STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G193	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 08/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	13711 BENNETTSVILLE RD MEMPHIS, IN 47143

(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
K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/17/12 Facility Number: 000723 Provider Number: 15G193 AIM Number: 100234760 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Res Care Community Alternatives SE IN was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and client sleeping rooms. The facility has a capacity of 7 and had a census of 7 at the time of this survey.	K0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.3. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/23/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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KS147	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1 Based on record review and interview, the facility administration failed to periodically instruct and keep employees informed with respect to their duties and responsibilities under the written emergency plan not less than every 2 months to protect 7 of 7 clients. A copy of the plan is readily available at all times within the facility. This deficient practice would affect all clients in the facility. Findings include: Based on review of the Fire Evacuation Plan policy and Emergency Evacuation Drill Reports on 08/17/12 at 10:10 a.m.	KS147	The Administration has put into effect a plan that the QA Team will oversee. Ensuring that the Operations Manager SGL, instructs the Program Coordinator periodically in the event of fire, so that staff responses are well informed with respect to their duties and responsibilities whenever any resident with unusual needs is admitted to the home. QA will follow up with the Program Coordinator / Staff on a monthly basis, ensuring that documentation / drills are done. Also that required documentation is turned in and meets Life Safety Code Standards. This will ensure the safety of 7 of 7 clients and all staff.	09/16/2012

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	with the home manager, there was no documentation indicating employees were periodically instructed and kept informed with respect to their duties and responsibilities under the plan for the period between 11/29/11 through 06/22/12. Based on an interview with the home manager on 08/17/12 at 10:20 a.m., the home manager indicated there was no other documentation available for review to indicate employees were periodically instructed and kept informed with respect to their duties and responsibilities under the Fire Evacuation Plan Policy every two months between 11/29/11 through 06/22/12.			

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KS152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) 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 - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be 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. Based on record review and interview, the facility failed to conduct fire drills at least quarterly on 3 of 3 shifts during the past year. This deficient practice affects all clients in the facility. Findings include: Based on a review of the Emergency Evacuation Drill Reports with the home	KS152	The Operations Manager SGL will develop and implement a process for evaluating all emergency drills under varied conditions. The drills will be completed by the Program Coordinator with input from the home staff. The drills will be kept on file in the home and a copy in the Quality Assurance Office. This will ensure the safety of all clients in the facility. The Operations Manager SGL will	09/16/2012

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	manager on 08/17/12 at 10:10 a.m., there was no evidence of a first shift, second shift or third shift fire drill for the first quarter of the year 2012. Based on a review of the Emergency Evacuation Drill Reports by the home manager and interview on 08/17/12 at 10:15 a.m., it was confirmed there was no other evidence available for review to indicate the missed fire drills were conducted.		periodically review the home files to ensure the drills and evaluations are completed. To meet the requirements of the NFPA Life Safety Code.	