						PRIN	TED:	10/12/2023
DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FOI	RM APP	ROVED
CENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OM	B NO. 09	938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	7
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	<u></u>	COMPL	ETED	
		15G080	B. WIN	G		09/14/	2023	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL				725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMP	LETION

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	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: 09/14/23			
	F 311 N 1 000600			
	Facility Number: 000623			
	Provider Number: 15G080			
	AIM Number: 100233870			
	At this Emergency Duenous duess suggest Des Comp			
	At this Emergency Preparedness survey, Res Care			
	Community Alternatives South Central was found			
	not in compliance with Emergency Preparedness			
	Requirements for Medicare and Medicaid			
	Participating Providers and Suppliers, 42 CFR			
	483.475.			
	TI 6 '1' 1 0 4' " 11 1 4441 4' 64			
	The facility has 8 certified beds. At the time of the			
	survey the census was 7.			
	Quality Review completed on 09/22/23			
	Quality review completed on 03/22/23			
	The requirement at 42 CFR, Subpart 483.475 is			
	NOT MET as evidenced by:			
E 0006	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)			
	(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2),			
Bldg	483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)			
Ŭ	(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2),			
	485.727(a)(1)-(2), 485.920(a)(1)-(2),			
	486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)			
	(1)-(2)			
	Plan Based on All Hazards Risk Assessment			
	§403.748(a)(1)-(2), §416.54(a)(1)-(2),			
	§418.113(a)(1)-(2), §441.184(a)(1)-(2),			
	§460.84(a)(1)-(2), §482.15(a)(1)-(2),			
	§483.73(a)(1)-(2), §483.475(a)(1)-(2),		1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Anna Brison **Program Director** 10/06/2023

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING COMPLET B. WING 09/14/20				ETED	
	PROVIDER OR SUPPLIER	R LTERNATIVES SOUTH CENTRAL	-	725 CAI	DDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
TAG	§484.102(a)(1)-(2) §485.625(a)(1)-(2) §485.920(a)(1)-(2) §491.12(a)(1)-(2), [(a) Emergency P develop and main preparedness pla and updated at le must do the follow (1) Be based on a facility-based and assessment, utiliz approach.* (2) Include strateg emergency events assessment. * [For Hospices at Plan. The Hospice maintain an emerg that must be revie every 2 years. The following: (1) Be based on a facility-based and assessment, utiliz approach. (2) Include strateg emergency events assessment, inclu the consequences disasters, and oth	c), §485.68(a)(1)-(2), c), §485.727(a)(1)-(2), c), §486.360(a)(1)-(2), dan. The [facility] must ration an emergency on that must be reviewed, ast every 2 years. The plan wing:] and include a documented, community-based risk ring an all-hazards gies for addressing s identified by the risk at §418.113(a):] Emergency are must develop and gency preparedness plan awed, and updated at least are plan must do the and include a documented, community-based risk ring an all-hazards gies for addressing s identified by the risk ring an all-hazards gies for addressing s identified by the risk ring an all-hazards gies for addressing s identified by the risk ring an all-hazards gies for addressing s identified by the risk ring an all-hazards gies for addressing s identified by the risk ring an all-hazards gies for addressing s identified by the risk ring an all-hazards gies for addressing s identified by the risk ring an all-hazards gies for addressing s identified by the risk ring an all-hazards gies for addressing s identified by the risk ring an all-hazards		IAG			DATE
	Emergency Plan.	The LTC facility must tain an emergency					

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Event ID:

