STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G136	A. BUILDING -- B. WING	12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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 State Department of Health in accordance with 42 CFR 483.475. Survey Date: 12/17/18 Facility Number: 000673 Provider Number: 15G136 AIM Number: 100248740 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 8 certified beds. At the time of the survey, the census was 7. Quality Review completed on 12/21/18 - DA	E 0000		
E 0004 Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all clients in the facility. Findings include: Based on record review of the Emergency Preparedness Plan on 12/17/18 at 12:30 p.m. with the Residential Manager (RM), documentation for	E 0004	1.The emergency preparedness program will be reviewed annually by the safety committee and a committee member will sign off on the review form located in the emergency preparedness manual. 2.The Safety Committee, program manager, area supervisor and associate executive director will ensure the documentation of annual review of the program is in place in the manual.	01/16/2019

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

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	a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review the RM stated the facility has not had its emergency preparedness program reviewed by the facility within the most recent twelve month period.			
E 0007 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 12:30 p.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not address delegations of authority and succession plans. Based on interview concurrent with record review it was acknowledged by the RM the EPP did not address delegations of authority and succession plans.	E 0007	1.The emergency plan policies and procedures will be updated to include a) continuity of operations and b) Delegations of authority and succession plans. 2.The area supervisor and program manager will train all staff on the policies and procedures updates and the updates will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	01/16/2019
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	E 0015	1.The administrator will ensure the emergency plan policies and procedures includes the updated Shelter-In-Place policy which	01/16/2019

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	clients, 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 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 record review and interview on 12/17/18 at 11:35 a.m. with the Residential Manager (RM) the emergency preparedness plan did not address: 1) Alternate sources of energy to maintain . 2) Emergency lighting. 3) Fire detection, extinguishing, and alarm systems 4) Proper disposal of sewage and waste. Based on interview concurrent with record review with the RM it was stated this policy did not contain information concerning items 1through 4.		addresses 1) alternative sources of energy, 2) emergency lighting, 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:	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	01/16/2019

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	Based on review of the Emergency Preparedness Plan with the Residential Manager (RM) on 12/17/18 at 12:40 p.m., there was no documentation of policy and procedures for the arrangement with other facilities to receive clients in the event of clients from another facility needed to evacuate. This was confirmed by the RM at the time of record review.		on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	
E 0030 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 12:38 p.m. with the Residential Manager (RM) the Emergency Preparedness Plan (EPP) did not document: a. Contracted entities. b. Client Physicians. c. Contact information for other ICF's, or d. Volunteers. Based on interview concurrent with record review with the RM it was confirmed the communication portion of the EPP did not include items a , b, c or d.	E 0030	1.The administrator will ensure the emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses a) contact information for other ICF's and b) client physicians. 2.The area supervisor and program manager will train all staff on the policies and procedures updates and the updates will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	01/16/2019
E 0031 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact	E 0031	1.The administrator will ensure the emergency plan policies and procedures will be updated to	01/16/2019

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	information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) Other sources of assistance (iii) The State Licensing and Certification Agency (iv) The State Protection and Advocacy Agency in accordance with 42 CFR 483.475(c)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 12:35 p.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not include how to communicate with the Indiana Protection and Advocacy Services (IPAS). Based on interview concurrent with record review with the RM it was acknowledged the EPP did not include the means to communicate with IPAS in the communication portion of the EPP.		include a continuity of operations plan which includes how to communicate with Indiana Protection and Advocacy Services (IPAS). 2.The area supervisor and program manager will train all staff on the continuity of operations plan and the plan will be present in the Emergency Disaster Preparedness Manual for reference as needed.	
E 0034 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. Findings include: Based on record review on 12/17/18 at 12:37 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include a method to share occupancy needs and ability to provide assistance to the Authority Having	E 0034	1.The administrator will ensure the emergency plan policies and procedures will be updated to include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction. 2.The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed.	01/16/2019

