STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G167	A. BUILDING -- B. WING	12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(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: 12/04/18 Facility Number: 000701 Provider Number: 15G167 AIM Number: 100248800 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 7 certified beds. At the time of the survey, the census was 7. Quality Review completed on 12/06/18 - DA The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0009 Bldg. --	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	E 0009	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	01/03/2019

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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	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 review of emergency preparedness documentation on 12/04/18 between 9:45 a.m. to 11:45 a.m. with the Area Supervisor present, the emergency preparedness plan did not include a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials 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. The aforementioned plan did not include notification of the Indiana State Department of Health other than for fire watch notification purposes. Based on interview at the time of record review, the Area Supervisor said the plan did not include a process for cooperation and collaboration with the Indiana State Department of Health other than for fire watch notification purposes.		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 residents, 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	E 0015	**E 015 Subsistence Needs for Staff and Patients:** 1.The administrator will ensure the emergency plan policies and procedures includes the updated Shelter-In-Place policy which addresses 1) alternative sources of energy, 2) emergency lighting,	01/03/2019

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	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 review of emergency preparedness documentation on 12/04/18 between 9:45 a.m. to 11:45 a.m. with the Area Supervisor present, the facility's emergency preparedness plan provided did not address the loss of sewage and waste disposal in an emergency. Based on interview at the time of records review, the Area Supervisor said the plan did not address the loss of sewage and waste disposal in an emergency.		3) fire detection, extinguishing and alarms, and 4) proper disposal of sewage and waste. 2.The area supervisor and program manager will train all staff on the updated Shelter-In-Place policy and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	
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: During review of the emergency preparedness documentation on 12/04/18 between 9:45 a.m. and 11:45 a.m. with the Area Supervisor present, there was no documentation in the facility's emergency preparedness plan of policy and procedures for	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 overview will be placed in the Emergency Disaster Preparedness Manual for	01/03/2019

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	the arrangement with other facilities to receive residents in the event of operations in the facility. Based on interview at the time of record review, the Area Supervisor said the emergency preparedness documentation did not include emergency preparedness policies and procedures for the arrangement with other facilities to receive residents in the event of operations in the facility.		reference as needed.	
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: 12/04/18 Facility Number: 000701 Provider Number: 15G167 AIM Number: 100248800 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 was not sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and common living areas. The facility has a capacity of seven and had a census of seven at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative	K 0000		

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	Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 2.84. Quality Review completed on 12/06/18 - DA			
K S712 Bldg. 01	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) Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 1 of 3 shifts during 2 of 4 quarters during the past 12 months. This deficient practice could affect all clients.	K S712	1.All staff at the home will be re-trained on completing fire drills every quarter and on all shifts. The Residential Manager will review all drills to ensure all	01/03/2019

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	Findings include: Based on review of the facility's fire drill reports on 12/04/18 between 9:45 a.m. and 11:45 a.m. with the Area Supervisor present, there was no fire drill documentation available for the second shift (evening) of the first quarter (January, February, and March), and second quarter (April, May, and June) of 2018. Based on interview at the time of record review, the Area Supervisor confirmed the lack of fire drills during the previously mentioned shift and quarters of 2018 and further said she thought the drills had been performed, but said they could not be found.		required drills are performed and that all employees are participating in the drills. 2.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home, accurately completed, and up to date.	