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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 03/01/22 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 At this Emergency Preparedness survey, Res Care Community Alternatives South Central was found 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 6. Quality Review completed on 03/03/22	E 0000		
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: 03/01/22 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 At this Life Safety Code survey, Res Care Community Alternatives South Central was found	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	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 areas and none in the resident bedrooms. The facility has a capacity of 8 and had a census of 6 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 1.6. Quality Review completed on 03/03/22			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure 2 of 2 interior emergency lights were tested and the records of the testing maintained. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by	K S100	**K0100:** General Requirements **Corrective Action:** · The Program Manager submitted a work order to Aramark to have the maintenance tech perform testing on the	03/17/2022

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. (2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the test. (5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction. This deficient practice could affect all clients and staff if the facility were required to evacuate in an emergency during a loss of normal power. Findings include: Based on review of "Emergency Light Testing" documentation with The Lead during record review from 10:55 a.m. to 12:35 p.m. on 03/01/22, 90 minute annual functional testing documentation for all facility battery operated lights conducted within the most recent twelve month period was not available for review. The aforementioned documentation stated battery operated lights were functional tested monthly for 30 seconds but did not state when 90 minute annual functional testing was conducted. Based on interview at the time of the observations, The Lead stated additional battery light testing documentation was not available for review and agreed 90 minute annual functional testing		emergency lights in the facility for 30 seconds monthly and 90 minutes annually. **(Attachment A)** · Program Manager updated the tracking form to note the type of test being performed on the emergency lights. **(Attachment B)** · Site Reviews are done monthly by Rescare Management, this includes all required testing including the emergency lights. **(Attachment C)** **Monitoring of Corrective Action:** · Program Manager will contact Aramark for all issues with emergency lights and testing of the emergency lights. · Site Reviews are entered into the CRM database and tracked by the Quality Assurance Manager to ensure completion and follow up on all issues with the Program Manager. **Completion Date: 3/17/22**	

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	documentation for all facility battery operated lights conducted within the most recent twelve month period was not available for review. Based on observations with The Lead during a tour of the facility from 12:35 p.m. to 1:00 p.m. on 03/01/22, a total of two battery powered emergency lights were noted in the facility and each battery operated lighting system functioned when its respective test button was pushed. This finding was reviewed with The Lead during the exit conference.			
K S253 Bldg. 01	NFPA 101 Number of Exits - Patient Sleeping and Non-Sl Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Prompt) Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, each sleeping room shall have a second means of escape that consists of one of the following: 1. It shall be a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape. 2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of			

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	escape. 3. It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 square feet. The width shall be not less than 20 inches. The height shall be not less than 24 inches. The bottom of the opening shall be not more than 44 inches above the floor. Such means of escape shall be acceptable where one of the following criteria are met: a. The window shall be within 20 feet of finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an exterior balcony. 4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following: 1. The ladder or steps do not extend more than 6 inches into the well. 2. The ladder or steps are not obstructed by the window. 5. If the sleeping room has a door leading directly to the outside of the building with access to finished ground level or to a stairway that meets the requirements of exterior stairs in 33.2.2.2.2, that means of			

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	escape shall be considered as meeting all the escape requirements for the sleeping room. a. A second means of escape from each sleeping room shall not be required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5. b. Existing approved means of escape shall be permitted to continue to be used. 33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through 33.2.2.3.4 Based on observation and interview, the facility failed to ensure 1 of 5 client sleeping rooms were provided with a secondary means of escape in accordance with 33.2.2.3. LSC 33.2.2.3 requires a secondary egress from each sleeping room with multiple provisions. This deficient practice could affect one client in the south bedroom. Findings include: Based on observations with The Lead during a tour of the facility from 12:35 p.m. to 1:00 p.m. on 03/01/22, the bedroom window in the south bedroom would not open following repeated attempts to open the window. Based on interview at the time of the observations, The Lead agreed the aforementioned means of egress in the south bedroom did not open to the minimum dimensions for a window to be used as a secondary means of egress. This finding was reviewed with The Lead during the exit conference.	K S253	**K0253: Number of Exits** **Corrective Action:** · Program Manager completed a work order and sent to Aramark for repair or replacement/repair of the bedroom window to ensure it opens and shut properly and to ensure the safety of all clients living in the facility. **(Attachment D)** · Rescare Management will complete environmental checks daily at this location until Aramark has completed the work order to have the bedroom window replaced/repaired. **(Attachment E)** · Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues. **(Attachment C)** **Monitoring of Corrective**	03/17/2022

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			Action: · Rescare Administration will complete monthly Site Reviews and send to the Program Director and Executive Director for monitoring of completion. · Environmental checks completed daily at the facility will be sent to the Program Manager for monitoring of completion and review. · Program Director will follow up on issues noted on the Site review and submit to the Program Manager for follow up on the issues. **Completion Date: 3/17/22**	
K S258 Bldg. 01	NFPA 101 Number of Exits - Patient Sleeping and Non-Sl Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Slow) In Slow Evacuation Capability facilities, the primary means of escape for each sleeping room shall not be exposed to living areas and kitchens, unless the building is protected by an approved automatic sprinkler system in accordance with 33.2.3.5 utilizing quick-response or residential sprinklers throughout. 33.2.2.2.3 Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier doors separating sleeping rooms from living areas and kitchens had no impediment to closing and	K S258	**K0258: Number of Exits** **Corrective Action:** · Program Manager	03/17/2022

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	latching into the door frame. This deficient practice could affect all clients and staff. Findings include: Based on observations with The Lead during a tour of the facility from 12:35 p.m. to 1:00 p.m. on 03/01/22, the smoke barrier door separating the kitchen and the living room from the west hallway was held in the fully open position with a wall mounted magnetic holding device set to release with fire alarm system activation. The door was prevented from closing because a chair and a laundry basket were placed in front of the door which would prevent the door from self-closing or automatic closing in the event the fire alarm system was activated. When the chair and laundry basket were removed, the magnetic holding device kept the door in the fully open position. When the door was manually closed, the door closed and latched into the door frame. The west hallway provided access to the five bedrooms in the facility. Based on interview at the time of the observations, The Lead stated a client moved the chair to be in front of the door, the chair is not normally in front of the door but agreed the smoke barrier door had an impediment to closing and latching into the door frame with the chair and the laundry basket placed in front of the smoke barrier door. This finding was reviewed with The Lead during the exit conference.		completed a work order and sent to Aramark for a door closure to be added to the bedroom door so that it will close properly and to ensure the safety of all clients living in the facility. **(Attachment F)** · All staff trained on not propping fire doors open with chairs, backpacks or any object at all that is not an approved magnetic closure. **(Attachment G)** · Rescare Management will complete environmental checks 3 times weekly to ensure there is nothing blocking the fire doors and preventing them from closing and latching properly. **(Attachment E)** · Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues. **(Attachment C)** **Monitoring of Corrective Action:** · Rescare Administration will complete monthly Site Reviews and send to the Program Director and Executive Director for monitoring of completion. · Environmental checks completed daily at the facility will be sent to the Program Manager for monitoring of completion and review.	

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			· Program Director will follow up on issues noted on the Site review and submit to the Program Manager for follow up on the issues. **Completion Date: 3/17/22**	
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 manual fire alarm systems was maintained in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 states all initiating devices shall be functional tested annually. This deficient practice could affect all clients, staff and visitors.	K S345	**K0345:** Testing and Maintenance **Corrective Action:** · Program Manager contacted Aramark to contact Koorsen to ensure when functional testing is completed on the fire alarm system that all reports are complete including whether the items tested pass or fail the test. **(Attachment H)** · Program Manager contacted	03/17/2022

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Findings include: Based on review of the fire alarm system inspection contractor's "Systems Service" documentation dated 12/14/21 with The Lead during record review from 10:55 a.m. to 12:35 p.m. on 03/01/22, documentation of an itemized list of the location and results of functional testing all fire alarm system initiating devices in the facility within the most recent twelve month period was not available for review. The 12/14/21 documentation stated under the "Job Description" section of the report "test heat detectors in the attic" but it did not state the results of the test. Additional fire alarm system inspection and testing documentation within the most recent twelve month period was not available for review. Based on interview at the time of record review, The Lead agreed documentation of an itemized listing of the location and results of functional testing for all fire alarm system initiating devices in the facility within the most recent twelve month period was not available for review. This finding was reviewed with the The Lead during the exit conference.		Aramark to discuss concern regarding Koorsen completing inspections, providing reports and reporting noted issues from reports. **(Attachment I)** **Monitoring of Corrective Action:** · Program Manager will follow up with Aramark to ensure all documents are received as completed and all inspections are completed as scheduled. · Aramark will send completed reports to Rescare Program Manager to ensure all reports are in the facility. **Completion Date: 3/17/22**	
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 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			

