

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 02/06/25</p> <p>Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190</p> <p>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.</p> <p>The facility has 7 certified beds. At the time of the survey, the census was 7.</p> <p>Quality Review completed on 02/07/25</p>	E 0000		
E 0039 Bldg. --	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2) EP Testing Requirements</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do all of the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID</p>	E 0039	<p>CNN/Provider Number: 15G175 AIM Number: 100243190 Facility ID: 000709</p> <p>PROVIDER: ResCare Community Alternative Se In 4341 Security Parkway Suite 101 New Albany, IN 47150</p>	02/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Tracy Callahan

Program Manager

02/21/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2025	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator 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. <p>(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.</p> <p>Findings include:</p> <p>Based on records review and interview with the Area Supervisor (AS) on 02/05/25 between 10:33 a.m. and 11:45 a.m., the facility did document participation in a tabletop exercise of choice which counted as one of the two required annual exercises but could not provide documentation of an actual emergency or a required full-scale exercise that is community-based or individual, facility-based for the past year. Based on interview concurrent with record review with the AS, it was stated there was no documentation of an actual emergency and she did not believe the facility participated in a full-scale exercise which implemented the EPP for the past twelve months.</p>			<p>Survey Event ID CVK821 3607 Middle Road, Jeffersonville DATE OF SURVEY: February 6, 2025</p> <p>E039 EP Testing Requirements CFR(s)483.475(d)(2)</p> <p>The Program Manager will ensure that the home participates in 2 annual community-based drills.</p> <p>The Program Manager will ensure that the certifications of completion are given to the area supervisor to place in the EPP manual.</p> <p>The Program manager will follow up and visit the site to check the EPP manual to ensure the certificates are in there.</p> <p>The Program manager will retrain the area supervisor and the DSL on the EPP manual to ensure that the proper paperwork is in the manual.</p> <p>Persons Responsible: AED, Quality Assurance Manager, QA Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Support lead, and DSP.</p> <p>DATE OF COMPLETION: February 28, 2025</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD 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
K 0000 Bldg. 02	<p>This deficient finding was acknowledged by the AS at the time of discovery and again at the exit conference with the AS and Team Lead present.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 02/06/25</p> <p>Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190</p> <p>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.</p> <p>This two-story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and in all living areas. The facility has heat detectors installed in the attic. The facility has a capacity of 7 and had a census of 7 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.56.</p> <p>Quality Review completed on 02/07/25</p>	K 0000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K S353 Bldg. 02	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads in the home were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect everyone in the facility.</p> <p>Findings include:</p> <p>Based on a tour of the facility and interview with the Area Supervisor (AS) on 02/05/25 between 11:45 a.m. and 12:10 p.m., most of the sprinkler heads in the home were covered in lots of dust or showed signs of loading.</p> <p>This deficient finding was acknowledged by the AS at the time of discovery and again at the exit conference with the AS and Team Lead present.</p>	K S353	<p>CNN/Provider Number:15G175 AIM Number: 100243190 Facility ID: 000709</p> <p>PROVIDER: ResCare Community Alternative Se In 4341 Security Parkway Suite 101 New Albany, IN 47150</p> <p>Survey Event ID CVK821 3607 Middle Road, Jeffersonville DATE OF SURVEY: February 6, 2025</p> <p>K0353 Sprinkler System-Maintenance and Testing CFR(s): NFPA 101 The maintenance manager will ensure that Koorsen is contacted to clean and replace any sprinkler heads that are damaged.</p> <p>The Program manager will follow up/work with the maintenance manager to ensure completion.</p> <p>The Area supervisor and the DSL will be in-serviced on contacting Program manager for any future issues with sprinkler heads.</p> <p>Persons Responsible: AED,</p>	02/28/2025

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K S511 Bldg. 02	<p>NFPA 101 Utilities - Gas and Electric</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 4 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location.</p> <p>Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders.</p> <p>(B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel.</p> <p>(1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors</p> <p>Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance</p>	K S511	<p>Quality Assurance Manager, QA Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Support lead, and DSP.</p> <p>DATE OF COMPLETION: February 28, 2025</p> <p>CNN/Provider Number:15G175 AIM Number: 100243190 Facility ID: 000709</p> <p>PROVIDER: ResCare Community Alternative Se In 4341 Security Parkway Suite 101 New Albany, IN 47150</p> <p>Survey Event ID CVK821 3607 Middle Road, Jeffersonville DATE OF SURVEY: February 6, 2025</p> <p>KO511 Utilities-Gas and Electric CFR(s): NPA101 The maintenance manager will replace the receptacle for the sump pump with a GFCI receptacle. The maintenance manager will repair or replace the exposed wires or light fixtures in the lights in the basement.</p>	02/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD 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
	<p>with 426.28 or 427.22, as applicable.</p> <p>Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection.</p> <p>(5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink.</p> <p>Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection.</p> <p>Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required.</p> <p>(6) Indoor wet locations</p> <p>(7) Locker rooms with associated showering facilities</p> <p>(8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools.</p> <p>NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p>		<p>The maintenance manager will contact an electrical company if he is not able to correct the issues.</p> <p>The Program manager will follow up with the maintenance manager to ensure completion.</p> <p>Persons Responsible: AED, Quality Assurance Manager, QA Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Support lead, and DSP.</p> <p>DATE OF COMPLETION: February 28, 2025</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2025	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Based on a tour of the facility and interview with the Area Supervisor (AS) on 02/05/25 between 11:45 a.m. and 12:10 p.m., the sump pump in the basement was plugged into a receptacle that was not a GFCI receptacle. It could not be confirmed that the aforementioned receptacle was on a GFCI circuit.</p> <p>This deficient finding was acknowledged by the AS at the time of discovery and again at the exit conference with the AS and Team Lead present.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring according to 33.2.5.1. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a tour of the facility and interview with the Area Supervisor (AS) on 02/05/25 between 11:45 a.m. and 12:10 p.m., in the living room electrical equipment including a TV and a charging device was plugged into and powered by a multi-plug adaptor. Based on interview at the time of observation, the AS agreed electrical equipment was plugged into a multi-plug adaptor. The adaptor was removed during the survey.</p> <p>This deficient finding was acknowledged by the AS at the time of discovery and again at the exit conference with the AS and Team Lead present.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
	<p>3. Based on observation and interview, the facility failed to ensure 2 of 2 exposed wiring lights located in the basement was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect all clients at staff.</p> <p>Findings include:</p> <p>Based on a tour of the facility and interview with the Area Supervisor (AS) on 02/05/25 between 11:45 a.m. and 12:10 p.m., there were exposed electrical wires in 2 replacement ceiling lights in the basement. Based on interview at the time of observation, the AS agreed there was exposed wiring and the covers were missing in 2 basement ceiling light fixtures.</p> <p>This deficient finding was acknowledged by the AS at the time of discovery and again at the exit conference with the AS and Team Lead present.</p>			