STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		15G127	B. WI	NG		07/19/	2021
	ROVIDER OR SUPPLIER	TERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
E 0000							
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.		E 00	000			
	Survey Date: 07/19	/2021					
	Facility Number: 00 Provider Number: 1002	15G127					
	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						
	-	ertified beds. All 8 beds are id. At the time of the survey,					
	Quality Review con	npleted on 07/26/21					
	The requirement at a NOT MET as eviden	42 CFR, Subpart 483.475 is need by:					
E 0007 Bldg	441.184(a)(3), 482 483.73(a)(3), 484. 485.68(a)(3), 485. 491.12(a)(3), 494. EP Program Patie §403.748(a)(3), §4 §441.184(a)(3), § §483.73(a)(3), §48 (3), §485.68(a)(3)	nt Population 416.54(a)(3), §418.113(a)(3), 6460.84(a)(3), §482.15(a)(3), 33.475(a)(3), §484.102(a)					

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 25EG21 Facility ID: 000664 If continuation sheet Page 1 of 78

PRINTED: 09/01/2021 FORM APPROVED

STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION DESCRIPTION NUMBER AND PLAN OF CORRECTION DESCRIPTION NUMBER 15G127 NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN NEW ALBANY, IN 47150 SUBMAKEY STATEMENT OF DEPICIENCIE PRIERY TAG REQULATORY OR LSC IDENTIFYING INFORMATION \$494-62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address (patient/client) population, including, but not limited to, persons at-risk; the type of services the [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do all of the following: (3) Address (patient/client) population, including, but not limited to, persons at-risk; the type of services the [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency, and continuity of operations, including delegations of authority and succession plans. **NOTE: [*Persons at risk* does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FOHC, or ESRD facilities; Based on record review and interview, the facility finited 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 (CFID) facility and succession plans. **NOTE: [*Persons at risk* does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FOHC, or ESRD facilities; Based on record review and interview, the facility finited to ensure the emergency preparedness plan that the emergency plan policies and procedures addresses the special needs of its client population, including, but not limited to, persons at r	CENTERS FOI	OMB NO. 0938-039					
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*NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] 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 *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] 5		operations, includ	ling delegations of authority				
ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] 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 E 0007 1.The administrator has developed a Transfer Agreement that will ensure the emergency plan policies and procedures addresses the special needs of its client population, including, but		and succession p	lans.				
ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] 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 E 0007 1.The administrator has developed a Transfer Agreement that will ensure the emergency plan policies and procedures addresses the special needs of its client population, including, but		*NOTE: ["Pareons	s at risk" does not apply to:				
RHC/FQHC, or ESRD facilities.] 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 E 0007 1.The administrator has developed a Transfer Agreement that will ensure the emergency plan policies and procedures addresses the special needs of its client population, including, but							
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 E 0007 1. The administrator has developed a Transfer Agreement that will ensure the emergency plan policies and procedures addresses the special needs of its client population, including, but							
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 developed a Transfer Agreement that will ensure the emergency plan policies and procedures addresses the special needs of its client population, including, but			-	F 0007	1 The administrator has		08/18/2021
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 that will ensure the emergency plan policies and procedures addresses the special needs of its client population, including, but			-	L 000/		nt	00/10/2021
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 plan policies and procedures addresses the special needs of its client population, including, but					· · · · · · · · · · · · · · · · · · ·		
at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and addresses the special needs of its client population, including, but		_					
has the ability to provide in an emergency; and client population, including, but						its	
			•		1		
		1 .	<u> </u>				

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authority and succession plans in accordance

with 42 CFR 483.4753(a)(3). This deficient practice

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type of services the ICF/IID facility

has the ability to provide in an

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED
		15G127	B. WI	NG		07/19/	2021
					_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					EST ST		
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	could affect all occu	ipants.			emergency, and continuity of		
					operations, including delegation	ns	
	Findings include:				of authority and succession pla		
					in accordance with 42 CFR		
	Based on record review and interview on				483.475(a)(3).		
	07/19/2021 between 11:20 a.m. to 2:30 p.m. with the				2.The need for transfer of a		
		d D.S.P., the emergency			person from YOUR FACILITY	to	
	_	or the facility did not address			RECEIVING FACILITY shall b		
		its client population and the			determined and recommended		
	_	facility has the ability to			the person's healthcare team,	, l	
		gency. Based on interview at			possibly including the attendin	a l	
		eview, the Area Supervisor			physician in such team's own	Ŭ	
	indicated that in the	event of an emergency the			judgment. When a transfer is		
		consumers for a short period			recommended as medically		
		nterview at the time of record			appropriate, a person supporte	ed at	
	review, the Area Su	pervisor, acknowledged that			YOUR FACILITY shall be		
		entation was not available for			transferred and admitted to		
	review at the time o	f the survey.			RECEIVING FACILITY as		
		•			promptly as possible under the		
	This deficiency was	reviewed with the Area			circumstances, provided that b		
	-	ord review of the Emergency			and other appropriate resource		
	-	locumentation on 07/19/2021.			are available.		
	•				3.The area supervisor and		
					program manager will train all	staff	
					on the policies and procedures		
					and the program overview will		
					placed in the Emergency Disa		
					Preparedness Manual for		
					reference as needed.		
					4.The corrective action will b	e l	
					monitored and reviewed for		
					effectiveness at a minimum		
					bi-annual		
					The persons responsible will	be	
					the, Program Manager, Area		
					Supervisor, and Residential		
					Manager		
			1				

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	OF HEALTH AND HUM MEDICARE & MEDIC.					FO	TED: 09/01/2021 RM APPROVED IB NO. 0938-039		
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	ULTIPLE CO JILDING	ONSTRUCTION	,	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	15G127	B. W			07/19			
	PROVIDER OR SUPPLIER	TERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE		
E 0009 Bldg	441.184(a)(4), 482 483.73(a)(4), 484. 485.68(a)(4), 485. 486.360(a)(4), 497 Local, State, Triba §403.748(a)(4), §4 §441.184(a)(4), §4 §483.73(a)(4), §48 §485.68(a)(4), §48 §485.920(a)(4), §4 §494.62(a)(4) [(a) Emergency PI develop and maining preparedness plar and updated at lea	6.54(a)(4), 418.113(a)(4), 6.15(a)(4), 483.475(a)(4), 102(a)(4), 485.625(a)(4), 727(a)(5), 485.920(a)(4), 1.12(a)(4), 494.62(a)(4) I Collaboration Process 16.54(a)(4), §418.113(a)(4), 160.84(a)(4), §482.15(a)(4), 133.475(a)(4), §484.102(a)(4), 135.625(a)(4), §485.727(a)(5), 186.360(a)(4), §491.12(a)(4), 186.360(a)(4), §491.12(a)(4), 186.360(a)(4), §491.12(a)(4), 186.360(a)(4), §491.12(a)(4), 186.360(a)(4), §491.12(a)(4), 186.360(a)(4), §491.12(a)(4),							

following:]

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. *

* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the facility

failed to ensure the emergency preparedness plan

E 0009

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1. The emergency plan policies

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	r í	JILDING	NSTRUCTION	(X3) DATE COMPL 07/19/	ETED
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD /EST ST LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	included a process of collaboration with I Federal emergency to maintain an integ disaster or emergen documentation of the contact such official participation in collaboration and coloregional, State, or Epreparedness official response during a distituation, including facility's efforts to compensation in collaborative and collaborative and collaborative and collaboration with I Federal emergency no effort to contact documented. This deficiency was Supervisor after recollaboration was supervisor after recollaborati	for cooperation and ocal, tribal, regional, State, or preparedness officials' efforts grated response during a cy situation, including he ICF/IID facility's efforts to ls and, when applicable, of its aborative and cooperative accordance with 42 CFR deficient practice could affect wiew and interview on he 11:20 a.m. to 2:30 p.m. with the d D.S.P., the emergency lid not include a process for laboration with local, tribal, rederal emergency als to maintain an integrated isaster or emergency documentation of the ICF/IID contact such officials and, its participation in properative planning efforts. at the time of record review, r, agreed the plan did not			and procedures has been upon to include a continuity of operations plan which address notification of the Indiana Stat Department of Health during a disaster or emergency. 2. The area supervisor and program manager will train all on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3. The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	ses de staff	
E 0015	, , , ,	8.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1),					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	E SURVEY PLETED 9/2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1031 W	ADDRESS, CITY, STATE, ZIP C /EST ST LBANY, IN 47150	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
Bldg	§403.748(b)(1), §4 §441.184(b)(1), §4 §441.184(b)(1), §4 §483.73(b)(1), §48 [(b) Policies and p must develop and preparedness policient on the emergency (a) of this section, paragraph (a)(1) of communication plates section. The policies and policies and policies and policies and policies and patients shelter in place, into the following: (i) The provision of staff and patients shelter in place, into the following: (ii) Alternate source the following: (A) Temperatures and safety and for storage of provision (B) Emergency light (C) Fire detection, systems. (D) Sewage and w *[For Inpatient Hose Policies and procession of the following and for hospice-operations.	460.84(b)(1), §482.15(b)(1), 33.475(b)(1), §485.625(b)(1) Procedures. [Facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated every 2 years facilities]. At a minimum, rocedures must address of subsistence needs for whether they evacuate or include, but are not limited edical and pharmaceutical ces of energy to maintain to protect patient health the safe and sanitary ons. hting. extinguishing, and alarm waste disposal.				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		r í	JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/19/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD /EST ST LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	address the follow (iii) The provision hospice employed they evacuate or sare not limited to to (A) Food, water, in supplies. (B) Alternate sour the following: (1) Temperatures and safety and for storage of provisio (2) Emergency lig (3) Fire detection, systems. (C) Sewage and vortice and procedures include to ensure emprovision of subsistic clients, whether the include, but are not in accordance with deficient practice control of the	ring: of subsistence needs for es and patients, whether shelter in place, include, but the following: nedical, and pharmaceutical ces of energy to maintain to protect patient health the safe and sanitary ons. hting. extinguishing, and alarm vaste disposal. view and interview, the facility ergency preparedness policies ude at a minimum, (1) The ence needs for staff and y evacuate or shelter in place, limited to the following: water 42 CFR 483.475(b)(1). This build affect all occupants. view and interview on in 11:20 a.m. to 2:30 p.m. with the d D.S.P., the emergency did not address policies and re water in an emergency. at the time of record review, reindicated that he knew where there in the event of an on interview at the time of Area Supervisor acknowledged tatain policies and procedures	E 00	015	1.The administrator will ensithe emergency plan policies a procedures addresses the provision of subsistence need staff and clients, whether they evacuate or shelter in place, including but not limited to the following: (i) Food, water, med and pharmaceutical supplies. Alternate sources of energy to maintain – (A) Temperatures protect resident health and sa and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewa and waste disposal in accorda with 42 CFR 483.475(b)(1). 2.The area supervisor and program manager will train all on the policies and procedure and the program overview will placed in the Emergency Disa	and Is for Is dical, (ii) Is to If to If the staff Is be	08/18/2021

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	of correction identification number 15G127	A. BUILDING B. WING	nstruction 	COMPLETED 07/19/2021
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	1031 W	ADDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021.		Preparedness Manual for reference as needed. 3. The corrective action will I monitored and reviewed for effectiveness at a minimum bi-annual The persons responsible will I the, Program Manager, Area Supervisor, and Residential Manager	
E 0020 Bldg	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6) (ii), §441.184(b)(3), §460.84(b)(3), §482.15(b) (3), §483.73(b)(3), §485.727(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 07/19/2021			
	PROVIDER OR SUPPLIER		1031 V	ADDRESS, CITY, STATE, ZIP COD VEST ST	
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN	NEW A	ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R 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
	and treatment need responsibilities; transfer of evacuation local alternate means of external sources of the properties	eludes consideration of care eds of evacuees; staff ansportation; identification ation(s); and primary and of communication with of assistance.			
	which includes the (i) Consideration of (ii) Staff responsible (iii) Transportation (iv) Identification of (v) Primary and al	of care needs of evacuees. bilities. bilities. bilities. contraction of evacuation			
	Rehabilitation Age §485.727(b)(1), al §494.62(b)(2):] Safe evacuation for Rehabilitation Age Agencies as Provinterapy and Spee Services; and ESI	A485.68(b)(1), Clinics, encies, OPT/Speech at and ESRD Facilities at from the [CORF; Clinics, encies, and Public Health iders of Outpatient Physical ech-Language Pathology RD Facilities], which consibilities, and needs of			
	evacuation from the includes appropriate staff responsibilities patients. Based on record reversely failed to ensure emergence and procedures includes.	Cs at §491.12(b)(1):] Safe the RHC/FQHC, which the placement of exit signs; the sand needs of the riew and interview, the facility the ergency preparedness policies ude information for safe the ICF/IID facility, which	E 0020	1.The emergency plan policies and procedures will be updated include a continuity of operation plan which addresses safe	l to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		15G127	B. WI	ING		07/19/	2021
NAME OF P	ROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP COD		
					EST ST		
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN		NEW A	LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG			DATE
		ion of care and treatment			evacuation of from the ICF/IID		
		and alternate means of			facility and includes considera		
		h external sources of			of care and treatment needs of		
		lance with 42 CFR 483.475(b)			evacuees; staff responsibilities		
		oractice could affect all			transportation; identification of	Í	
	occupants.				evacuation location(s); and		
					primary and alternate means	of .	
	Findings include:				communication with external		
					sources of assistance.		
		view and interview on			2.The area supervisor and		
		n 11:20 a.m. to 2:30 p.m. with the			program manager will train all	staff	
	•	d D.S.P., the EPP did not			on the updated policies and		
		eatment needs of evacuees			procedures and the program		
	(consumers) and alt				overview will be placed in the		
		h external sources of			Emergency Disaster		
		n interview at the time of			Preparedness Manual for		
		Area Supervisor described			reference as needed.		
		y be used in an evacuation but			3.The corrective action will be	е	
		plan did not address policies			monitored and reviewed for		
	_	the care and treatment of			effectiveness at a minimum ev	/ery	
	·	rs) and alternative means of			two years.		
	communication with	h external sources.					
					The persons responsible will be	е	
	_	s reviewed with the Area			the, Program Manager, Area		
	_	ord review of the Emergency			Supervisor, and Residential		
	Preparedness Plan	documentation on 07/19/2021.			Manager		
					/p>		
E 0023	403.748(b)(5), 416	6.54(b)(4), 418.113(b)(3),					
	, , , ,	2.15(b)(5), 483.475(b)(5),					
Bldg		102(b)(4), 485.625(b)(5),					
Ŭ	, , , ,	.727(b)(3), 485.920(b)(4),					
		1.12(b)(3), 494.62(b)(4)					
	Policies/Procedure						
	Documentation						
		416.54(b)(4), §418.113(b)					
	() ()	b), §460.84(b)(6), §482.15(b)					
	(5), §483.73(b)(5)	, , , , ,					
		485.68(b)(3), §485.625(b)					
	(5), §485.727(b)(3	=					

	T OF HEALTH AND HUN						TED: 09/01/2021 RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/19/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	[(b) Policies and promust develop and preparedness policion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policibe reviewed and uyears [annually for minimum, the policiaddress the follow [(5) or (3),(4),(6)] Adocumentation that information, protecting information, and seavailability of reconstitution of the procedures. (5) A separed procedures. (5) A separed procedures.	A system of medical at preserves patient cts confidentiality of patient ecures and maintains rds. 403.748(b):] Policies and system of care at does the following:					

(ii) Protects confidentiality of patient information.

(iii) Secures and maintains the availability of records.

*[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. Based on record review and interview, the facility failed to ensure emergency preparedness policies

E 0023

1.The emergency plan policies and procedures will be updated to

08/18/2021

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		15G127	B. W	ING		07/19/	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ude a system of medical			include a continuity of operation		
		preserves client information,			plan which addresses a syster		
	-	ality of client information, and			medical documentation of fron	n the	
	secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This				ICF/IID facility and includes		
					consideration of maintaining		
	deficient practice co	ould affect all occupants.			protection of confidentiality of		
					patient information and secure	s	
	Findings include:				and maintains availability of		
					records.		
	Based on record rev	view and interview on			2.The area supervisor and		
	07/19/2021 between	n 11:20 a.m. to 2:30 p.m. with the			program manager will train all	staff	
	Area Supervisor and	d D.S.P., no policies and			on the updated policies and		
	procedures which in	nclude a system of medical			procedures and the program		
	documentation that	preserves client information,			overview will be placed in the		
	*	ality of client information, and			Emergency Disaster		
	secures and maintai	ins the availability of records			Preparedness Manual for		
	was available to rev	view. Based on interview at the			reference as needed.		
	time of record revie	ew, the Area Supervisor			3.The corrective action will b	е	
		documentation was not in the			monitored and reviewed for		
	EPP and unavailabl	e for review.			effectiveness at a minimum		
					bi-annual		
	This deficiency was	s reviewed with the Area					
	Supervisor after rec	ord review of the Emergency			The persons responsible will be	е	
	Preparedness Plan	documentation on 07/19/2021.			the, Program Manager, Area		
					Supervisor, and Residential		
					Manager		
E 0025	` ' ' '	8.113(b)(5), 441.184(b)(7),					
	. , , ,	.475(b)(7), 483.73(b)(7),					
Bldg	, , , ,	5.920(b)(6), 494.62(b)(6)					
	Arrangement with						
	. , , , ,	418.113(b)(5), §441.184(b)					
), §482.15(b)(7), §483.73(b)				ļ	
		7), §485.625(b)(7),				ļ	
	§485.920(b)(6), §4	494.62(b)(6).					
	(b) Policies and n	procedures. The [facilities]					
	-, ,	implement emergency				ļ	
		icies and procedures, based				ļ	
		plan set forth in paragraph					

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	ENT OF HEALTH AND HU FOR MEDICARE & MEDIC		FORM APPROVED OMB NO. 0938-039			
	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/19/2021	
NAME	OF PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD VEST ST)	
RES (CARE COMMUNITY A	ALTERNATIVES SE IN	NEW A	LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
170	(a) of this section paragraph (a)(1) communication p section. The poli be reviewed and years [annually forminimum, the pol address the follow *[For Hospices at §441.184,(b) Hose LTC Facilities at § procedures. (7) [content of limitations or community of the providers to of limitations or community of the providers to of limitations or community of the providers to of limitations or community of the providers of limitations or community of services patients in cessation of oper continuity of services of the procedures. (7) The procedures of the providers to receive patients with providers to receive limitations or cession.	, risk assessment at of this section, and the lan at paragraph (c) of this cies and procedures must updated at least every 2 or LTC facilities]. At a icies and procedures must				