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	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: a. 2 of 5 client bedrooms had no impediment to closing and latched into the door frame. b. 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 Lead during a tour of the facility from 12:35 p.m. to 1:00 p.m. on 03/01/22, the corridor door to the northwest bedroom was propped in the fully open position with a back pack placed on the floor in front of the door. The corridor door to the north bedroom was propped in the fully open position with a wedged placed on the floor under the door. The corridor door to the southwest bedroom by the west hallway exit door was not self-closing or automatic closing. The door was not equipped with a self-closing device or self-closing hinges. Based on interview at the time of the observations, The Lead stated the client in the north bedroom needs to have supervision at all times but agreed the aforementioned bedroom doors had an impediment to closing and latching into the door frame or were not self-closing or automatic closing.	K S363	**K0363:** Corridor Doors **Corrective Action:** · All staff trained on not propping fire doors open with chairs, backpacks or any object at all that is not an approved magnetic closure. **(Attachment G)** · Rescare Management will complete environmental checks 3 times weekly to ensure there is nothing blocking the fire doors and preventing them from closing and latching properly. **(Attachment E)** · Program Manager completed a work order and sent to Aramark for a door closure to be added to the bedroom door so that it will close properly and to ensure the safety of all clients living in the facility. **(Attachment F)** · Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues. **(Attachment C)**	03/17/2022

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	This finding was reviewed with The Lead during the exit conference.		**Monitoring of Corrective Action:** · All maintenance requests are called in to Aramark for repair and follow up is completed by the Program Manager. · Aramark will send completed reports to Rescare Program Manager to ensure all reports are in the facility. **Completion Date: 3/17/22**	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be			

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second shift for 2 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Emergency Evacuation Drill: Fire" with The Lead during record review from 10:55 a.m. to 12:35 p.m. on 03/01/22, documentation of a fire drill conducted on the second shift in the first quarter (January February, March) 2021 was not available for review. In addition, documentation for a fire drill conducted on the second shift in the second quarter (April, May, June) 2021 was also not available for review. Based on interview at the time of record review, The Lead stated the facility operates three shifts per day, additional fire drill documentation was not available for review and agreed second shift fire drill documentation for the aforementioned calendar quarters in 2021 was not available for review. This finding was reviewed with The Lead during the exit conference.	K S712	**K0712: Fire Drills** **Corrective Action:** ·Fire Drills were completed at the facility in the first and second quarter of 2021 but staff failed to file them properly. Upon checking the database that is managed by the Quality Assurance Manager, she had record of both fire drills being completed for the quarters in question. ·The Quality Assurance Manager will be maintaining a file at the office of all information she enters in the database regarding drills and we will be able to ensure upon request that we have a copy of all completed drills. ·Area Supervisor will complete a weekly check to ensure drills are conducted as scheduled. **(Attachment J)** ·Rescare Administration will complete monthly site reviews to ensure all drills are completed as scheduled**. (Attachment C)**	03/17/2022

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			Monitoring of Corrective Action: ·The Area Supervisor will conduct a weekly check to ensure scheduled completions of the drills and send to the Program Manager. ·The Safety Committee will monitor quarterly for completion of scheduled drills. ·Rescare Administration Site Reviews wills be sent to the Program Director and Executive Director once completed. **Completion Date: 3/17/22**	
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2			

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Based on record review, observation and interview; the facility failed to ensure the facility's smoking policy was current and smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 areas where smoking is permitted. This deficient practice could affect all clients, staff and visitors. Findings include: Based on review of "Smoking Guidelines/Policy for Group Homes" documentation with The Lead during record review from 10:55 a.m. to 12:35 p.m. on 03/01/22, the designated smoking area for the home was stated as "outside back door". The smoking policy also stated "there should be only one smoking area for each home" and "the smoking area should be away from guest entrances. For example, do not smoke at the front door". Based on observations with The Lead during a tour of the facility from 12:35 p.m. to 1:00 p.m. on 03/01/22, the designated smoking area was on the front porch with a smoking tower supplied for the area in which to deposit cigarette butts. The front porch also had one open top ash tray with an extinguished cigarette but in the ashtray. The west hallway exit was the only other facility exit and it was not supplied with an ashtray of noncombustible material and safe design and a metal container with self-closing cover devices into which ashtrays can be emptied. Based on interview at the time of record review, The Lead stated no clients smoke but staff members smoke. The Lead stated the smoking area for the facility has been moved to the front porch and agreed the smoking area was now on the front porch which	K S741	**K0741: Smoking Regulations** **Corrective Action:** · Area Supervisor will inservice all staff that smoking can only occur where a noncombustible receptacle is located for disposal of cigarette butts. **(Attachment G)** · Program Manager completed a work order to Aramark to have them order a new noncombustible ashtray to be used at the facility. **(Attachment K)** · Area Supervisor will include the smoking policy and train all staff that they can only use the safety type ashtrays at the facility on the back area of the facility and not other non-safe containers monthly during staff meetings. **Monitoring of Corrective Action:** · Area Supervisor will send the Program Manager all trainings or inservices completed on staff for proper disposal of their cigarette waste and monthly staff meetings. · Site Reviews are completed monthly by Management staff to ensure safety at the facility. Management staff will note the use of proper disposal of cigarette waste is being used.	03/17/2022

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	03/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	was not current with the smoking policy for the facility. This finding was reviewed with The Lead during the exit conference.		**Completion Date: 3/17/22**	