STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING 01 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL 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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 10/31/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 12/08/22 Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810 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 building with a basement was non sprinklered. The facility has a fire alarm system with smoke detection in corridors and all living areas, plus the basement. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.8. Quality Review completed on 12/12/22	K 0000		
K S100	NFPA 101 General Requirements - Other			

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

Patrick O'Heran | QIDP Manager | 01/06/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING 01 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL 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
Bldg. 01	General Requirements - Other 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 3 of 3 interior emergency lights were tested, maintained, and the records of the testing maintained. 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 clients and staff. Findings include: Based on observations on 12/08/22 between 12:00	K S100	To correct the deficient practice, the service provider inspected and repaired the emergency lights on 12-12-22. All staff responsible for LSC features have been re-trained ensuring LSC features are functional and inspected timely. Supervisory staff have been trained ensuring all POC items are addressed by the due date set within the POC. Ongoing monitoring will be achieved by the lead and AS completing a LSC inspection monthly. As well as that, the QIDP Lead will be monitoring the progress of all submitted POCs.	01/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING 01 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL 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
	p.m. and 12:30 p.m. during a tour of the facility with the QIDP, the facility had three battery powered emergency light units. Based on record review between 12:00 p.m. and 12:30 p.m., there was no documentation to show the battery powered emergency lights were tested for 30 seconds monthly during the past 12 month period, furthermore, there was no documentation available for an annual 90 minute test during the past 12 months. Based on interview at the time of record review and observations, the QIDP said there was no documentation to show a 30 monthly test for for the past 12 month period, plus an annual 90 minute test during the past 12 months for the three battery powered emergency lights. This finding was reviewed with the QIDP during the exit conference. This deficiency was cited on 10/31/22. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K S300 Bldg. 01	NFPA 101 Protection - Other Protection - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.3 Protection 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, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 6 of 6 battery operated smoke alarms in client rooms was available for review. NFPA 101 in 4.6.12.3 states existing life safety features obvious	K S300	To correct the deficient practice the batteries will be replaced. The battery replacement will be documented on monitoring sheet. All staff responsible for LSC features have been re-trained	01/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING 01 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL 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
	to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review on 12/08/22 between 12:00 p.m. and 12:30 p.m. with the QIDP present, there was no documentation available to show that client room battery operated smoke alarms were tested monthly, furthermore, there was no documentation to show when the batteries were last changed in the client room battery operated smoke alarms. Based on interview at the time of record review, the QIDP said there was no documentation available to show a monthly test of the client room smoke alarms or when the batteries were last changed in the smoke alarms. Based on observations during a tour of the facility with the QIDP, there was one battery operated smoke alarm in each of the six client sleeping rooms. This finding was reviewed with the QIDP during the exit conference. This deficiency was cited on 10/31/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		ensuring LSC features are functional and inspected timely. Supervisory staff have been trained ensuring all POC items are addressed by the due date set within the POC. Ongoing monitoring will be achieved by the lead and AS completing a LSC inspection monthly. As well as that, the QIDP Lead will be monitoring the progress of all submitted POCs.	
K S345	NFPA 101 Fire Alarm System - Testing and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING 01 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL 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
Bldg. 01	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 complete documentation was provided for 1 of 1 fire alarm system 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. This deficient practice could affect all clients and staff. Findings include: Based on record review on 12/08/22 between 12:00 p.m. and 12:30 p.m. with the QIDP present, there was documentation for an annual fire alarm system test/inspection, plus smoke detector sensitivity test dated 02/17/22, and a semi-annual fire alarm system visual inspection dated 08/17/22 by the facility's fire alarm system vendor, however, the documentation for both reports was incomplete. The inspection reports provided did not include an test/inspection/sensitivity test of the three hard wired smoke detectors and the one pull station located in the basement. Based on interview at the time of record review, the QIDP acknowledged the lack of information about the	K S345	To correct the deficient practice the smoke detectors and pull station were inspected on 12-19-22. All staff responsible for LSC features have been re-trained ensuring LSC features are functional and inspected timely. Supervisory staff have been trained ensuring all POC items are addressed by the due date set within the POC. Ongoing monitoring will be achieved by the lead and AS completing a LSC inspection monthly. As well as that, the QIDP Lead will be monitoring the progress of all submitted POCs. Addendum: The service provider will be contacted to complete sensitivity testing on the three basement smoke detectors and inspect the pull station in the basement. A written report will be available for review upon completion of the	01/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING 01 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL 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
	three basement smoke detectors and one pull station being tested/inspected/sensitivity tested during the annual and semi-annual fire alarm system inspections dated 02/17/22 and 08/17/22. This finding was reviewed with the QIDP during the exit conference. This deficiency was cited on 10/31/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		inspections.	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING 01 B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL 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
	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 a fire drill was conducted quarterly on 3 of 3 shifts during 3 of 4 quarters during the past 12 months. This deficient practice could affect all clients. Findings include: Based on record review on 12/08/22 between 12:00 p.m. and 12:30 p.m. with the QIDP present, there were no fire drill reports available for review for the following shifts and quarters: a. First Shift (day) of the forth quarter (October, November, and December) of 2021 and so far in 2022, and the first quarter (January, February, and March) of 2022 b. Second shift (evening) of the first quarter (January, February, and March) of 2022, and the third quarter (July, August, and September) of 2022 c. Third shift (night) of the forth quarter (October, November, and December) of 2021 and so far in 2022, and the third quarter (July, August, and September) of 2022. Furthermore, the facility was unable to provide a fire drill report since the time of the annual Life Safety Code survey conducted on 10/31/22. Based on interview at the time of record review, the QIDP said there were no other fire drill reports available to review. This finding was reviewed with the QIDP during the exit conference. This deficiency was cited on 10/31/22. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S712	To correct the deficient practice drills will be conducted for each shift prior to 1-8-22. A drill calendar for 2023 has been created and staff have been trained. All staff responsible for LSC features have been re-trained ensuring LSC features are functional and inspected timely. Supervisory staff have been trained ensuring all POC items are addressed by the due date set within the POC. Ongoing monitoring will be achieved by the lead and AS completing a LSC inspection monthly. As well as that, the QIDP Lead will be monitoring the progress of all submitted POCs.	01/08/2023