STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING -- B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

(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: 12/20/18 Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510 At this Emergency Preparedness survey, Res Care Community Alternatives Se In 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 4 Quality Review completed on 01/02/19 - DA The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	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 483.475(a). This deficient practice could affect all occupants. Findings include:	E 0004	**E 004 EP Develop EP Plan, Review and Update Annually:** 1.The emergency preparedness program will be reviewed annually by the safety committee and a committee member will sign off on the review form located in the emergency preparedness manual.	01/19/2019

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 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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	Based on record review with the Program Manager on 12/20/18 at 11:02 a.m., the emergency preparedness documentation indicated the last time the plan was reviewed on 07/21/17. Based on interview at the time of record review, the Program Manager confirmed the plan was updated over a year ago.		2.The Safety Committee, program manager, area supervisor and associate executive director will ensure the documentation of annual review of the program is in place in the manual.	
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 with the Program Manager on 12/20/18 at 11:03 a.m., the emergency preparedness plan failed to address 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. Based on interview at the time of record review then again during the exit conference, the Program Manager confirmed the lack of documentation.	E 0007	**E 007 EP Program Patient Population:** 1.The administrator will ensure the emergency plan policies and procedures addresses 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). 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. **DATE OF COMPLETION: January 19, 2019**	01/19/2019
E 0009 Bldg. --				

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	Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 12/20/18 at 11:05 a.m., no documentation was available to show the group home included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Based on interview at the time of record review, the Program Manager confirmed no contact has been made and no more documentation was available for review.	E 0009	**E 009 EP Local, State, Tribal Collaboration Process:** 1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses notification of the Indiana State Department of Health during a disaster or emergency. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	01/19/2019
E 0013 Bldg. --	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants.	E 0013	**E 013 EP Development of Policies and Procedures:** 1.The emergency plan policies and procedures will be updated and reviewed annually. 2.The area supervisor and program manager will train all staff	01/19/2019

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	Findings include: Based on record review with the Program Manager on 12/20/18 at 11:05 a.m., the policies and procedures of the facility's emergency preparedness plan indicated the plan was last updated on 07/21/17. Based on interview at the time of record review then again at the exit conference, the Program Manager confirmed the plan has not been updated in over a year.		on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	
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 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 observation with the Program Manager on 12/20/18 at 11:23 a.m., the facility was unable to provide documentation for the policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place for sewage and waste disposal. Based on interview at the time of record review, the Program Manager confirmed no	E 0015	**E 015 Subsistence Needs for Staff and Patients:** 1.The administrator will ensure the emergency plan policies and procedures addresses the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, including but 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). 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be	01/19/2019

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	documentation was available to review for the provision of the aforementioned subsistence needs.		placed in the Emergency Disaster Preparedness Manual for reference as needed.	
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 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 with the Program Manager on 12/20/18 at 11:25 a.m., no policies and procedures which 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 was available to review. Based on interview at the time of record review, the Program Manager confirmed no such documentation was available to review.	E 0018	1.The administrator will ensure the emergency plan policies and procedures addresses the tracking of staff and clients, whether they evacuate or shelter in place. Including the consideration of care and treatment needs of evacuees, staff responsibilities; transportation; identification of evacuation locations; and primary and means of communication with external assistance. 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	01/19/2019
E 0020 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the ICF/IID facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities;	E 0020	1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses safe evacuation of from the ICF/IID facility and includes consideration	01/19/2019

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	transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.475(b)(3). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 12/20/18 at 11:32 a.m., no policies and procedures which include information for safe evacuation from the ICF/IID facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance was available for review. Based on interview at the time of record review then again during the exit conference, the Program Manager confirmed no evacuation policy was available for review.		of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	
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 ICF/IID 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 12/20/18 at 11:32 a.m., the Program Manager confirmed no policies and procedures which include information	E 0022	1.The administrator will ensure the emergency plan policies and procedures addresses a means to shelter in place for staff, volunteers and clients who remain in the facility. Including but 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;	01/19/2019

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	about a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility was available for review.		(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). 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	
E 0023 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 12/20/18 at 11:33 a.m., no policies and procedures which include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records was available to review. Based on interview at the time of record review, the Program Manager confirmed no such documentation was available for review.	E 0023	1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses a system of medical documentation of from the ICF/IID facility and includes consideration of maintaining protection of confidentiality of patient information and secures and maintains availability of records. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	01/19/2019
E 0024				

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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 with the Program Manager on 12/20/18 at 11:33 a.m., no policies and procedures which include the use of volunteers in an emergency or other emergency staffing strategies was available for review. Based on interview at the time of record review, the Program Manager confirmed no such documentation was available for review.	E 0024	1.The emergency plan policies and procedures will be updated to include volunteers in an emergency or other emergency staffing strategies including the integration of State and Federal designated healthcare professionals to address surge needs during an emergency. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	01/19/2019
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 record review with the Program Manager on 12/20/18 at 11:33 a.m., no policies and	E 0025	1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses arrangements with other ICF/IID facilities and/or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program	01/19/2019

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	procedures which 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 was available for review. Based on interview at the time of record review, the Program Manager confirmed no such documentation was available for review.		overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed	
E 0026 Bldg. --	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 occupants. Findings include: Based on record review with the Program Manager on 12/20/18 at 11:39 a.m., no policies and procedures which include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was available for review. Based on interview at the time of record review, the Program Manager confirmed no such documentation was available for review.	E 0026	1.The administrator will ensure the table of contents for the emergency disaster preparedness manual is updated to include the location of the policy on the Roles of the facility Under a Waiver declared by Secretary is in the emergency preparedness manual. 2.The area supervisor and program manager will train all staff on the table of contents, the policy and procedure, where to locate the policy, and the policy will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	01/19/2019
E 0029 Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency	E 0029	1.The emergency plan policies and procedures will develop and	01/19/2019

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	preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.475(c). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 12/20/18 at 11:40 a.m., the emergency preparedness communication plan was updated on 07/21/17. Based on interview at time of record review, the Program Manager confirmed the communication plan was updated over a year ago.		maintain an emergency preparedness plan that complies with Federal, State and local laws that must be reviewed annually. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	
E 0033 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 12/20/18 at 11:33 a.m., no documentation was available for a communication plan which includes (4) A method for sharing	E 0033	1.The emergency plan policies and procedures will develop and maintain an emergency preparedness plan that complies with Federal, State and local laws that must be reviewed annually to include a method for sharing information and medical documentation for patients under the facility's care; a means of releasing patient information as permitted under 45 CFR 164.510(b)(1)(ii); a means of providing information general information and location of patients as permitted under 45 CFR 164.510(b)(1)(ii). 2.The area supervisor and program manager will train all staff on the communication plan and the plan will be present in the Emergency Disaster	01/19/2019