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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 or other

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1.The emergency plan policies and procedures will be updated to

include a continuity of operations

plan which addresses

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/19/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1031 V	ADDRESS, CITY, STATE, ZIP COD VEST ST ALBANY, IN 47150	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	providers to receive	residents in the event of	TAG	arrangements with other ICF/	I
	the continuity of ser	tion of operations to maintain vices to ICF/IID clients in		facilities and/or other provider receive residents in the event	
		CFR 483.475(b)(7). This ould affect all occupants.		limitations or cessation of operations to maintain the	
	Findings include:			continuity of services. 2.The area supervisor and	
	Based on record rev	riew and interview on		program manager will train all on the updated policies and	l staff
		n 11:20 a.m. to 2:30 p.m. with the d D.S.P., the emergency		procedures and the program overview will be placed in the	
		or the facility did not include ures for the development of		Emergency Disaster Preparedness Manual for	
	arrangements with o	other ICF/IID facilities and eccive residents in the event		reference as needed. 3.The corrective action will	he
	of limitations or ces	sation of operations to uity of services to ICF/IID		monitored and reviewed for effectiveness at a minimum	
	clients beyond the to	emporary relocation to the ed on interview at the time of		bi-annual	
	record review, the A	Area Supervisor described a see consumers to other Res		The persons responsible will the, Program Manager, Area	be
	Care facilities in the	e area. Based on interview at eview, the Area Supervisor		Supervisor, and Residential Manager	
	acknowledged that j	policies and procedures nents with other providers		iviariagei	
		the EPP and unavailable for			
		reviewed with the Area			
	Supervisor after rec	ord review of the Emergency locumentation on 07/19/2021.			
E 0030	, , , ,	5.54(c)(1), 418.113(c)(1), 2.15(c)(1), 483.475(c)(1),			
Bldg	483.73(c)(1), 484. 485.68(c)(1), 485.	102(c)(1), 485.625(c)(1), 727(c)(1), 485.920(c)(1), 1.12(c)(1), 494.62(c)(1)			
	§403.748(c)(1), §4	116.54(c)(1), §418.113(c)(1), 160.84(c)(1), §482.15(c)(1),			

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	OF CORRECTION	IDENTIFICATION NUMBER 15G127		ILDING		COMPL 07/19/	ETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150		EST ST		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION]	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
TAG	§483.73(c)(1), §48 §485.68(c)(1), §48 (1), §485.920(c)(1) §491.12(c)(1), §49 (1), §491.12(c)(1),	33.475(c)(1), §484.102(c)(1), 85.625(c)(1), §485.727(c)), §486.360(c)(1), 94.62(c)(1). ust develop and maintain eparedness communication with Federal, State and st be reviewed and updated ears [annually for LTC mmunication plan must following:] Intact information for the mag services under scians [and CAHs]. §482.15(c) and CAHs at communication plan must following: Intact information for the mag services under scians [and CAHs].		TAG			DATE
	following: (1) Names and co following: (i) Staff.	ntact information for the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		A. BUILDING COMPLE B. WING 07/19/2				
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API TAG DEFICIENCY)		LD BE	(X5) COMPLETION DATE
IAU	(ii) Entities providing arrangement. (iii) Next of kin, gu (iv) Other RNHCls (v) Volunteers. *[For ASCs at §41 communication ple following: (1) Names and confollowing: (i) Staff. (ii) Entities providing arrangement. (iii) Patients' phys (iv) Volunteers. *[For Hospices at communication ple following: (1) Names and confollowing: (1) Names and confollowing: (ii) Entities providing arrangement. (iii) Patients' phys (iv) Other hospice *[For HHAs at §48 communication ple following: (1) Names and confollowing: (1) Names and confollowing: (1) Names and confollowing: (1) Staff.	ing services under lardian, or custodian. s. 16.45(c):] The an must include all of the ontact information for the ing services under icians. §418.113(c):] The an must include all of the ontact information for the yees. ing services under icians. ss. 34.102(c):] The an must include all of the ontact information for the icians. ss. ss. sq. 102(c):] The an must include all of the ontact information for the ing services under icians.	IAU			DATE

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		-
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPL		
		15G127	B. WING		07/19/	/2021	
NAME OF	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD			
				VEST ST			
RES CA	RE COMMUNITY A	LTERNATIVES SE IN	NEW A	ALBANY, IN 47150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	_
	I -	an must include all of the					
	following:	unta at information for the					
	· '	ontact information for the					
	following:						
	(i) Staff.	ing contince under					
		ing services under					
	arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and						
			E 0030	1.The administrator will ensu	ıre	08/18/2021	
			L 0030	the emergency plan policies a		00/10/2021	
				procedures will be updated to			
	_	for the following: (i) Staff, (iv)		include names and contact			
		ities, and (v) Volunteers in		information for staff.			
		CFR 483.475(c)(1). This		2.Due to screening and vetti	ng		
		ould affect all occupants.		of volunteers ResCare uses	Ü		
		•		internal sources for assistance	·.		
	Based on record rev	view and interview on		ResCare's ResCare -On-Call			
	07/19/2021 between	n 11:20 a.m. to 2:30 p.m. with the		Team (ROC) pulling from 54,0	00		
	Area Supervisor an	d D.S.P., the EPP has a contact		current employees nationwide	was		
		entitled "Emergency Telephone		developed to aid operations th	at		
		17 and a list of staff to be		are in need of additional suppo			
		Staff Recall Procedures" on		and staffing that is activated by	y		
		interview at the time of record		the Executive Director or			
		pervisor acknowledged that		subordinate Manager. All staf			
		contact information. A contact		the facility will be trained on th			
		ound in the EPP does not list		development of this program a	ınd		
		information. Based on		its purpose.			
		ne of record review, the Area		3.The area supervisor and			
	_	nat some employees had no		program manager will train all			
		ce of contact and the numbers		on the policies and procedures			
		to a family members that		updates and the updates will b			
		ally contact the employee on		placed in the Emergency Disa	ster		
	behalf of the emplo	nyer.		Preparedness Manual for			
	This deficience	a marriannad vrith the A		reference as required.			
	I his deficiency was	s reviewed with the Area	1	4.Emergency Disaster		I	

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Supervisor after record review of the Emergency

Preparedness Plan documentation on 07/19/2021.