QAEM21 Facility ID: 000623

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	<u></u>	COMPL	LETED	
		15G080	B. WIN	IG		09/14/	/2023	
			┪	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIE	R		725 CA				
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL			IN 47031			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		n that must be reviewed,						
		ast annually. The plan must						
	do the following:	and include a decumented						
	, ,	and include a documented,						
	facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.							
		gies for addressing						
	l ' '	s identified by the risk						
	assessment.	3 Identified by the flak						
	accessinent.							
	*[For ICF/IIDs at 8	§483.475(a):] Emergency						
		must develop and maintain						
		eparedness plan that must						
	be reviewed, and	updated at least every 2						
	years. The plan m	nust do the following:						
	(1) Be based on a	and include a documented,						
	facility-based and	l community-based risk						
		zing an all-hazards						
		ng missing clients.						
	l ' '	gies for addressing						
	1 -	s identified by the risk						
	assessment.	11, 1 3 0 95	Fac	0.0			10/05/2022	
		view and interview, the facility	E 000	06	E006: Plan Based on All		10/07/2023	
		emergency preparedness plan n a facility-based and			Hazards Risk Assessment			
		n a facility-based and risk assessment, utilizing an			Commontive action:			
		ch that was reviewed and			Corrective action:			
		ery two years in accordance			Program Director comple	tod		
	_	75(a) was specific to the Carr			the template to update the Ha			
		is deficient practice could			and Vulnerability Assessment			
	affect all occupants				Tool to include the risk of train			
					derailment/chemical spill.	•		
	Findings include:				Upon receiving the Hazar	⁻ d		
					and Risk Assessment back from			
	Based on review of	f "Emergency/Disaster			M&A Transaction Solutions D			
		ual" documentation dated			and Analytics it will be placed	in		
	_	Direct Support Lead during			the facility in the Emergency			
		10:40 a.m. to 11:50 a.m. on			Preparedness Binder.			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/14/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL	725 CA	ADDRESS, CITY, STATE, ZIP COD IRR ST , IN 47031	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and community-bas an all-hazards appro updated at least eve	ot be ensured the facility-based ed risk assessment, utilizing bach that was reviewed and ry two years was specific to tion. The "Operation		Emergency Preparednes Plans are updated annually a needed by the Program Direc Monitoring of Corrective	nd as
	Description" portion of emergency preparedness program documentation stated it was for the "Evan Lane Group Home" location. The "Hazard & Vulnerability Assessment Tool" section of the documentation did not specify it was for the Carr Street location. Based on interview at the time of record review, the Direct Support Lead stated the Carr Street facility was vacant from 01/17/23 to 04/10/23 after which time Evan Lane group home clients were moved to the Carr Street group home location. Telephone interview with the Program Manager during record review indicated emergency preparedness program documentation for the Evan Lane group home was moved to the Carr Street location. Portions of the the			Action: Program Manager will continue to update Emergenc Preparedness Plans annually	·
				as needed. Once the Assessment To has been updated it will be train the facility and placed in the Emergency Preparedness Ma	ained e
				Completion Date: 10/7/23	
	which were reviewed the Carr Street locate ensured the facility- risk assessment, util	dness program documentation, ed on 05/03/23, were updated to tion but it could not be based and community-based dizing an all-hazards approach			
	period was specific These findings were	within the most recent two year to the Carr Street location. The reviewed with the Direct graph the exit conference.			
E 0013	403.748(b), 416.5 441.184(b), 482.1	4(b), 418.113(b), 5(b), 483.475(b), 483.73(b),			
Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §460	25(b), 485.68(b), 20(b), 486.360(b),			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G080	A. BU B. W	JILDING		COMPL 09/14/	
		130000	В. W.			09/14/	12023
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DES CVI		LTERNATIVES SOUTH CENTRA	ı	725 CA	RR ST IN 47031		
KES CAI	RE COMMUNITY A	LIERNATIVES SOUTH CENTRA		WILAN,	111 47031		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION 625(b), §485.727(b),		TAG	DEFICIENCE!		DATE
	- , , -	6.360(b), §491.12(b),					
	§494.62(b).	5.000(5), 3.101.12(5),					
	(b) Policies and procedures. [Facilities] must						
	develop and imple						
		icies and procedures, based					
		plan set forth in paragraph					
	' '	risk assessment at of this section, and the					
		an at paragraph (c) of this					
		cies and procedures must					
	be reviewed and ι	updated at least every 2					
	years.						
	_	s at §483.73(b):] Policies					
	develop and imple	The LTC facility must					
		icies and procedures, based					
		plan set forth in paragraph					
		risk assessment at					
		of this section, and the					
	•	an at paragraph (c) of this					
	-	cies and procedures must					
	be reviewed and t	updated at least annually.					
	*Additional Requir	rements for PACE and					
	ESRD Facilities:	omonio for 17102 and					
	*[For PACE at §46	60.84(b):] Policies and					
	-	PACE organization must					
	develop and imple	- ·					
		icies and procedures, based					
		/ plan set forth in paragraph risk assessment at					
	' '	of this section, and the					
		an at paragraph (c) of this					
	· ·	cies and procedures must					
	-	nent of medical and					
	_	gencies, including, but not					

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Event ID:

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	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	î ´	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MDILAN	or condition	15G080	B. WI			09/14		
NAME OF P	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP COD			
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL			IN 47031			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		quipment, power, or water ed emergencies; and natural						
	l '	threaten the health or						
	· ·	cipants, staff, or the public.						
	The policies and procedures must be							
		lated at least every 2 years.						
	*[For ESRD Facili	ities at §494.62(b):] Policies						
	and procedures.	The dialysis facility must						
	develop and imple	ement emergency						
		icies and procedures, based						
		y plan set forth in paragraph						
	1 ' '	, risk assessment at						
		of this section, and the						
	I -	an at paragraph (c) of this						
	· ·	cies and procedures must						
		updated at least every 2 ergencies include, but are						
	1 -	, equipment or power						
		ted emergencies, water						
		n, and natural disasters						
		he facility's geographic						
	area.	, , , , ,						
	Based on record re-	view and interview, it could not	E 00	13	E013: Development of EP		10/07/2023	
	be ensured all polic	cies and procedures based on			policies and Procedures			
	I -	nd community-based risk						
		ng an all-hazards approach was			Corrective Action:			
	1 ^	Street location. The policies			The Emergency Plan is			
	_	st be reviewed and updated at			updated annually and as need			
	1	rs in accordance with 42 CFR			Area Supervisor trains all	starr		
	483.4/5(b). This d	eficient practice could affect all			annually. (Attachment A) All new hires are trained a	36		
	occupants.				part of their On the Job Training			
	Findings include:				and then annually.	ı ıy		
					Program Director complete	ted		
	Based on review of	f "Emergency/Disaster			the template to update the Ha			
		ual" documentation dated			and Vulnerability Assessment			
	_	Direct Support Lead during			Tool to include the risk of train			
		10:40 a.m. to 11:50 a.m. on			derailment/chemical spill.			
	09/14/23, it could r	not be ensured all policies and			Upon receiving the Hazar	⁻ d		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	A. E	MULTIPLE CO BUILDING VING	ONSTRUCTION	COM	TE SURVEY TPLETED 14/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRA	ΑL	725 CA	address, city, state, z RR ST IN 47031	IP COD	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF procedures based or community-based r all-hazards approac Street location. The portion of emergene documentation state Group Home" locat Vulnerability Asses documentation did Street location. Base record review, the I Carr Street facility 04/10/23 after whice clients were moved location. Telephon Manager during rece emergency preparer for the Evan Lane g Carr Street location emergency preparer which were reviewed the Carr Street location emergency preparer which were reviewed the Carr Street location emergency preparer which were reviewed the Carr Street location emergency preparer which were reviewed the Carr Street location. These findings were	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION In the facility-based and isk assessment, utilizing an in was specific to the Carr e "Operation Description" by preparedness program and it was for the "Evan Lane ion. The "Hazard & sment Tool" section of the mot specify it was for the Carr and on interview at the time of Direct Support Lead stated the was vacant from 01/17/23 to in time Evan Lane group home to the Carr Street the treview with the Direct the reviewed with the Direct the treviewed with the Direct the reviewed with the Direct the treviewed with the Direct	AL		PROVIDERS PLAN OF (EACH CORRECTIVE ACTIVE ACTIVE CROSS-REFERENCED TO T DEFICIENCY) and Risk Assessme M&A Transaction So and Analytics it will the facility in the Empreparedness Binder Program Manage form to track when explans are reviewed (Attachment B) Program Direct the facility has the magnetic plans, policies and plans	ent back from olutions Data be placed in nergency er. ger created a emergency and updated. For will ensure most current procedures. For will review when dness is iility staff. ective ger will update paredness plan and as needed ated facility and I tracking form. Ining is sent to r and Human	(X5) COMPLETION DATE
E 0039 Bldg	441.184(d)(2), 482 483.73(d)(2), 484	5.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2),			Resources for revie monitoring for comp Completion Date:	oletion.	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL		
		15G080	B. Wl	ING		09/14/	/2023	
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
				725 CA				
RES CAI	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL		MILAN,	IN 47031			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
	486.360(d)(2), 49 EP Testing Requi	1.12(d)(2), 494.62(d)(2)						
		rements 18.113(d)(2), §441.184(d)(2),						
	§460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)							
	(2), §491.12(d)(2)							
	*IFor ASCs at 841	16.54, CORFs at §485.68,						
		ons" under §485.727,						
		220, RHCs/FQHCs at						
	_	RD Facilities at §494.62]:						
	(2) Testing The If	facility] must conduct						
	. ,	he emergency plan						
		ility] must do all of the						
	following:	mity] mast as an or allo						
	(i) Participate in a	full-scale exercise that is						
	community-based							
		nunity-based exercise is						
		onduct a facility-based						
		e every 2 years; or						
	· · · -	ility] experiences an actual						
		ade emergency that requires						
		mergency plan, the [facility]						
	-	gaging in its next required						
		or individual, facility-based						
		e following the onset of the						
	actual event.	ditional exercise at least						
	` '	posite the year the full-scale						
		cise under paragraph (d)(2)						
		s conducted, that may						
	, , ,	limited to the following:						
		scale exercise that is						
	' '	or individual, facility-based						
	functional exercise	•						
	(B) A mock disast							
	1 ' '	ercise or workshop that is						