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	information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care. Based on interview at the time of record review, the Program Manager confirmed no documentation was available for review.		Preparedness Manual for reference as needed.	
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 with the Program Manager on 12/20/18 at 11:45 a.m., the facility was unable to provide documentation for a communication plan including 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. Based on interview at the time of record review, the Program Manager confirmed no documentation was available for review.	E 0034	1.The administrator will ensure the emergency plan policies and procedures will be updated to include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction. 2.The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed	01/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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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 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 with the Program Manager on 12/20/18 at 11:45 a.m., the facility was unable to provide documentation for a communication plan which includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives. Based on interview at the time of record review, the Program Manager confirmed no documentation was available for review.	E 0035	1.The administrator will develop and maintain an emergency preparedness plan that complies with Federal, State and local laws that must be reviewed annually to include a method for sharing information the facility has determined appropriate, with clients and their family or representatives. 2.The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed	01/19/2019
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 with the Program Manager on 12/20/18 at 11:50 a.m., no emergency preparedness training and testing plan was	E 0036	1.The administrator will ensure the emergency plan policies and procedures annual emergency training and testing program in accordance with CFR 483.475(d) is implemented in all locations and evidence of the annual training and testing is present in the EPP manual. 2.The area supervisor and program manager will train all staff on the annual training and testing	01/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING -- B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	available for review. Based on interview at the time of record review, the Program Manager confirmed no such documentation was available for review.		and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed.	
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training 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 with the Program Manager on 12/20/18 at 11:50 a.m., no emergency preparedness training and testing program was available for review. Based on interview at the time of record review, the Program Manager confirmed no documentation was available for the emergency preparedness training and testing program.	E 0037	1.The administrator will ensure the emergency plan policies and procedures initial training in emergency preparedness policies and procedures to all new and existing staff, annual emergency training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed in accordance with CFR 483.475(d)(1) and present in the EPP manual. 2.The area supervisor and program manager will provide initial training to all existing staff and new staff and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed.	01/19/2019
E 0039 Bldg. --	Based on record review and interview, the facility	E 0039	1.The administrator will ensure	01/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING -- B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	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 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 with the Program Manager on 12/20/18 at 11:55 a.m., no documentation was available for a second community-based or tabletop exercise drill. Based on interview at the time of record review, the Program Manager confirmed that only one exercise was available for review.		the emergency plan policies and procedures includes the participation in a full-scale community based exercise and a table top exercise in accordance with CFR 483.475(d)(2) and present in the EPP manual. 2.The area supervisor and program manager will conduct the table top exercise and ensure documentation of the table top exercise and the community based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 03 B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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K 0000 Bldg. 03	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: 12/20/18 Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510 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 one 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 rooms. The facility has a capacity of 8 and had a census of 4 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 0.2. Quality Review completed on 01/02/19 - DA	K 0000		
K S100 Bldg. 03	NFPA 101 General Requirements - Other General Requirements - Other			

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	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 observation and interview, the facility failed to ensure 1 of 1 Kitchen portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect all occupants. Findings include: Based on observation with the Program Manager on 12/20/18 at 12:50 a.m., the Kitchen fire extinguisher located sixty three inches from the floor. Based on interview at the time of observation, the Program Manager provided the measurement.	K S100	1.The maintenance coordinators will be trained by the program managers to ensure the Portable Fire Extinguishers are secured on hangers in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4. 2.The maintenance coordinators will ensure all fire extinguishers in the facility are secured on hangers.	01/19/2019
K S200 Bldg. 03	NFPA 101 Means of Egress Requirements - Other Means of Escape Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.2 Means of Escape 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 and interview, the facility	K S200	1.The maintenance coordinators	01/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 03 B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	failed to maintain 1 of 1 battery operated emergency light in accordance with 33.1.1.3. 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 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 occupants if the facility were required to evacuate in an emergency during a loss of normal power. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include:		will be trained by the program managers to ensure the battery-operated emergency lighting in accordance with 33.1.1.3 LSC. The facility will ensure function testing is preformed monthly with a minimum of 3 weeks and maximum of 5 weeks between tests for not less than 30 seconds. Function test shall be conducted annually for a minimum of 1 ½ hours ensuring the emergency lighting equipment is fully operational for the duration of the test. The facility will maintain written records of visual inspections for the Authority Having Jurisdiction. 2.Maintenance coordinators will ensure all battery-operated emergency lighting is tested in accordance with 33.1.1.3 LSC and written documentation of testing is maintained and available for the Authority Having Jurisdiction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 03 B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Based on record review with the Program Manager on 12/20/18 between 12:28 a.m. .and 12:56 p.m., no documentation for the monthly and annual battery operated emergency light documentation. Based on interview at the time of observation, the Program Manager acknowledged the lack of monthly and annual testing documentation.			
K S253 Bldg. 03	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 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			