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Preparedness Manual will be

review Annually at a minimum by

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		A. BUILDING COMPLET			(X3) DATE SURVEY COMPLETED 07/19/2021	
	PROVIDER OR SUPPLIEI	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ΓΙΟΝ
E 0032	403.748(c)(3), 41 441.184(c)(3), 48	3.54(c)(3), 418.113(c)(3), 2.15(c)(3), 483.475(c)(3), 102(c)(3), 485.625(c)(3),		TAG	the Quality Assurance Manage ensure all information remains to date. Persons Responsible: Progra Manager, Area Supervisor, an Residential Manager, DSP, Quality Assurance Department	m d	
3	485.68(c)(3), 485 486.360(c)(3), 49 Primary/Alternate §403.748(c)(3), § §441.184(c)(3), § §483.73(c)(3), §4	727(c)(3), 485.920(c)(3), 1.12(c)(3), 494.62(c)(3) Means for Communication 416.54(c)(3), §418.113(c)(3), 460.84(c)(3), §482.15(c)(3), 33.475(c)(3), §484.102(c)(3), 85.625(c)(3), §485.727(c) 8), §486.360(c)(3),					
	an emergency pre plan that complies local laws and mu at least every 2 ye	nust develop and maintain eparedness communication with Federal, State and state be reviewed and updated ears [annually for LTC mmunication plan must ollowing:					
	communicating w (i) [Facility] staff.	tribal, regional, and local					
	and alternate mea	(483.475(c):] (3) Primary ans for communicating with Federal, State, tribal, I emergency management					

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	OF CORRECTION	IDENTIFICATION NUMBER 15G127	ſ '		INSTRUCTION	COMPLETED 07/19/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE A CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	failed to ensure the communication plan alternate means for following: (i) ICF/I State, tribal, regions management agencial 483.475(c)(3). This all occupants. Based on record revo7/19/2021 between Area Supervisor and list for employees e Numbers" on page contacted entitled "page 20. Based on i review, the Area Suneither list has his contacted in the list of employees for alternative contact in This deficiency was Supervisor after recommunication.	view and interview, the facility emergency preparedness in includes (3) Primary and communicating with the ID facility's staff (ii) Federal, al, or local emergency ites in accordance with 42 CFR deficient practice could affect view and interview on in 11:20 a.m. to 2:30 p.m. with the id D.S.P., the EPP has a contact intitled "Emergency Telephone 17 and a list of staff to be Staff Recall Procedures" on interview at the time of record interview at the time of record interview at the time of record interview at the EPP does not list information. So reviewed with the Area ford review of the Emergency documentation on 07/19/2021.	E 00	032	1.The method of communication using both a primary and altern means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies will be place in the EPP by the Program Manager. 1.All staff will be trained on the method of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies. 1.Area Supervisor will ensure the EPP includes a copy the method of communicating using both a primary and alternate means of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies. 1.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home are all its content. Upon visiting a home, the Program Manager of the Emergency Preparedness Manual and document the visit on the Hom Visitor Sign In form located in each home.	e e e e e e e e e e e e e e e e e e e	08/18/2021

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY PLETED 9/2021		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP (VEST ST	COD			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	NEW ALBANY, IN 47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
E 0033 Bldg	(4)-(6), 441.184(c) 483.475(c)(4)-(6), (4)-(5), 485.625(c) 485.727(c)(4), 485.494.62(c)(4)-(6) Methods for Shari §403.748(c)(4)-(6) §460.84(c)(4)-(6), §460.84(c)(4)-(6), §483.73(c)(4)-(6), §484.102(c)(4)-(5) (4)-(6), §485.727(c) (4)-(6), §485.727(c) (4)-(6), §485.727(c) §491.12(c)(4), §485.727(c) The [facility] man emergency preplan that complies local laws and muat least every 2 years.	a), §416.54(c)(4)-(6), b), §441.184(c)(4)-(6), §441.184(c)(4)-(6), §482.15(c)(4)-(6), §483.475(c)(4)-(6), b), §485.68(c)(4), §485.625(c) c)(4), §485.920(c)(4)-(6), c)(4)-(6). aust develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC mmunication plan must		1.Monitoring of Corr Action: A member of the Review Team, consisting QA department, Programment, Programment, Programment, AED, and A Supervisors will composite reviews of each look document any issues/ the site review. Site Fiber eviewed by each A Supervisor and Programment of the Programment of	the Site ting of the ram Nurse trea elete monthly ocation and findings on Review will Area am Manager ow-up as			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTI		ONSTRUCTION	(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	LETED
		15G127	B. W.	ING		07/19	/2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	<u> </u>	1031 W	ADDRESS, CITY, STATE, ZIP COD /EST ST LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
	medical documen [facility's] care, as health providers to care. (5) A means, in th	charing information and tation for patients under the necessary, with other or maintain the continuity of e event of an evacuation, to formation as permitted					
		4.510(b)(1)(ii). [This					
		quired for HHAs under					
	§484.102(c), CORFs under §485.68(c)]						
	about the general patients under the	eans of providing information condition and location of [facility's] care as 5 CFR 164.510(b)(4).					
	for sharing inform documentation for care, as necessar maintain the conti written election sta	\$403.748(c):] (4) A method ation and care repatients under the RNHCl's y, with care providers to nuity of care, based on the atement made by the er legal representative.					
	means of providin general condition	Cs at §491.12(c):] (4) A g information about the and location of patients care as permitted under 45					
	Based on record rev failed to ensure the communication pla sharing information for clients under the necessary, with oth maintain the contin the event of an evac information as perm	view and interview, the facility emergency preparedness in includes (4) A method for and medical documentation in the ICF/IID facility's care, as ear health care providers to uity of care; (5) A means, in cuation, to release client in itted under 45 CFR 164.510(b) are of providing information about	E 00	033	1.The emergency plan police and procedures will develop a maintain an emergency preparedness plan that composite with Federal, State and local that must be reviewed annual include a method for sharing information and medical documentation for patients unthe facility's care; a means of	ind ies aws ly to der	08/18/2021

