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	01/22/2019

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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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 12/20/18 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 01/22/19 Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510 At this PSR survey, Res Care Community Alternatives Se In was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey, the census was 4 Quality Review completed on 01/28/19	E 0000		
K 0000 Bldg. 03	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/20/18 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 01/22/19 Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510	K 0000		

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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	At this PSR 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 01/28/19			
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 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	K S200	1.The maintenance coordinators will be trained by the program managers to ensure the battery-operated emergency lighting in accordance with	03/31/2019

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	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: Based on record review with the Program Manager on 01/22/19 at 2:59 p.m., no documentation for the monthly and annual battery		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. 3.The Emergency Exit light will be relocated to a position that will allow required testing without use of special equipment. Bids will be collected by February 15, 2019 and contractor selected by February 28, 2019. The Emergency Light will be moved before March 31, 2019. 4.ResCare Maintenance will preform monthly 30 Second testing of the Emergency Lighting is complete and documented and ensure Koorsen Fire and Security preforms annual 90 minute test as required. 5.ResCare Maintenance will document monthly test of	

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	operated emergency light documentation. Based on interview at the time of observation, the Program Manager acknowledged the lack of monthly and annual testing documentation. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		Emergency Lighting. Documentation of testing will remain on sight for verification and a backup cop kept off sight. Testing will be verified by Program Manager and Area Supervisor quarterly. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager	
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			

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	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 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			

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	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 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 01/22/19 between 2:56 p.m. and 3:20 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.	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. 3.Bedroom window 1 and bedroom window 5 will be replaced to ensure an approved means of escape. February 15, 2019 and contractor selected by February 28, 2019. The replacement windows will be installed before	05/31/2019

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	This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence. 2. Based on observation and interview, the facility failed to ensure 1 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 1 client. Findings include: Based on observation with the Program Manager on 01/22/19 at 2:59 p.m., bedroom #2 had a window as a secondary escape. In front of the window was a piece of furniture. Based on interview at the time of each observation, the Program Manager acknowledged the window was obstructed. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		March 31, 2019. 4.The facility will perform function check of windows during monthly drills to ensure windows are operating properly and report any defect through the maintenance request form when discovered. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager ***** Additional Information ***** The original window selected from provider did not meet the 5.7 square foot egress requirement. A second provider has been located the window has been purchased and is currently scheduled for manufacture with Gilkey windows. The program manager met with Kelly Lockman to ensure the replacement window meets egress requirement the new window will have 10.57sq ft opening 32.75x46.50 size. This window has a 8-12 week manufacture lead time, and will be installed as soon as possible by Gilkey Window Company Louisville. The 4 Casement windows will be replaced with single hung windows that does not require a crank to open, these windows meet the 5.7 sq ft egress requirement. They have been purchased from Menards and will be installed by ResCare Maintenance by 31	

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			March 2019. Point of contact for this work is Mark Slaughter Program Manager (502) 609-5333.	
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 compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include:	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 year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will	02/21/2019

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	Based on record review with the Program Manager on 01/22/19 at 2:59 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. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		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	02/21/2019

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	Findings include: Based on observation with the Program Manager on 01/22/19 between 2:56 p.m. and 3:20 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. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		doors have self-closing or automatic-closing devices installed. 3.All corridor doors had self closing latches installed by ResCare Maintenance and doors positively latch to frame installation and repair on February 18, 2019. 4.Self closing doors will be tested monthly by staff to ensure doors positively latch to frame. If a defective door is found it will be reported through the ResCare Maintenance form and repairs scheduled. Area Supervisor and Program Manager will inspect door closers quarterly to ensure proper operation. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager	