STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING -- B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

(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: 09/14/23 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 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. The facility has 8 certified beds. At the time of the survey the census was 7. Quality Review completed on 09/22/23 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0006 Bldg. --	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), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(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),			

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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	15G080	A. BUILDING -- B. WING	09/14/2023

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	§484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(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) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency			

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	preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to ensure the emergency preparedness plan which was based on a facility-based and community-based risk assessment, utilizing an all-hazards approach that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(a) was specific to the Carr Street location. This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" documentation dated 05/03/23 with the Direct Support Lead during record review from 10:40 a.m. to 11:50 a.m. on	E 0006	**E006: Plan Based on All Hazards Risk Assessment** **Corrective action:** Program Director completed the template to update the Hazard and Vulnerability Assessment Tool to include the risk of train derailment/chemical spill. Upon receiving the Hazard and Risk Assessment back from M&A Transaction Solutions Data and Analytics it will be placed in the facility in the Emergency Preparedness Binder.	10/07/2023

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	15G080	A. BUILDING -- B. WING	09/14/2023

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	09/14/23, it could not be ensured the facility-based and community-based risk assessment, utilizing an all-hazards approach that was reviewed and updated at least every two years was specific to the Carr Street location. The "Operation 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 emergency preparedness program documentation, which were reviewed on 05/03/23, were updated to the Carr Street location but it could not be ensured the facility-based and community-based risk assessment, utilizing an all-hazards approach that was reviewed within the most recent two year period was specific to the Carr Street location. These findings were reviewed with the Direct Support Lead during the exit conference.		Emergency Preparedness Plans are updated annually and as needed by the Program Director. **Monitoring of Corrective Action**: Program Manager will continue to update Emergency Preparedness Plans annually and as needed. Once the Assessment Tool has been updated it will be trained in the facility and placed in the Emergency Preparedness Manual. **Completion Date: 10/7/23**	
E 0013 Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b),			

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	15G080	A. BUILDING -- B. WING	09/14/2023

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	§485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not			

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	15G080	A. BUILDING -- B. WING	09/14/2023

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	limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, it could not be ensured all policies and procedures based on the facility-based and community-based risk assessment, utilizing an all-hazards approach was specific to the Carr Street location. The policies and procedures must be reviewed and updated at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" documentation dated 05/03/23 with the Direct Support Lead during record review from 10:40 a.m. to 11:50 a.m. on 09/14/23, it could not be ensured all policies and	E 0013	**E013: Development of EP policies and Procedures** **Corrective Action:** The Emergency Plan is updated annually and as needed. Area Supervisor trains all staff annually. **(Attachment A)** All new hires are trained as part of their On the Job Training and then annually. Program Director completed the template to update the Hazard and Vulnerability Assessment Tool to include the risk of train derailment/chemical spill. Upon receiving the Hazard	10/07/2023

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	procedures based on the facility-based and community-based risk assessment, utilizing an all-hazards approach was specific to the Carr Street location. The "Operation 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 emergency preparedness program documentation, which were reviewed on 05/03/23, were updated to the Carr Street location but it could not be ensured all emergency preparedness policies and procedures were specific to the Carr Street location. These findings were reviewed with the Direct Support Lead during the exit conference.		and Risk Assessment back from M&A Transaction Solutions Data and Analytics it will be placed in the facility in the Emergency Preparedness Binder. Program Manager created a form to track when emergency plans are reviewed and updated. **(Attachment B)** Program Director will ensure the facility has the most current plans, policies and procedures. Area Supervisor will review the plans in the book when emergency preparedness is reviewed during facility staff meetings. **Monitoring of Corrective Action:** Program Manager will update the emergency preparedness plan at least every year and as needed and ensure the updated information is in the facility and sign on the updated tracking form. On the job training is sent to the Rescare Trainer and Human Resources for review and monitoring for completion. **Completion Date: 10/7/23**	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2),			

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	15G080	A. BUILDING -- B. WING	09/14/2023

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	486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is			

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

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	discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.			

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

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	*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises			

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	15G080	A. BUILDING -- B. WING	09/14/2023

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RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

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	to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING -- B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

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	following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise			

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	15G080	A. BUILDING -- B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

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	is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of			

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	15G080	A. BUILDING -- B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

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	problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires	E 0039	**E039: EP Testing Requirements** **Corrective action:** The facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually and will use the Mock Drill Form **(Attachment C)** for completion and proof of the exercise. The exercise was	10/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING -- B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" documentation dated 05/03/23 with the Direct Support Lead during record review from 10:40 a.m. to 11:50 a.m. on 09/14/23, documentation for at least two exercises conducted within the most recent twelve month period to test the emergency plan using the emergency procedures was not available for review. Based on interview at the time of record review, the 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		completed on 5/6/23. Staff training to ensure the facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually and will use the Mock Drill Form **(Attachment D)** for completion and proof of the exercise. The training was completed on 6/1/23. Staff will be tested annual on the EPP. **(Attachment E)** **Monitoring of Corrective Action**: Copies of the completed drills will be sent to the Program Manager and will also remain in the EPP binder in the facility. Completed staff tests will be kept in the EPP binder and will be sent to Human Resource to remain in staff file. **Completion Date: 10/7/23**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING -- B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

