STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G184	A. BUILDING -- B. WING	12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	1818 H ST BEDFORD, IN 47421

(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 State Department of Health in accordance with 42 CFR 483.475. Survey Date: 12/17/18 Facility Number: 000717 Provider Number: 15G184 AIM Number: 100234700 At this Emergency Preparedness survey, Res Caare Community Alt Se 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 8. Quality Review completed on 12/26/18 - DA	E 0000		
E 0004 Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all clients in the facility. Findings include: Based on record review of the Emergency Preparedness Plan on 12/17/18 at 12:30 p.m. with the Residential Manager (RM), documentation for	E 0004	**E004: Develop EP Plan, Review and Update Annually** **Corrective action:** · Emergency Preparedness Plan, EPP (Attachment A) updated on 1-10-19 and will be placed in the home. · Staff training (Attachment B) on the EPP. **How we will identify others**: · Area Supervisor will ensure	01/16/2019

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

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	15G184	A. BUILDING -- B. WING	12/17/2018

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	a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review the RM stated the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve month period.		the EPP is updated annually. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all of its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	

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E 0007 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 12:30 p.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not address a. patient population that would be at risk. b. address what services the facility would be able to provide. c. continuity of operations. Based on interview concurrent with record review it was acknowledged by the RM the EPP did not address items a, b, or c.	E 0007	**E007: EP Program Patient Population** **Corrective action:** · Patient Population that would be at risk is identified at the bottom of the "Operation Description" form (Attachment C). · Staff training (Attachment E) on the "Operation Description" form and all it entails. · The EPP will address what services the facility would be able to provide in the Continuity of Operations Plan (Attachment D). · The Continuity of Operations Plan (Attachment D) will be in place in the EPP to specify the continuity of operations. · Staff Training (Attachment E) on the Continuity of Operations form. **How we will identify others**: · Area Supervisor will ensure the EPP has the Operation Description form in place. · Area Supervisor will ensure the Continuity of Operations Form is in place and staff are trained. **Measures to be put in place:** · The Area Supervisor will ensure the EPP has the Operation Description form in the Emergency Preparedness Manual and staff have knowledge of where it is kept	01/16/2019

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			in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0015 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and	E 0015	**E015: Subsistence Needs for Staff and Patients** **Corrective action:**	01/16/2019

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	clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 12/17/18 at 11:35 a.m. with the Residential Manager (RM) the emergency preparedness plan did not address: 1) Alternate sources of energy to maintain . 2) Emergency lighting. 3) Fire detection, extinguishing, and alarm systems 4) proper disposal of sewage and waste. Based on interview concurrent with record review with the RM it was stated this policy did not contain information concerning items 1through 4.		· Sheltering-in-place Policy (Attachment F) details the alternate sources of energy to maintain other than seeking alternate shelter in an emergency. · The Emergency Food Supply Form (Attachment G) details the items needed, including emergency lighting, for an emergency and should be in the emergency food supply containers. · The Fire Watch Plan (Attachment H) details how to handle fire detection, extinguishing, and alarm during an emergency disaster. · Sheltering-in-place Policy (Attachment F) informs of the proper disposal of sewage and waste. · All staff will be trained (Attachment E) in the following plans and how to implement: Sheltering-in-place, Emergency Food Supply Form and The Fire Watch Plan. **How we will identify others**: · Area Supervisor will ensure the EPP is updated annually. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the	

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			Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0018 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and	E 0018	**E018: Procedures for Tracking of Staff and Patients** **Corrective action:** · A form to track the whereabouts of staff and clients during an emergency evacuation	01/16/2019

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	location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 1:36 p.m. with the Residential Manager (RM) there was nothing in the Emergency Preparedness policy which addressed a system to track the whereabouts of staff and clients during an emergency evacuation. Based on interview concurrent with record review with the RM it was acknowledged there was nothing in the policy which addressed the tracking of staff and clients.		will be implemented for management staff by 1-16-19. **How we will identify others**: · The system to track the whereabouts of staff and clients during an emergency evacuation will start with staff following the chain of command. Upon any emergency, staff will follow the chain of command to alert management staff of the emergency. Management staff will be responsible for alerting all team members and guardians of the emergency. · Area Supervisor will ensure the EPP is updated annually. **Measures to be put in place:** · The Program Manager or designee will be responsible for the tracking of clients and staff during an emergency situation. · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all of its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's,	

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			Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0022 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for clients, staff, and volunteers who remain in the facility in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 12/17/18 at 1:42 p.m. with the Residential Manager (RM), a policy and procedure that included a means to shelter in place for residents, staff, and volunteers who remain in the facility was not available for review. Based on interview at the time of review it was acknowledged by the RM the Emergency	E 0022	**E022: Policies/Procedures for Sheltering in Place** **Corrective action:** · Sheltering-in-place Policy (Attachment F) will be placed in the EPP to acknowledge a shelter in place for clients, staff and volunteers who remain in the facility. · Staff will be trained (Attachment F) on the Sheltering-in-Place Policy. **How we will identify others**: · Area Supervisor will ensure Sheltering-in-place Policy and the	01/16/2019