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL		
		15G080	B. W	ING		09/14/	/2023	
C. o			•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF			725 CA	RR ST			
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAI	L	MILAN,	IN 47031			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		and includes a group						
	discussion using a							
	· ·	emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er							
	_ ` '	acility's] response to and						
		ntation of all drills, tabletop						
		nergency events, and revise						
	the [facility's] eme	rgency plan, as needed.						
	*[For Hospices at	418.113(d):]						
	(2) Testing for ho	spices that provide care in						
	the patient's home	e. The hospice must						
	conduct exercises	to test the emergency						
	plan at least annu	ally. The hospice must do						
	the following:							
	(i) Participate in a	a full-scale exercise that is						
	community based	every 2 years; or						
	(A) When a comm	nunity based exercise is not						
	accessible, condu	ct an individual facility						
	based functional e	exercise every 2 years; or						
	(B) If the hospice	experiences a natural or						
	man-made emerg	ency that requires activation						
	of the emergency	plan, the hospital is						
	exempt from enga	aging in its next required full						
	scale community-	based exercise or individual						
	facility-based fund	tional exercise following the						
	onset of the emer	gency event.						
	(ii) Conduct an ac	dditional exercise every 2						
	years, opposite th	e year the full-scale or						
		e under paragraph (d)(2)(i)						
	of this section is c	onducted, that may						
	include, but is not	limited to the following:						
	(A) A second full-	scale exercise that is						
	community-based	or a facility based						
	functional exercise	e; or						
	(B) A mock disas	ter drill; or						
	(C) A tabletop ex	ercise or workshop that is						
	led by a facilitator	and includes a group						

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	OF CORRECTION	IDENTIFICATION NUMBER 15G080	A. B	UILDING VING	nstruction 	COMI	PLETED 4/2023
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTR	AL	725 CAI	.ddress, city, state, zii RR ST IN 47031	PCOD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	set of problem sta messages, or pre to challenge an er	emergency scenario, and a tements, directed pared questions designed					
	exercises to test to per year. The hos (i) Participate in a that is community (A) When a comm	hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise -based; or aunity-based exercise is not ct an annual individual					
	facility-based fund (B) If the hospice man-made emerg of the emergency exempt from enga full-scale commun	etional exercise; or experiences a natural or ency that requires activation plan, the hospice is eging in its next required enity based or facility-based					
	emergency event. (ii) Conduct an acthat may include, following: (A) A second full-	dditional annual exercise but is not limited to the scale exercise that is					
	functional exercise (B) A mock disas (C) A tabletop exe	ter drill; or ercise or workshop led by a udes a group discussion					
	emergency scena statements, direct questions designe emergency plan. (iii) Analyze the h	rio, and a set of problem ed messages, or prepared					
	exercises, and em	nation of all drills, tabletop nergency events and revise ergency plan, as needed.					

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Event ID:

QAEM21 Facility ID: 000623

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 09/14/2023	
	PROVIDER OR SUPPLIER	TERNATIVES SOUTH CENTRAL		725 CAF	DDRESS, CITY, STATE, ZIP COD RR ST IN 47031	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
	§482.15(d), CAHs (2) Testing. The [F conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community- (A) When a comm accessible, condu facility-based func (B) If the [PRTF, F an actual natural of that requires activ plan, the [facility] i its next required fu or individual, facilif following the onse (ii) Conduct a exercise or and th limited to the follow (A) A second full- community-based facility-based func (B) A mo (C) A tabletop is led by a facilitat discussion, using a clinically-relevant set of problem sta messages, or prep to challenge an er (iii) Analyze th and maintain docu tabletop exercises	PRTF, Hospital, CAH] must to test the emergency r. The [PRTF, Hospital, following: n annual full-scale exercise based; or unity-based exercise is not ct an annual individual, tional exercise; or dospital, CAH] experiences or man-made emergency ation of the emergency sexempt from engaging in ull-scale community based by-based functional exercise to fthe emergency event. In [additional] annual at may include, but is not wing: scale exercise that is or individual, a tional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed						

