STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING -- B. WING	10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

(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: 10/30/18 Facility Number: 013405 Provider Number: 15G811 AIM Number: 201267570 At this Emergency Preparedness survey Res-Care Inc., was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has20 certified beds. All 20 beds are certified for Medicaid. At the time of the survey, the census was 20. Quality Review completed on 11/07/18 - DA	E 0000		
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: 10/30/18 Facility Number: 013405 Provider Number: 15G811 AIM Number: 201267570 At this Life Safety Code survey, Res-Care Inc. was found not in compliance with Requirements	K 0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 01 B. WING	10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

(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
	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 and with 410 IAC 9, Community Residential Facilities for Persons with Developmental Disabilities. This one story facility with a partial basement was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection on all levels including client sleeping rooms, corridors and common living areas. The facility has the capacity for 20 and had a census of 20 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.52. Quality Review completed on 11/07/18 - DA			
K S200 Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Escape Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.2 Means of Escape 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 1 of 10 battery powered emergency lights were maintained in accordance with LSC 33.3.2.9 states Emergency Lighting in accordance with section 7.9 shall be provided in	K S200	Means of Egress Requirements The battery operated emergency light in the Rec Room failed to	10/31/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 01 B. WING	10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

(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
	all facilities meeting any of the following criteria: (1) Facilities having an impractical evacuation capability. (2) Facilities having a prompt or slow evacuation capability with more than 25 rooms, unless each room has a direct exit to the outside of the building at the finished or ground level. LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all clients within the facility. Findings include: Based on record review on 10/30/18 at 12:20 p.m. with the Environmental Services Supervisor and the Q.A. Coordinator, the battery operated emergency light in the Rec room failed to function when its respective test button was pushed five times. Based on interview at the time of the observations, Environmental Services Supervisor and the Q.A. Coordinator both acknowledged the aforementioned battery operated emergency light failed to function when its respective test button was pushed.		function when its respective test button was pushed. The battery was replaced on 10/31/2018. Person Responsible: Environmental Services Supervisor Date of Completion: 10/31/2018	
K S521 Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air-conditioning equipment comply with 9.2.1 and 9.2.2, except as otherwise permitted by Chapter 33. 32.2.5.2.1, 33.2.5.2.1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 01 B. WING	10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

(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
	Based on record review, observation and interview; the facility failed to ensure fire / smoke dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 33.3.6.2.1 states Heating, ventilation and air-conditioning equipment shall comply with the provisions of Section 9.2. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all clients within the facility. Findings include: Based on record review on 10/30/18 at 12:20 p.m. with the Environmental Services Supervisor and the Q.A. Coordinator, Fire / Smoke Damper records were not available for review. When asked if there were fire / smoke dampers in the building,	K S521	HVAC CFR Fire/Smoke dampers in the facility were inspected on 10/31/2018 and necessary maintenance is being completed. Four year inspections will be completed. Person responsible; Environmental Services Supervisor Date of Completion; 10/31/2018	10/31/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 01 B. WING	10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

(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
	the Environmental Services Supervisor answered that there were. Based on observation during a tour of the facility at 1:26 p.m., fire / smoke dampers were located throughout the facility. The stickers on these dampers showed the last time they were inspected was in 2011, and therefore they were beyond the 4 year inspection date. The lack of four year maintenance on the fire / smoke dampers throughout the facility was verified by the Environmental Services Supervisor and the Q.A. Coordinator, at the time of record review and then again at the at the exit conference on 10/30/18 at 3:45 p.m.			