

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

PRINTED: 01/03/2024
FORM APPROVED
OMB NO. 0938-039

| | | | |
|--------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G136 | X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2023 |
|--------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------|

| | |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 427 W LONGEST ST PAOLI, IN 47454 |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------|

| (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 Department of Health in accordance with 42 CFR 483.475. Survey Date: 12/06/23 Facility Number: 000673 Provider Number: 15G136 AIM Number: 100248740 At this Emergency Preparedness 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 8. Quality Review completed on 12/08/23 | E 0000 | | |
| K 0000 Bldg. 01 | A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 12/06/23 Facility Number: 000673 Provider Number: 15G136 AIM Number: 100248740 At this Life Safety Code survey, Res Care Community Alternatives SE IN was found not in | K 0000 | | |

| | | |
|---------------------------------------------------------------------------------------------|------------------|-----------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Mark Slaughter | TITLE AED | (X6) DATE 12/21/2023 |
|---------------------------------------------------------------------------------------------|------------------|-----------------------------|

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.

| | | | |
|--------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G136 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2023 |
|--------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------|

| | |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 427 W LONGEST ST PAOLI, IN 47454 |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------|

| (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. 01 | <p>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 one story facility with a basement was not sprinklered. This facility has a fire alarm system with hard wired smoke detection on both levels including the corridors, common living areas, the basement and all client sleeping rooms. The facility has a capacity of 8 and had a census of 8 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 Prompt with an E-Score of 0.6.</p> <p>Quality Review completed on 12/08/23</p> <p>NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 4 wet locations was 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</p> | K S511 | <p>1 The Program Manager will ensure GFCI protection circuit is installed for receptacles within 6 feet of the kitchen sink.</p> <p>2 The Program Manager contacted ResCare Maintenance and schedule a service call to ensure GFCI protected outlets are</p> | 12/21/2023 |

| | | | |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G136 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2023 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

| | |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP COD 427 W LONGEST ST PAOLI, IN 47454 |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------|

| (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>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 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</p> | | <p>installed as required by NFPA 101.</p> <p>3 ResCare Maintenance will ensure the installation of GFCI protected outlets within 6 feet of the kitchen sink as required by NFPA 70, Nec 2011 at 210.8 before December 21, 2023.</p> <p>Persons Responsible: Program Manager, ResCare Maintenance.</p> | |

| | | | |
|--------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G136 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 12/06/2023 |
|--------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------|

| | |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE 427 W LONGEST ST PAOLI, IN 47454 |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCY (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>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>Based on observation on 12/06/23 between 9:30 a.m. and 11:30 a.m. during a tour of the facility with the Area Supervisor and Maintenance Tech, there were three electric receptacles within five feet of the kitchen sink that were not provided with GFCI protection. When tested with a GFCI testing device it did not break the electrical circuit for any of the three receptacles within five feet of the kitchen sink. Based on interview at the time of observations, the Area Supervisor and Maintenance Tech agreed the electric receptacles within five feet of the kitchen sink were not provided with GFCI protection, and further said GFCI receptacles would be added as soon as possible.</p> <p>This finding was reviewed with the Area Supervisor and Maintenance Tech during the exit conference.</p> | | | |