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDERA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		15G080	B. W	ING		09/14/	/2023
NAME OF T	DROLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C .		725 CA	RR ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAI	L	MILAN,	IN 47031		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For PACE at §46	· / =					
	1 ' '	PACE organization must					
		s to test the emergency					
	plan at least annu	-					
	organization must	-					
	(i) Participate in an annual full-scale exercise						
	that is community-based; or (A) When a community-based exercise is not						
	1 ' '	-					
		ict an annual individual,					
	facility-based functional exercise; or						
	(B) If the PACE experiences an actual natural						
	or man-made emergency that requires						
	activation of the emergency plan, the PACE is exempt from engaging in its next required						
	-	nity based or individual,					
		ctional exercise following the					
	onset of the emer	_					
		in additional exercise every					
	, ,	the year the full-scale or					
	1	e under paragraph (d)(2)(i)					
		conducted that may include,					
	but is not limited to						
		scale exercise that is					
	l ` '	or individual, a facility					
	based functional e	-					
	(B) A mock disas						
	1 ' '	ercise or workshop that is					
		and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
	· ·	pared questions designed					
	to challenge an er						
		PACE's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
	*[For LTC Facilitie	oc at 8/183 73/d)·1					
		itv] must conduct exercises					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		A. B	MULTIPLE CO UILDING VING	NSTRUCTION	CON	TE SURVEY MPLETED 14/2023
	OF PROVIDER OR SUPPLIE	R LITERNATIVES SOUTH CENTRA	AL	725 CAI	ADDRESS, CITY, STATE, ZIP CO RR ST IN 47031	OD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		IOULD BE	(X5) COMPLETION DATE
	to test the emerge year, including un the emergency properties of its participate in a that is community (A) When a community (A) When a community-based function accessible, conduction accessible, conduction accessible, conduction accessible, conduction accessible, conduction actual natural or requires activation actually following the onse (ii) Conduct an atthat may include, following: (A) A second full community-based functional (B) A mock disass (C) A tabletop explain actually-relevant set of problem star messages, or preto challenge an expense to and response to a decrease to a de	ency plan at least twice per lannounced staff drills using rocedures. The [LTC facility, the following: an annual full-scale exercise rebased; or munity-based exercise is not uct an annual individual, ctional exercise. Sility] facility experiences an man-made emergency plan, the empt from engaging its next ale community-based or eleased functional exercise et of the emergency event. In other exercise that is a for an individual, facility exercise; or exercise or workshop that is includes a group a narrated, emergency scenario, and a exercise duestions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		15G080	B. WI	NG		09/14/	/2023
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
DE0.041				725 CA			
RES CAI	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL	-	MILAN,	IN 47031		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	following:						
	(i) Participate in a	n annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ct an annual individual,					
	facility-based fund	ctional exercise; or.					
	(B) If the ICF/IID experiences an actual						
	natural or man-made emergency that requires						
	activation of the e	mergency plan, the ICF/IID					
	is exempt from en	gaging in its next required					
	full-scale community-based or individual,						
	facility-based functional exercise following the						
	onset of the emergency event.						
	(ii) Conduct an additional annual exercise						
	that may include,	but is not limited to the					
	following:						
	(A) A second full-s	scale exercise that is					
	community-based	or an individual,					
	facility-based fund	tional exercise; or					
	(B) A mock disast	er drill; or					
	(C) A tabletop exe	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze the IC	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	-					
	, , , ,	e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						
	(A) When a c	ommunity-based exercise					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		A. BUILDING B. WING			COMPLETED 09/14/2023		
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
RES CAI	RE COMMUNITY A	LTERNATIVES SOUTH CENTRA	L	725 CAI MILAN,	IN 47031		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	BEFELENCIT		DATE
		conduct an annual based functional exercise					
	every 2 years; or.						
		A experiences an actual					
	' '	ade emergency that requires					
	activation of the e	mergency plan, the HHA is					
	exempt from enga	aging in its next required					
		nity-based or individual,					
	· ·	ctional exercise following the					
	onset of the emer						
	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or						
	functional exercise under paragraph (d)(2)(i)						
	of this section is conducted, that may						
	include, but is not limited to the following:						
	· ·	full-scale exercise that is					
	community-based						
	facility-based fund	ctional exercise; or					
	, ,	isaster drill; or					
	, ,	o exercise or workshop that					
	_	tor and includes a group					
	discussion, using						
	set of problem sta	emergency scenario, and a					
	1	pared questions designed					
	to challenge an er	·					
	_	HA's response to and					
	, ,	ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §48	86.360]					
	(d)(2) Testing. The	e OPO must conduct					
		he emergency plan. The					
	OPO must do the	S					
		er-based, tabletop exercise					
		ast annually. A tabletop					
		a facilitator and includes a using a narrated, clinically					
		cy scenario, and a set of					
	L'olovani cilicigen	oy cochano, and a set of					