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING COMPLET B. WING 07/19/20			ETED		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	the facility's care as 164.510(b)(4) in ac (4). This deficient p occupants. Based on record rev 07/19/2021 between Area Supervisor and have no information information on consumpter-based on interview the Area Supervisor computer-based rec used by the facility indicated that the deviewed on compute is the first location facility evacuation. that the facility had all of the medical in consumer. Based or record review, the Area policies and prorecord-keeping and the EPP documenta.	ord documentation system The Area Supervisor becumentation system could be rs at the "Core Office", which to be used in the event of a The Area Supervisor explained a "Red Book" that contained information necessary for each in interview at the time of Area Supervisor acknowledged becedures of the on-line "Red Book" were not part of			releasing patient information a permitted under 45 CFR 164.510(b)(1)(ii); a means of providing information general information and location of patients as permitted under 45 CFR 164.510(b)(1)(ii). 2.The area supervisor and program manager will train all on the communication plan and the plan will be present in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	staff ad	
E 0034 Bldg	441.184(c)(7), 482 483.73(c)(7), 484.	3.54(c)(7), 418.113(c)(7), 2.15(c)(7), 483.475(c)(7), 102(c)(6), 485.625(c)(7), 727(c)(5), 485.920(c)(7),					
	Information on Oc §403.748(c)(7), §4 §441.184(c)(7), §4						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G127	A. BUILDIN B. WING	NG <u></u>		LETED 0/2021
		100121		EET ADDRESS CITY STATE IVE CO.		
NAME OF F	PROVIDER OR SUPPLIEI	R		EET ADDRESS, CITY, STATE, ZIP COI 31 WEST ST)	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		W ALBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT ACTION OF CORRECT ACT		(X5)
	,			CROSS-REFERENCED TO THE APP		
PREFIX TAG	REGULATORY OF (6), §485.68(c)(5) (5), §485.625(c)(7) §491.12(c)(5), §44 [(c) The [facility] in an emergency proposed plan that complies local laws and must least every 2 yes facilities]. The coinclude all of the formation about needs, and its abit to the authority has lincident Comman and its ability to pauthority having just Command Center [For Inpatient Homeans of providing informations about the authority having just Command Center [For Inpatient Homeans of providing informations ability to provide authority having just Command Center Based on record refailed to ensure the communication pla providing information pla providing informations.	nust develop and maintain eparedness communication is with Federal, State and ust be reviewed and updated ears [annually for LTC immunication plan must following: Ineans of providing the [facility's] occupancy, ality to provide assistance, aving jurisdiction, the ind Center, or designee. In about the ASC's needs, rovide assistance, to the urisdiction, the Incident in occupancy, needs, and the assistance, to the utoccupancy, needs, and the assistance, to the urisdiction, the Incident in occupancy, needs, and the assistance, to the urisdiction, the Incident	E 0034	CROSS-REFERENCED TO THE APP	I ensure sies and ed to e	COMPLETION DATE
	the Incident Comm accordance with 42	athority having jurisdiction or and Center, or designee in CFR 483.475(c)(7). This ould affect all occupants.		provide assistance to the Having Jurisdiction. 2.The area supervisor program manager will en policies and procedures	Authority and sure the	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		A. BUILDING B. WING	onstruction	COMPLETED 07/19/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD VEST ST	
RES CAF	RE COMMUNITY AL	TERNATIVES SE IN		ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
E 0035 Bldg	O7/19/2021 between Area Supervisor and have no information information on consumation on consumation on computer and the Area Supervisor computer-based recoused by the facility. Indicated that the doviewed on computer is the first location that the facility evacuation. That the facility had all of the medical in consumer. Based on record review, the Athat policies and proprecord-keeping and the EPP documentate. This deficiency was Supervisor after record-review and ICF/IID Squares Plan design and ICF/IID	The Area Supervisor recumentation system could be set at the "Core Office", which to be used in the event of a The Area Supervisor explained a "Red Book" that contained formation necessary for each interview at the time of the area Supervisor acknowledged recedures of the on-line "Red Book" were not part of the cion. The Area Supervisor explained as "Red Book" were not part of the on-line "Red Book" were not part of the Emergency occumentation on 07/19/2021. 3.73(c)(8) Sharing Plan with Patients 13.475(c)(8)		including a method to share occupancy needs and ability to provide assistance to the Auth Having Jurisdiction is present the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager.	ority in e
	*[For ICF/IIDs at § [(c) The ICF/IID m	483.475(c):] ust develop and maintain an			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/19/2021	
	OF PROVIDER OR SUPPLIED	R LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
	plan that complies local laws and must least every 2 ye plan must include (8) A method for semergency plan, determined is appropriate of the communication plainformation from the facility has determined and their families of with 42 CFR 483.4 could affect all occurrence of the communication plainformation from the facility has determined and their families of with 42 CFR 483.4 could affect all occurrence of the complete of th	redness communication is with Federal, State and set be reviewed and updated ears. The communication all of the following:] sharing information from the that the facility has propriate, with residents [or families or representatives. Wiew and interview, the facility emergency preparedness in includes a method for sharing the emergency plan that the ned is appropriate with clients or representatives in accordance (75(c)(8). This deficient practice upants. Wiew and interview on in 11:20 a.m. to 2:30 p.m. with the d D.S.P., the EPP was found to the diagram of the diagram of the invalidation of the meting existence of the invalidation of the meeting existence of the invalidation of the inv	EO	035	1.The administrator will dever and maintain an emergency preparedness plan that complements with Federal, State and local lathat must be reviewed annually include a method for sharing information the facility has determined appropriate, with clients and their family or representatives. 2.The area supervisor and program manager will ensure policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Auth Having Jurisdiction is present the Emergency Disaster Preparedness Manual for reference as needed. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	ies aws y to the te o nority in	08/18/2021