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	Preparedness Plan did not include a means to shelter in place for clients, staff, and volunteers who remain in the facility		EPP is updated annually and all staff are trained. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	

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E 0024 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 1:46 p.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not address the use of volunteers in an emergency. Based on interview at the time of record review with the RM it was confirmed the plan did not address use of volunteers.	E 0024	**E024: Policies/Procedures-Volunteers and Staffing** **Corrective action:** · The ROC Handbook Overview (Attachment I) details the use of volunteers in an emergency. · All staff will be trained (Attachment E) on the ROC Handbook Overview. **How we will identify others**: · Area Supervisor will ensure the ROC Handbook overview is in the EPP and all staff are trained. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's,	01/16/2019

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			Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0025 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Plan with the Residential Manager (RM) on 12/17/18 at 1:40 p.m., there was no documentation of policy and procedures for the arrangement with	E 0025	**E025: Arrangement with Other Facilities** **Corrective action:** · The Continuity of Operations Plan (Attachment D) addresses the arrangement with other facilities to receive clients in the event of clients from another facility needed to evacuate. **How we will identify others**: · Area Supervisor will ensure the EPP is updated annually. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated	01/16/2019

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	other facilities to receive clients in the event of clients from another facility needed to evacuate. This was confirmed by the RM at the time of record review.		annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0026 Bldg. --				

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	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all clients. Findings include: Based on record review on 12/17/18 at 1:53 p.m. with the Residential Manager (RM) there was nothing in the emergency preparedness manual which addressed compliance with the 1135 waiver declared by the Secretary. Based on interview concurrent with record review with the RM it was stated she was unaware this waiver needed to be addressed and stated the policy would be updated to include the 1135 waiver.	E 0026	**E026: Roles Under a Waiver Declared by Secretary** **Corrective action:** · "Requesting an 1135 Waiver" (Attachment J) defines the role of the ICF/IID facility under a waiver declared by the secretary, in accordance with section 1135 of the Act. · All staff will receive training (Attachment E) on the "Requesting an 1135 Waiver" (Attachment J). **How we will identify others**: · Area Supervisor will ensure the EPP includes a copy of the "Requesting an 1135 Waiver" for and is updated annually. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of	01/16/2019

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			each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0030 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 1:38 p.m. with the Residential Manager (RM) the Emergency Preparedness Plan (EPP) did not document: a. Client Physicians. b. Contact information for other ICF's, or c. Volunteers. Based on interview concurrent with record review	E 0030	**E030: Names and Contact Information** **Corrective action:** · A copy of everyone's Emergency Phone List (Attachment K) will be placed in the EPP. · The Continuity of Operations Plan (Attachment D) lists information for other ICF's and will be placed in the EPP. · The ROC's (Attachment L) identifies volunteers to use in an emergency. **How we will identify others**: · The Emergency Phone List (Attachment K) details all client	01/16/2019

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	1818 H ST BEDFORD, IN 47421

(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
	with the RM it was confirmed the communication portion of the EPP did not include items a , b, or c.		physicians and will be placed in the EPP. · Area Supervisor will ensure all Emergency Phone Lists are placed in the EPP. · The ROC's phone list identifies volunteers and will be placed in the EPP. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing	

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			Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0034 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 12:37 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction (AHJ) or IC. Based on interview cocurrent with record review with the RM it was acknowledged the EPP did not include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction (AHJ) or IC.	E 0034	**E034: Information on Occupancy/Needs** **Corrective action:** · The Continuity of Operations Plan (Attachment D) provides a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction or IC and will be placed in the EPP. · All staff will be trained (Attachment E) on the Continuity of Operations Plan. **How we will identify others**: · Area Supervisor will ensure the EPP includes a copy of the Continuity of Operations Plan (Attachment D) and staff training. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual	01/16/2019

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			and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0035 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients	E 0035	**E035: LTC and ICF/IID Sharing Plan with Patients** **Corrective action:** · A method to share	01/16/2019

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	and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 1:58 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include a method to share information the facility has deemed appropriate with clients and their families or representatives. Based on interview concurrent with record review with the RM it was acknowledged the EPP did not include a method to share appropriate information with clients and their families or representatives.		appropriate information with clients and their families or representatives will be written by the Program Manager by 1-16-19 and will be placed in the EPP. · All staff will be trained on the new method to share information. **How we will identify others**: · Area Supervisor will ensure the EPP includes a copy of manual to share information to clients and families. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that	