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES		OMB NO. 0938-039		
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPL	
		15G080	B. WING		09/14/	/2023
NAME OF F	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD		
				ARR ST		
RES CAR	RE COMMUNITY A	LTERNATIVES SOUTH CENTRA	L MILAN	I, IN 47031		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	· •	nts, directed messages, or				
		ns designed to challenge an				
		If the OPO experiences an				
		man-made emergency that				
	1	n of the emergency plan, the				
		om engaging in its next				
		xercise following the onset				
	of the emergency					
		PO's response to and				
		ntation of all tabletop				
	· ·	nergency events, and revise				
	l -	OPO's] emergency plan, as				
	needed.					
	*[RNCHIs at §40	3 7481·				
		e RNHCI must conduct				
	' ' ' '	he emergency plan. The				
	RNHCI must do th					
		er-based, tabletop exercise				
	1 ''	A tabletop exercise is a				
	1	led by a facilitator, using a				
		/-relevant emergency				
	· ·	et of problem statements,				
		es, or prepared questions				
	_	enge an emergency plan.				
	1 -	NHCI's response to and				
	l ' '	ntation of all tabletop	1			
		nergency events, and revise				
	· ·	rgency plan, as needed.				
		view and interview, the facility	E 0039	E039: EP Testing Requireme	nts	10/07/2023
		least two exercises to test the				
		an annual basis using the		Corrective action:		
		res. The ICF/IID facility must		The facility will conduct at		
		ing: (i) Participate in an annual		least two full scale or one full		
		that is community-based; or		scale exercise and a table top		
		ity-based exercise is not		exercise to test the emergency	/	
		an annual individual,		plan at least annually and will u		
	facility-based funct			the Mock Drill Form (Attachme		

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b. If the ICF/IID facility experiences an actual

natural or man-made emergency that requires

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C) for completion and proof of the

exercise. The exercise was

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/14/2023		
		PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRAI	725 C	T ADDRESS, CITY, STATE, ZIP COD CARR ST N, IN 47031	
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
	TAG	activation of the em facility is exempt fi full-scale communi facility-based full-syear following the Gii) Conduct an addinclude, but is not la. A second full-sca community-based of functional exercise. b. A mock disaster c. A tabletop exercifacilitator that inclua facilitator, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the IC maintain document	R LSC IDENTIFYING INFORMATION theregency plan, the ICF/IID from engaging its next required ty-based or individual, totale functional exercise for 1 tonset of the actual event. itional exercise that may imited to the following: the exercise that is or an individual, facility-based	TAG	cross-referenced to the APPROPRI DEFICIENCY) completed on 5/6/23. Staff training to ensure the facility will conduct at least two scale or one full scale exercise and a table top exercise to tee the emergency plan at least annually and will use the Mod Drill Form (Attachment D) for completion and proof of the exercise. The training was completed on 6/1/23. Staff will be tested annual the EPP. (Attachment E) Monitoring of Corrective Action: Copies of the completed will be sent to the Program Manager and will also remain the EPP binder in the facility. Completed staff tests will	he vo full se est ck or all on drills
		accordance with 42	mergency plan, as needed in CFR 483.475(d)(2). ice could affect all occupants.		kept in the EPP binder and w sent to Human Resource to remain in staff file.	ill be
		Preparedness Manu 05/03/23 with the I record review from 09/14/23, documen conducted within the period to test the enemergency procedureview. Based on i review, the Direct Street facility was vafter which time Examples.	E"Emergency/Disaster Ial" documentation dated Direct Support Lead during 10:40 a.m. to 11:50 a.m. on tation for at least two exercises the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month the mergency plan using the thres was not available for the most recent twelve month th		Completion Date: 10/7/23	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		15G080	B. W	ING		09/14/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			725 CAI			
RES CAR	RE COMMUNITY AL	LTERNATIVES SOUTH CENTRA	L		IN 47031		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		t Support Lead provided					
		se documentation dated					
		ed emergency evacuation					
	policy and procedures but agreed the facility has						
		econd community based					
		drill, workshop or conducted a					
	-	thin the most recent twelve					
		greed additional testing not available for review at the					
	time of the survey.	not available for review at the					
	time of the survey.						
	These findings were	reviewed with the Direct					
	These findings were reviewed with the Direct Support Lead during the exit conference.						
	Support Zaud during	5 440 0440 00440 0440					
K 0000							
Bldg. 01							
Diag. 01	A Life Safety Code	Recertification Survey was	K 0	000			
	-	diana Department of Health in	KU	000			
	accordance with 42	-					
	Survey Date: 09/14	1/22					
	·						
	Facility Number: 0	00623					
	Provider Number:	15G080					
	AIM Number: 1002	233870					
	-	Code survey, Res Care					
	•	tives South Central was found					
	-	vith Requirements for					
	•	dicaid, 42 CFR Subpart					
	• .	ety from Fire and the 2012					
	Edition of the Natio						
	,) 101, Life Safety Code (LSC),					
		g Residential Board and Care					
	Occupancies.						
	This one store build	ling was not sprinklered. The					
	-	arm system with hard wired					
	-	corridors, in common living					
	SHOKE GETECTION III	corridors, in common fiving					