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		JILDING	NSTRUCTION	COMPL 07/19/	ETED	
NAME OF PROVIDE		TERNATIVES SE IN	1031 W	NDDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150		
TAG R This Supe	EACH DEFICIENCE EGULATORY OR deficiency was rvisor after reco	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION reviewed with the Area ord review of the Emergency ocumentation on 07/19/2021.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
Bldg 441. Bldg 484. 485. 491. EP T §403 §441 §483 §485 §494 *[For Hosp PAC HHA CAH 485.] §486 Trairr deve prep that i in pa asse secti (b) o plan traini revie expenses and in the section of the sec	184(d), 482.15 102(d), 485.62 727(d), 485.92 12(d), 494.62(c) Training and Tolerance 3.748(d), §416 1.184(d), §460 3.73(d), §483.4 5.68(d), §485.6 5.920(d), §486 6.920(d),					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/19/2021	
	PROVIDER OR SUPPLIE	LTERNATIVES SE IN	1031	T ADDRESS, CITY, STATE, ZIP COD WEST ST ALBANY, IN 47150	
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	of this section, ris (a)(1) of this secti at paragraph (b) of communication pl section. The train	an set forth in paragraph (a) k assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this hing and testing program and updated at least			
	testing. The ICF/I maintain an emer and testing progra emergency plans this section, risk a (a)(1) of this secti at paragraph (b) communication pl section. The trair must be reviewed 2 years. The ICF/	§483.475(d):] Training and ID must develop and gency preparedness training am that is based on the set forth in paragraph (a) of assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this hing and testing program and updated at least every IID must meet the evacuation drills and training			
	Training, testing, dialysis facility multiple emergency prepared and patient orient on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the community of this section.	ties at §494.62(d):] and orientation. The ust develop and maintain an redness training, testing ation program that is based v plan set forth in paragraph risk assessment at of this section, policies and ragraph (b) of this section, cation plan at paragraph (c) ne training, testing and m must be evaluated and 2 years.			
	Based on record re- failed to develop ar	view and interview, the facility an emergency preparedness accordance with 42 CFR	E 0036	1.The administrator will ensitive emergency plan policies approcedures annual emergency.	and

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING COMPLETI B. WING 07/19/20			ETED	
		15G127	B. WING			07/19/	2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	10)31 WI	DDRESS, CITY, STATE, ZIP COD EST ST BANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRE TA		CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	occupants. Findings include: Based on record rev 07/19/2021 between Area Supervisor and required testing of e Preparedness Plan v The section of the E had an outline or ter interview at the time Supervisor acknowl and documentation included in the EPP This deficiency was Supervisor after rec	riew and interview on a 11:20 a.m. to 2:30 p.m. with the d D.S.P., documentation of the employees on the Emergency was not available for review. EPP for training & Education et al. Education et al. Education et al. Education et al. Education of staff over the subject matter was edged that no testing of staff over the subject matter was et reviewed with the Area ord review of the Emergency documentation on 07/19/2021.			training and testing program in accordance with CFR 483.475 is implemented in all locations evidence of the annual training testing is present in the EPP manual. 2. The area supervisor and program manager will train all on the annual training and test and the training and testing documentation will be present the Emergency Disaster Preparedness Manual for reference as needed. 3. The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	o(d) and g and staff ting in	
E 0037 Bldg	441.184(d)(1), 482.483.73(d)(1), 484.485.68(d)(1), 485.486.360(d)(1), 497.54841.184(d)(1), §48483.73(d)(1), §48485.68(d)(1), §485.68(d)(1), §485.68(d)(1). *[For RNCHIs at § Hospitals at §482.	am 116.54(d)(1), §418.113(d)(1), 160.84(d)(1), §482.15(d)(1), 33.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d)					

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL		
		15G127	B. W	ING		07/19/	/2021	
NAME OF I	DDOMDED OD GUDDI IEI)	•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
	PROVIDER OR SUPPLIEF			1031 W				
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		NEW AI	LBANY, IN 47150			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE	
	-	at §486.360, RHC/FQHCs						
	at §491.12:] (1) Training program. The [facility] must do							
	all of the following							
	. , ,	n emergency preparedness						
	1 '	edures to all new and						
		viduals providing services nt, and volunteers,						
	_	eir expected roles.						
		ency preparedness training						
	at least every 2 ye							
		mentation of all emergency						
	preparedness training.							
	(iv) Demonstrate staff knowledge of							
	emergency proce	_						
		cy preparedness policies						
	· ,	re significantly updated, the						
	1	duct training on the						
	updated policies a	-						
		0440 440(N) 1 (4) T						
		§418.113(d):] (1) Training.						
		do all of the following:						
	. , ,	n emergency preparedness						
		edures to all new and						
		employees, and individuals						
		s under arrangement, eir expected roles.						
	(ii) Demonstrate s	•						
	emergency proce	_						
		gency preparedness training						
	at least every 2 ye							
		eview and rehearse its						
	. ,	redness plan with hospice						
		ding nonemployee staff),						
		nasis placed on carrying out						
		ecessary to protect patients						
	and others.	, ,						
		mentation of all emergency						
	preparedness trai							
	(vi) If the emergency preparedness policies							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		A. BUILDING COMPLE B. WING 07/19/2				
	PROVIDER OR SUPPLIER		1031 V	ADDRESS, CITY, STATE, ZIP COD VEST ST		
RES CAL	RE COMMUNITY A	LTERNATIVES SE IN	NEW A	ALBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	1	re significantly updated, the duct training on the and				
	program. The PR' following: (i) Initial training ir policies and proceexisting staff, indivunder arrangement consistent with the (ii) After initial train preparedness trai (iii) Demonstrate semergency proceed (iv) Maintain docupreparedness trai (v) If the emergen and procedures a	eir expected roles. ning, provide emergency ning every 2 years. staff knowledge of dures. mentation of all emergency ning. cy preparedness policies re significantly updated, the act training on the updated				
	organization must (i) Initial training ir policies and proce existing staff, individed in the services under are participants, and witheir expected role (ii) Provide emerg at least every 2 ye (iii) Demonstrate as emergency proceuparticipants of whom to contact i (iv) Maintain docu	ency preparedness training				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127		UILDING	NSTRUCTION	COM	TE SURVEY TPLETED 19/2021	
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150					
NES CA		LIERNATIVES SE IN		INEW AL	DANT, IN 47 130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION DATE	
TAG	and procedures a	re significantly updated, the uct training on the updated		IAG			DAIL	
	Training Program of the following:	es at §483.73(d):] (1) . The LTC facility must do all n emergency preparedness						
	existing staff, indi	edures to all new and viduals providing services nt, and volunteers, eir expected role						
	(ii) Provide emerg at least annually. (iii) Maintain docu	ency preparedness training						
	preparedness trai (iv) Demonstrate : emergency proce	staff knowledge of						
	CORF must do al (i) Provide initial to preparedness pol	485.68(d):](1) Training. The I of the following: raining in emergency icies and procedures to all staff, individuals providing						
	consistent with the (ii) Provide emerg at least every 2 years.							
	(iv) Demonstrate emergency proce must be oriented	mentation of the training. staff knowledge of dures. All new personnel and assigned specific						
	emergency plan v workday. The trai	garding the CORF's vithin 2 weeks of their first ning program must include ocation and use of alarm						
	equipment. (v) If the emerge	als and firefighting ency preparedness policies re significantly updated, the						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/19/2021	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		VEST ST ALBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	CORF must cond policies and proce	uct training on the updated edures.			
	*[For CAHs at §48 program. The CAI following: (i) Initial training in policies and procedures and procedures and exiting staff, individuals provided and disaster authorized at least every 2 yes (iii) Maintain docut (iv) Demonstrate and procedures to all and individuals providing arrangement, and their expected role	as 5.625(d):] (1) Training In must do all of the In emergency preparedness adures, including prompt Inguishing of fires, Inere necessary, evacuation Innel, and guests, fire Inoperation with firefighting Industry of the wand Industry of the			
	must demonstrate emergency proce	staff knowledge of dures. Thereafter, the			
	CMHC must provi	- ·			
		ning at least every 2 years. view and interview, the facility	E 0037	1.The administrator will ens	00/10/2021
		emergency preparedness	E 003/	the emergency plan policies a	00/10/2021