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			home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0036 Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 1:59 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include a training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.475(d). Based on interview concurrent with record review with the RM it was acknowledged the EPP did not include a training and testing program.	E 0036	**E036: Training and Testing** **Corrective action:** · Staff will receive the EPP Required Training and document on the training form (Attachment M). All training will be completed annually. · All staff will complete the Emergency Preparedness Testing (Attachment N). Upon completion, this test will be placed with the EPP. **How we will identify others**: · Area Supervisor will ensure the EPP includes a copy of the EPP Required Training and all staff Emergency Preparedness Testing form. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness	01/16/2019

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			Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training	E 0037	**E037: EP Training Program** **Corrective action:**	01/16/2019

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	program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 12/17/18 at 1:49 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include a. Initial training in emergency preparedness policies and procedures to all new and existing staff. b. Provide EPP training at least annually. c. Maintain documentation of the training. d. Demonstrate staff knowledge of emergency procedures. Based on interview concurrent with record review with the RM it was stated the EPP did not contain items a, b, c, and d described above.		· All new and existing staff will receive the EPP Required Training and document on the training form (Attachment M). · All training will be completed annually and maintained in the EPP. **How we will identify others**: · Area Supervisor will ensure the EPP includes a copy of the Annual EPP Required Training on all new and existing staff. · A Mock Drill (Attachment O) will be completed by staff to demonstrate staff knowledge of emergency procedures. Completed Drill will be faxed to Program Manager upon completion for review and follow-up if necessary. Program Manager will forward drill on to the QA department for review/follow-up and filing purposes. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team,	

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			consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional	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 O) for completion and proof of the exercise. · 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	01/16/2019

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	exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise 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 record review on 12/17/18 at 1:50 p.m. with the Residential Manager (RM) the facility did not document the participation in a (i) full scale community-based or individual, facility-based exercise and (ii) conduct a second exercise or a table top exercise for the past year. Nor had the facility experienced an actual natural or manmade emergency which required the activation of the facility's emergency plan. Based on interview concurrent with record review with the RM it was stated the facility had not participated in at least two full scale exercises or one full scale exercise and a table top exercise for the past year.		the emergency plan at least annually and will use the Mock Drill Form (Attachment O) for completion and proof of the exercise. · **How we will identify others**: · Area Supervisor will ensure Mock drill form is sent to the Program Manager for review and follow-up. Program Manager will forward Mock Drill to the QA department for review and filing. **Measures to be put in place:** · The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. · Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. **Monitoring of Corrective Action**: · The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. · Site Review forms will be reviewed by each Area Supervisor and Program Manager for that	

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			home and follow-up as necessary to correct all issues. · AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	
K 0000 Bldg. 01	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: 12/17/18 Facility Number: 000717 Provider Number: 15G184 AIM Number: 100234700 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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This two story facility with a basement was not sprinkled. This facility has a fire alarm system with smoke detection on all levels including the corridors, common living areas, basement and hard wired smoke detectors in all client sleeping	K 0000		

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	rooms. The facility has a capacity of 8 and had a census of 8 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 Prompt with an E-Score of 0.9. Quality Review completed on 12/26/18 - DA			
K S346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written fire watch policy for when the fire alarm system is out of service for more than 4 hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review on 12/17/18 at 1:55 p.m. with the Residential Manager (RM), the facility provided a fire watch plan but it was incomplete. The plan failed to contact the Indiana State Department of Health (ISDH) through the "gateway". Based on interview during the record review with the RM it was confirmed the fire watch documentation provided did not contact	K S346	**K0346: Fire Alarm System – Out of Service** **Corrective action:** · The fire watch plan (Attachment H) will include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health Gateway. · All Staff will be in-serviced (Attachment E) on the updated fire watch plan which includes the web link for the ISDH gateway. **How we will identify others:** · Direct Support Lead and	01/17/2019

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	ISDH through the "gateway".		Area Supervisor will review the Fire Watch Plan monthly during the Monthly Staff meetings. Monthly staff meeting in-service to be sent to Program Manager for review. · DSL and AS will maintain the web link for the ISDH website and ensure all staff are aware of where and how to use it, if need be. **Measures to be put in place:** · Program Manager to review the monthly house meeting agenda to ensure all staff have been trained on the Fire Watch Plan and all its contents. **Monitoring of Corrective Action**: · Program Manager to review monthly house meeting agenda and ensure all staff have been trained on the Fire Watch Plan. · Management team will complete monthly site review checklist at each home. Team member completing the checklist will check to see the Fire Watch Plan, including web link for ISDH, is present in the plan. · Program Director, Program Manager, Executive Director, HR Manager, Nursing Manager will perform Best in Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 1-16-19**	