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	OF CORRECTION	IDENTIFICATION NUMBER 15G080	A. B	UILDING /ING	01	COM	IPLETED 14/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTR	AL	725 CAF	DDRESS, CITY, STATE, Z RR ST IN 47031	IP COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	areas and none in th	te resident bedrooms. The ty of 8 and had a census of 7		9			
	(E-Score) using NF						
K S347	NFPA 101	•					
Bldg. 01	accordance with 9 following exist:	alarms shall be provided in 1.6.2.10, unless either of the					
	approved automat accordance with 3 response or reside	ected throughout by an cic sprinkler system, in 3.2.3.5, that uses quick ential sprinklers, and proved smoke alarms leeping room in					
	by the building ele 2. Buildings are	protected throughout by an ic sprinkler system, in					
	existing battery-po each sleeping roo opinion of the auth	residential sprinklers, with owered smoke alarms in m, and where, in the nority having jurisdiction, the strated that testing,					
	maintenance, and program ensure the smoke alarms. Smoke alarms sha including basemen	a battery replacement ne reliability of power to all be installed on all levels, nt but excluding crawl shed attics. Additional					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 09/14/2023	
	PROVIDER OR SUPPLIEF	R LTERNATIVES SOUTH CENTRA	725 CA	ADDRESS, CITY, STATE, ZIP COD IRR ST , IN 47031	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	smoke alarms sharooms, dens, day These alarms sharooms, dens, day These alarms sharooms, dens, day These alarms sharooms decivated, shall initial audible in all sleep 33.2.3.4.3. Based on observation states smoke alarms building electrical shall initiate an alar areas. This deficient clients, staff and visual findings include: Based on observation decivation of the state of the	on and interview, 5 of 5 client arm in accordance with LSC ally, LSC Section 33.2.3.4.3.5 as shall be powered from the system and, when activated, arm that is audible in all sleeping a practice could affect all sitors. The facility from 11:50 a.m. to 4/23, each of the five client the facility did not have an arm installed in the room. Each soon had a single station to the room. Each smoke alarm installed in the room door to the room. Each smoke ered by the building electrical by operated smoke alarm droom and MC's bedroom were to all other bedroom smoke moke alarm in each of the two da a local alarm in the room bector was tested to alarm.	K S347	K0347: Smoke Detection Corrective Action: Program Director contact Koorsen to obtain a quote to h smoke detectors installed in a bedrooms in the facility. This h ensure all alarms are wired to system and will all sound whe initiated. Program Director will follo up with Koorsen to ensure all documents are received as completed and all inspections completed as scheduled. Monitoring of Corrective Action: Program Director will stay communication with Koorsen a ensure they are scheduling all inspections at the facility. Upon receiving the quote Koorsen for the smoke detect Program Director will sign the quote and schedule the	nave uil will the en ow are / in to I from ors,
	each of the client sl	irect Support Lead agreed eeping rooms was not oke alarm which was powered		installation of the smoke alarn the bedrooms of the facility. Completion Date: 10/7/23	ns in

