance Director agreed an internal pipe inspection he most recent five year period for review.		Program Security Albany later tha 3 Th repaired ceiling t as a col significa	er upon completion m Manager at 4341 y PKWY Suite 101 I IN 47150. Complete an 8/16/2024 he Maintenance Ma d the garage furnac to ensure a smooth intinuous ceiling free ant irregularities, lur tions in the ceiling o	New e no anager e room ceiling e from mps, or	
		nding was reviewed with the Area visor and Maintenance Director at the exit ence.		4 Th repaired the ceili	he Maintenance Ma d a 3/4 inch penetra ing around the sprir and a 12 inch by 3 fi	ation in nkler	
	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			penetra the attic furnace	ation in the ceiling g c was observed arous a. Additionally, a per 1 of 2 office sprinkl	oing to und the netration	
		uous ceiling free from rities, lumps, or indentations.			of 1 inch on 7/10/20 he Maintenance Ma		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

IDER OR SUPPLII		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		07/02/2024
SOUTHEAST		16611	address, city, state, zip cod SIMA GRAY RD YVILLE, IN 47126	
SUMMAR' (EACH DEFICIE REGULATORY O re ceiling traps I rinkler and cause ecified temperat uld affect all cli addings include: used on observat 07/02/2024 bet e Area Supervis rector, a 3/4 inco ound the sprinkl netration in the served around t netration around nch was observ rector agreed thorementioned lo easurements. The rector agreed thorementioned lo easurements. The rector agreed thorementioned lo easurements. The rector agreed thorementioned lo easurements. The rector agreed thorementioned lo casurements. The rector agreed thorementioned lo casurements. The rector agreed thorements are to a supervisor and that it conference. Based on obser led to ensure that ads were not ob cordance with 3 ction 8.5.5.1, st as to minimize fined in 8.5.5.2 rinklers shall be verage of the has not permit corristructions less t	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION not air and gases around the es the sprinkler to operate at a ture. This deficient practice ents and staff in the facility ween 1:00 PM and 1:30 PM with or and the Maintenance h penetration in the ceiling er piping and a 12 inch by 3 foot ceiling going to the attic was he furnace. Additionally, a d 1 of 2 office sprinkler heads of ed. Based on interview at the ations, the Maintenance ere were present in the cations and provided the le penetration in the office was ne of observations. reviewed with the Area e Maintenance Director at the vation and interview, the facility e spray pattern for sprinkler structed in 1 of 1 garages in 3.2.3.5. NFPA 13, 2010 edition, ates sprinklers shall be located obstructions to discharge as and 8.5.5.3 or additional provided to ensure adequate uzard. Section 8.5.5.2 and 8.5.5.3 tinuous or noncontinuous han or equal to 18 inches below	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) removed obstructions to ensure 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	D V Of D
	rinkler and caus ecified temperat uld affect all cli andings include: used on observat 07/02/2024 bet e Area Supervis rector, a 3/4 inco- bund the sprinkl netration in the served around t netration around nch was observ rector agreed th brementioned lo easurements. The rrected at the time is finding was re- pervisor and the it conference. Based on observ iled to ensure the ads were not ob cordance with 3 ction 8.5.5.1, st as to minimize fined in 8.5.5.2 rinklers shall be verage of the has not permit conta- structions less t e sprinkler defle- om fully develop	ased on observation during a tour of the facility 07/02/2024 between 1:00 PM and 1:30 PM with e Area Supervisor and the Maintenance rector, a 3/4 inch penetration in the ceiling ound the sprinkler piping and a 12 inch by 3 foot netration in the ceiling going to the attic was served around the furnace. Additionally, a netration around 1 of 2 office sprinkler heads of inch was observed. Based on interview at the ne of the observations, the Maintenance rector agreed there were present in the orementioned locations and provided the easurements. The penetration in the office was rrected at the time of observations.	rinkler and causes the sprinkler to operate at a ecified temperature. This deficient practice uld affect all clients and staff in the facility. andings include: used on observation during a tour of the facility 07/02/2024 between 1:00 PM and 1:30 PM with e Area Supervisor and the Maintenance rector, a 3/4 inch penetration in the ceiling bound the sprinkler piping and a 12 inch by 3 foot netration in the ceiling going to the attic was served around the furnace. Additionally, a netration around 1 of 2 office sprinkler heads of nch was observed. Based on interview at the ne of the observations, the Maintenance rector agreed there were present in the orementioned locations and provided the easurements. The penetration in the office was rrected at the time of observations. this finding was reviewed with the Area apervisor and the Maintenance Director at the it conference. Based on observation and interview, the facility led to ensure the spray pattern for sprinkler ads were not obstruction in 1 of 1 garages in cordance with 33.2.3.5. NFPA 13, 2010 edition, ction 8.5.5.1, states sprinkler shall be located as to minimize obstructions to discharge as fined in 8.5.5.2 and 8.5.5.3 or additional rinklers shall be provided to ensure adequate verage of the hazard. Section 8.5.5.2 and 8.5.5.3 . on permit continuous or noncontinuous structions less than or equal to 18 inches below e sprinkler deflector that prevent the pattern om fully developing. This deficient practice	<ul> <li>inches of clearance from the ceiling in the garage.</li> <li>6 The Area Supervisor will in-service staff on storage is in with accordance with 33.2.3.5.</li> <li>NFPA 13, 2010 edition Section 8 5.5.2 and 8.5.5.3 to allow continuous or noncontinuous or provided the assurements. The penetration in the office was rrected at the time of observations, the Maintenance rector agreed there were present in the orementioned locations and provided the assurements. The penetration in the office was rrected at the time of observations.</li> <li>Based on observation and interview, the facility led to ensure the spra pattern for sprinkler ads were not obstructions to discharge as fined in 8.5.5.2 and 8.5.5.3 or additional rinklers shall be located as to minimize obstructions to discharge as fined in 8.5.5.2 and 8.5.5.3 or additional rinklers shall be provided to ensure the spray pattern for sprinkler adgiver provisor ad the Maintenance Director at the it conference.</li> </ul>

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FO	R MEDICARE & MEDIC	CAID SERVICES				ON	1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 07/02/2024		
	PROVIDER OR SUPPLIE			16611 5	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD VILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR( DEFICIENCY)	O BE	(X5) COMPLETION DATE
	with the Area Supe Director on 07/02/2 PM, storage in the from the ceiling. B observation, the Ar Maintenance Direct the garage less than The measurement w Maintenance Direct This finding was reasoning the storage of	on during a tour of the facility rvisor and the Maintenance 2024 between 1:00 PM and 1:30 garage was less than 10 inches ased on interview at the time of ea Supervisor and the tor agreed there was storage in a 18 inches from the ceiling. was provided by the tor.					

HXPR21 Facility ID: 011663