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	location. The Direct Support Lead provided "Evacuation" exercise documentation dated 05/06/23 which tested emergency evacuation policy and procedures but agreed the facility has not documented a second community based disaster drill, mock drill, workshop or conducted a tabletop exercise within the most recent twelve month period and agreed additional testing documentation was not available for review at the time of the survey. These findings were reviewed with the Direct Support Lead during the exit conference.			
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: 09/14/22 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 At this Life Safety Code survey, Res Care Community Alternatives South Central was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building was not sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in common living	K 0000		

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	15G080	A. BUILDING 01 B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	areas and none in the resident bedrooms. The facility has a capacity of 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.3. Quality Review completed on 09/22/23			
K S347 Bldg. 01	NFPA 101 Smoke Detection Smoke Alarms 2012 EXISTING (Prompt) Approved smoke alarms shall be provided in accordance with 9.6.2.10, unless either of the following exist: 1. Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system, or 2. Buildings are protected throughout by an approved automatic sprinkler system, in accordance with 33.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms. Smoke alarms shall be installed on all levels, including basement but excluding crawl spaces and unfinished attics. Additional			

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	15G080	A. BUILDING 01 B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

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	smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. These alarms shall be powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas. 33.2.3.4.3. Based on observation and interview, 5 of 5 client sleeping rooms were not provided with an approved smoke alarm in accordance with LSC 9.6.2.10. Additionally, LSC Section 33.2.3.4.3.5 states smoke alarms shall be powered from the building electrical system and, when activated, shall initiate an alarm that is audible in all sleeping areas.This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Direct Support Lead during a tour of the facility from 11:50 a.m. to 12:10 p.m. on 09/14/23, each of the five client sleeping rooms in the facility did not have an approved smoke alarm installed in the room. Each resident sleeping room had a single station battery operated smoke alarm installed in the room above the corridor door to the room. Each smoke alarm was not powered by the building electrical system. The battery operated smoke alarm installed in SR's bedroom and MC's bedroom were not interconnected to all other bedroom smoke alarms as the the smoke alarm in each of the two rooms only sounded a local alarm in the room when the room detector was tested to alarm. Based on interview at the time of the observations, the Direct Support Lead agreed each of the client sleeping rooms was not provided with a smoke alarm which was powered by the building electrical system.	K S347	**K0347: Smoke Detection** **Corrective Action:** Program Director contacted Koorsen to obtain a quote to have smoke detectors installed in all bedrooms in the facility. This will ensure all alarms are wired to the system and will all sound when initiated. Program Director will follow up with Koorsen to ensure all documents are received as completed and all inspections are completed as scheduled. **Monitoring of Corrective Action:** Program Director will stay in communication with Koorsen to ensure they are scheduling all inspections at the facility. Upon receiving the quote from Koorsen for the smoke detectors, Program Director will sign the quote and schedule the installation of the smoke alarms in the bedrooms of the facility. **Completion Date: 10/7/23**	10/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING 01 B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	These findings were reviewed with the Direct Support Lead during the exit conference.			
K S362 Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING (Prompt) Unless otherwise indicated below, corridor walls shall meet all of the following: * Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, 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. * Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity. * Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are wired glass not exceeding 9 square feet each in area and installed in approved frames. This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels. In Prompt Evacuation facilities, all sleeping rooms shall be separated from the escape route by smoke partitions in accordance with 8.2.4. Sleeping arrangements that are not located in sleeping rooms shall be permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be			

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	15G080	A. BUILDING 01 B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	sleeping. In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms shall be separated from escape routes by walls and doors that are smoke resistant. 33.2.3.6 Based on observation and interview, the facility failed to ensure corridor doors to 1 of 5 client bedrooms would resist the passage of smoke. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Direct Support Lead during a tour of the facility from 11:50 a.m. to 12:10 p.m. on 09/14/23, two separate holes were noted in the corridor door to SR's bedroom near the bottom of the door just above the floor which would not resist the passage of smoke when the door was in the fully closed and latched position. Based on interview at the time of the observations, the Direct Support stated the client damages the door frequently and agreed the corridor door to SR's bedroom would not resist the passage of smoke when the door was in the fully closed and latched position. These findings were reviewed with the Direct Support Lead during the exit conference.	K S362	**K0362: Corridors** **Corrective Action:** Program Director submitted a work order to the Maintenance Tech to have the door to SR bedroom replaced due to holes in the door. **(Attachment F)** **Monitoring of Corrective Action:** All maintenance requests are called in to the Program Director for repair and follow up. **Completion Date: 10/7/23**	10/07/2023
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or			

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	15G080	A. BUILDING 01 B. WING	09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

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	other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. 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			
	Based on observation and interview, the facility failed to ensure corridor doors to 1 of 5 client bedrooms was self-closing or automatic closing for a non-sprinklered facility. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Direct Support Lead during a tour of the facility from 11:50 a.m. to 12:10 p.m. on 09/14/23, the corridor door to SR's bedroom near the west exit door of the facility was equipped with a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Direct Support Lead agreed the aforementioned bedroom door did not self close and latch into the door frame when tested to close multiple times. These findings were reviewed with the Direct Support Lead during the exit conference.	K S363	**K0363: Corridors-Doors** **Corrective Action:** Program Director submitted a work order to Rescare Maintenance Tech to have all the doors inspected to make sure they close and latch properly when the alarm is initiated. **(Attachment G)** **Monitoring of Corrective Action:** All maintenance requests are called in to Program Director for repair and follow up. **Completion Date: 10/7/23**	10/07/2023