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPI	LETED
		15G080	B. W	ING		09/14	/2023
	PROVIDER OR SUPPLIER	L LTERNATIVES SOUTH CENTRA	AL.	725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROUDERIG N. I.V. OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
	These findings were	e reviewed with the Direct					
	Support Lead during	g the exit conference.					
K S362	NFPA 101 Corridors - Constr						
Bldg. 01	Corridors - Constr						
	2012 EXISTING (I	• /					
		indicated below, corridor					
	walls shall meet a	ng sleeping rooms have a					
		fire resistance rating,					
		<u> </u>					
	which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute						
	thermal barrier.	ionale promanig a reminate					
		doors are substantial					
		ose of 1-3/4 inch thick,					
	· ·	d-core construction or other					
		ual or greater stability and					
	fire integrity.						
	* Any vision pan	els are fixed fire window					
		ordance with 8.3.4 or are					
	wired glass not ex	ceeding 9 square feet each					
	in area and install	ed in approved frames.					
	This requirement s	shall not apply to corridor					
	walls that are smo	ke partitions in accordance					
		are protected by automatic					
	sprinklers in accor	dance with 33.2.3.5 on					
		vall and door. In such					
		hall be no limitation on the					
	type or size of glas	•					
	·	tion facilities, all sleeping					
		parated from the escape					
		artitions in accordance with					
	8.2.4.						
		ments that are not located in					
		nall be permitted for					
		members, provided that the					
	•	arm in the sleeping area is					
	ı sufficient to awake	en staff that might be	ı				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/14/2023	
	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL	725 C/	ADDRESS, CITY, STATE, ZIP COD ARR ST I, IN 47031	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	group achieves ar using the board ar NFPA 101A, Guid Approaches to Life shall be separated walls and doors the 33.2.3.6 Based on observation failed to ensure combedrooms would restrained visitors. Findings include: Based on observation Lead during a tour of 12:10 p.m. on 09/14 noted in the corrido the bottom of the downwas in the fully Based on interview observations, the Didamages the door from the passage of smoke fully closed and later. These findings were	e Safety, sleeping rooms of from escape routes by the facility of the facility of the facility from 1 of 5 client sist the passage of smoke. The facility from 11:50 a.m. to 14/23, two separate holes were or door to SR's bedroom near foor just above the floor which passage of smoke when the cyclosed and latched position. The facility from 1 of the facility from 1 or just above the floor which passage of smoke when the cyclosed and latched position. The facility and agreed the cyclosed show the floor would not resist the when the door was in the	K S362	K0362: Corridors Corrective Action: Program Director submitt work order to the Maintenance Tech to have the door to SR bedroom replaced due to hole the door. (Attachment F) Monitoring of Corrective Action: All maintenance requests called in to the Program Director repair and follow up. Completion Date: 10/7/23	e es in s are
K S363	NFPA 101 Corridor - Doors				
Bldg. 01	Corridor - Doors Doors shall meet a requirements: 1. Doors shall b	all of the following be provided with latches or			

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JENTERS FOI	C MEDICARE & MEDIC					•	IB NO. 0936-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	LETED
		15G080	B. WII	NG		09/14/	/2023
			<u> </u>		_		
NAME OF I	PROVIDER OR SUPPLIEI	R		STREET A	ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDER OR SOLVEID			725 CA	RR ST		
RES CA	RE COMMUNITY A	LTERNATIVES SOUTH CENTRA	۱ <u>L</u>	MILAN,	IN 47031		
(X4) ID	SUMMADV	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX					PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		
	•	NCY MUST BE PRECEDED BY FULL	•	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	BEITEIENETT		DATE
		s suitable for keeping the					
	door closed.						
		all be arranged to prevent					
		n closing the door.					
	Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected						
	throughout by an	approved automatic					
	sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15.						
	33.2.3.6.4, 33.7.7						
	I	on and interview, the facility	K S	363	K0363: Corridors-Doors		10/07/2023
		ridor doors to 1 of 5 client	11 5505				10/0//2023
		closing or automatic closing			Corrective Action:		
		ed facility. This deficient			Program Director submitt	ed a	
	_	et all clients, staff and visitors.			work order to Rescare	cu a	
	practice could arrec	an enems, starr and visitors.				the	
	Eindings in slude				Maintenance Tech to have all		
	Findings include:				doors inspected to make sure		
	D 1 1	'4 4 D' 40			they close and latch properly		
		ons with the Direct Support			when the alarm is initiated.		
		of the facility from 11:50 a.m. to			(Attachment G)		
	•	4/23, the corridor door to SR's					
		vest exit door of the facility was					
		If closing device but the door			Monitoring of Corrective		
		and latch into the door frame			Action:		
		e multiple times. Based on			All maintenance requests		
		ne of the observations, the			called in to Program Director	or	
	* *	d agreed the aforementioned			repair and follow up.		
		not self close and latch into the					
	door frame when to	ested to close multiple times.					
	These findings wer	re reviewed with the Direct			Completion Date: 10/7/23		
	Support Lead durin	ng the exit conference.					

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