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	15G157	A. BUILDING 03 B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	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 escape shall be considered as meeting all the escape requirements for the sleeping room. a. A second means of escape from each			

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	15G157	A. BUILDING 03 B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	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 1. Based on observation and interview, the facility failed to ensure 5 of 5 clients sleeping rooms was provided with a secondary means of escape in accordance with 33.2.2.3. LSC 33.2.2.3 requires a secondary escape from each sleeping room with multiple provisions. This deficient practice could affect all occupants. Findings include: Based on observation with the Program Manager on 12/20/18 between 12:36 p.m. and 12:56 p.m., the following was discovered: a) bedroom 1 only window would not open b) bedroom 2 window provided a clear width of eleven inches when opened c) bedroom 3 window provided a clear width of eleven inches when opened d) bedroom 4 window provided a clear width of eleven inches when opened e) bedroom 5 window crank was missing Based on interview at the time of each observation, the Program Manager confirmed the windows wouldn't open and the ones that did only provided eleven inches of clear width when opened. 2. Based on observation and interview, the facility failed to ensure 2 of 5 clients sleeping rooms was provided with an unobstructed secondary means of escape in accordance with 33.2.2.3. This deficient practice could affect at least 2 clients.	K S253	1.The administrator will ensure client sleeping rooms maintain a secondary escape with multiple provisions including windows providing a clear with of eleven inches when open and an unobstructed secondary means of escape in accordance with 33.2.2.3. 2.The Program Director will schedule repair/replacement of the window with the ResCare maintenance coordinator. The ResCare maintenance coordinator will inspect all windows to ensure they meet all criteria for means of escape. The facility manager will ensure secondary means of escape are not blocked with furniture.	01/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 03 B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	Findings include: Based on observation with the Program Manager on 12/20/18 between 12:36 p.m. and 12:56 p.m., bedroom #1 had a window as the secondary escape. In front of the window was a table. Then again, the bedroom #2 had a window as a secondary escape. In front of the window was furniture. Based on interview at the time of each observation, the Program Manager acknowledged each window was obstructed.			
K S345 Bldg. 03	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 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NPFA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by	K S345	1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate	01/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 03 B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 12/20/18 between 12:28 a.m. and 12:56 p.m., no documentation for an annual fire alarm test and a biannual smoke detector sensitivity test was available for review. Based on interview at the time of record review, the Program Manager acknowledged the aforementioned condition and confirmed no other documentation was available for review.		year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. 3.The executive director and the QA manager will meet with Koorsen Fire and Security to ensure they are completing all system testing as required by LSC 9.6.1.3 and NFPA 14.4.5.3.2.	
K S363 Bldg. 03	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 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 5 of 5 client rooms doors were self-closing or automatic-closing and positively latched into the frame. This deficient practice could affect all occupants.	K S363	1.The administrator will ensure clients bedroom doors have self-closing or automatic-closing devices installed. 2.The maintenance coordinator will ensure all clients bedroom	01/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 03 B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	Findings include: Based on observation with the Program Manager on 12/20/18 between 12:36 p.m. and 12:56 p.m., all five client bedrooms doors did not have self-closing devices installed. Based on interview at the time of each observation, the Program Manager confirmed the doors did not have self-closing hardware installed.		doors have self-closing or automatic-closing devices installed.	
K S712 Bldg. 03	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 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)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 03 B. WING	12/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

(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
	Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters in accordance with 42 CFR 483.470(i). 42 CFR 483.470(i) Standard: Evacuation drills. This deficient practice affects all staff and clients. Findings include: Based on record review of the "Emergency Evacuations Drill" form with the Program Manager on 12/20/18 between 12:28 a.m. and 12:56 p.m., there was no documentation for a third shift fire drill in the second quarter of 2018. Based on interview at the time of record review, the Program Manager acknowledged the lack of documentation.	K S712	1.All staff at the home will be re-trained on conducting fire drills quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date.	01/19/2019