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	Jurisdiction (AHJ) or IC. Based on interview cocurrent with record review with the RM it was acknowledged the EPP did not include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction (AHJ) or IC.			
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise 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; (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.	E 0039	1.The administrator will ensure the participation in a full-scale community-based exercise and a table top exercise is present in the EPP manual. 2.The area supervisor and program manager will ensure documentation of the table top exercise and the community-based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review, and update annually as needed.	01/16/2019

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	Findings include: Based on record review on 12/17/18 at 12:30 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include the participation in a full scale community based exercise for the past year. Based on interview concurrent with record review with the RM it was stated the facility had not participated in a full scale community based exercise for the past year.			
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: 12/17/18 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 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	K 0000		

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	census of 7 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 0.95. Quality Review completed on 12/21/18 - DA			
K S100 Bldg. 01	NFPA 101 General Requirements - Other 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 record review and interview; the facility failed to ensure 1 of 1 battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. 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 on 12/17/18 at 12:13 p.m., with the Residential Manager (RM) there were	K S100	1.The administrator will ensure a functional test of emergency lighting equipment will be conducted for 30 seconds at 30-day intervals and an annual test will be conducted on every required battery-operated emergency lighting system for not less than a 90-minute duration. Koorsen Fire and Security will conduct the 90-minute annual testing and the maintenance coordinator will conduct the monthly 30 seconds testing. Both parties conducting the testing will then provide proper documentation to the Program Manager upon completion. 2.The Program Manager will monitor to ensure the facility	01/16/2019

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	battery powered lights located in the Family room first floor and the basement. Only the Family room light had been tested for 30 seconds one a month, but no 90 minute annual test had been done. The basement light had not been tested at all for the past year. Based on interview at the time of record review, the RM acknowledged there was no documentation for an annual 90 minute test for the Family room light and no tests had been done for the light in the basement..		remains in compliance with regulatory requirements. The Program Manager will train the maintenance coordinators on conducting the testing and maintaining documentation.	
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15.			

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	33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii) 1. Based on observation and interview, the facility failed to ensure 1 of 3 exterior exit doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect all occupants in the facility. Findings include: Based on observation on 12/17/18 at 12:10 p.m. during a tour of the facility with the Resident Manager (RM) the basement exit door was equipped with two latching devices, a regular door handle with a turn lock and a separate deadbolt lock. This was acknowledged by the RM at the time of observation. 2. Based on observation and interview, the facility failed to ensure 1 of 2 bathroom doors with locks on the inside were arranged such that staff can rescue clients in an emergency if the bathroom door becomes locked from the inside. This deficient practice could affect all occupants. Findings include: Based on observation on 12/17/18 at 12:45 p.m. with the Residential Manager (RM), the family	K S222	1.The area supervisor and program manager will ensure all exterior doors are provided with only one latching mechanism to release the door and open. The area supervisor and program manager will ensure the bathroom door locks are key locks and all staff have access to the keys to unlock the doors and rescue clients in an emergency. 2.The program manager will ensure the exterior basement door is provided with only one latching mechanism to release the door and open. The program manager will ensure the bathroom doors are equipped with key locks and all staff have access to the keys. The program manager will conduct periodic checks to ensure the exterior doors are equipped with only one latching mechanism and keys for bathroom doors are present in the facility and all staff know the location of the keys. The area supervisor will conduct monthly checks and the residential manager will conduct weekly checks to ensure the keys are present in the facility and all staff know the location of the keys.	01/16/2019

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	room bathroom door could be locked from the inside and when the RM was asked to provide a key to unlock the bathroom door a key to do so could not be located. Based on interview at the time of observation, the RM lacked the knowledge to unlock the client bathroom door.			
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 conduct fire drills quarterly on each shift for 1 of the last 4 quarters over the past year. This	K S712	1.All staff at the home will be re-trained on completing fire drills every quarter and on all shifts.	01/16/2019

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	deficient practice could affect all clients. Findings include: Based on a review of Emergency Evacuation Drill Reports on 12/17/18 at 12:10 p.m. with the Residential Manager (RM), there was no record of a fire drill conducted on the third shift, second quarter 2018. Based on an interview with the RM at the time of record review, there was no other documentation available for review to indicate the third shift, second quarter of 2018 had been conducted.		The Residential Manager will review all drills to ensure all 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.	