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	ľ	UILDING	NSTRUCTION	(X3) DATE COMPL 07/19/	ETED
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD /EST ST LBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE .	(X5) COMPLETION DATE
	includes a training production and an outline or ten interview at the time Supervisor acknowle training in the emery to all new and exist services under arrar consistent with their emergency prepared two years; (iii) Main emergency prepared Demonstrate staff k procedures; (v) If the policies and proced the facility must composite and proced CFR 483.475(d) (1) affect all occupants Findings include: Based on record reveron 19/2021 between the Area Supervisor and required testing of the Preparedness Plan of the Indian outline or ten interview at the time Supervisor acknowle training in the emergency was supervisor after record record reveron 19/2021 the training in the emergency was supervisor after record record reversion after record record record record reversion after record reco	nowledge of emergency ne emergency preparedness ures are significantly updated, induct training on the updated ures in accordance with 42 of this deficient practice could of the employees on the Emergency was not available for review. EPP for training & Education emplate only. Based on the employees on the Emergency was not available for review. EPP for training & Education emplate only. Based on the edged that he had no formal gency preparedness plan for the ebecame the supervisor emonths ago. The reviewed with the Area tord review of the Emergency documentation on 07/19/2021.			procedures initial training in emergency preparedness poli and procedures to all new and existing staff, annual emerger training, documentation of the training and staff demonstratic knowledge of the emergency procedures is completed in accordance with CFR 483.478 (1) and present in the EPP manual. 2. The area supervisor and program manager will provide initial training to all existing stand new staff and the training testing documentation will be present in the Emergency Disaster Preparedness Manuareference as needed. 3. The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual The persons responsible will the, Program Manager, Area Supervisor, and Residential Manager	on of of of aff and al for oe	
E 0039 Bldg	441.184(d)(2), 482	3.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2),					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUIT A. BUILDING COMPLET O7/19/20			LETED		
	PROVIDER OR SUPPLIE		•	1031 W		•	
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		NEW AL	BANY, IN 47150		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	N SHOULD BE COMPLE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JENIATE	DATE
	486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § (2), §491.12(d)(2) *[For ASCs at §4' OPO, "Organizati CMHCs at §485.9 §491.12, and ESF (2) Testing. The [i exercises to test t annually. The [fact following:	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) , §494.62(d)(2). 16.54, CORFs at §485.68, ons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]: facility] must conduct the emergency plan cility] must do all of the					
	community-based (A) When a community accessible, confunctional exercis (B) If the [factionatural or man-material confunctional c	full-scale exercise that is every 2 years; or munity-based exercise is enduct a facility-based e every 2 years; or ility] experiences an actual ade emergency plan, the facility!					
	is exempt from er community-based functional exercis actual event. (ii) Conduct an ad every 2 years, op or functional exer- (i) of this section i include, but is not (A) A second full-						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127		UILDING	NSTRUCTION	(X3) DATE COMPI 07/19	LETED	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPP DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	led by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an er (iii) Analyze the [famaintain documer exercises, and enthe [facility's] emeth [for Hospices at (2) Testing for hother patient's home conduct exercises plan at least annuthe following: (i) Participate in a community based (A) When a community based functional emergor of the emergency exempt from engascale community-facility-based functionset of the emer (ii) Conduct an accessible product and years, opposite the functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast	emergency scenario, and a tements, directed pared questions designed mergency plan. acility's] response to and natation of all drills, tabletop mergency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in each that provide care in each that provide care in each to test the emergency ally. The hospice must do exercise that is every 2 years; or experiences a natural or experiences a natural or ency that requires activation plan, the hospital is eiging in its next required full exercise every 2 years; or experiences or individual exercise or individual exercise or individual exercise or individual exercise every 2 eyear the full-scale or experiences, that may limited to the following: scale exercise that is or a facility based exercise that is or a facility based exercise that is or a facility based exercise or individual exercise that is or a facility based exercise that is or a facility based exercise or an facility bas						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		A. BUILDING B. WING	COMPLETED 07/19/2021		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD WEST ST	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		ALBANY, IN 47150	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	led by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an error to test the per year. The hose (i) Participate in a that is community. (A) When a community-based functional exercise emergency exempt from enganger full-scale community exempt from enganger growth (ii) Conduct an activate may include, following: (A) A second full-community-based functional exercise (B) A mock disassi (C) A tabletop exerciclitator that inclusing a narrated, emergency scena statements, direct questions designed.	and includes a group a narrated, emergency scenario, and a tements, directed cared questions designed mergency plan. spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise rbased; or funity-based exercise is not act an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required aity based or facility-based be following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared	TAG		DATE DATE
	maintain documer	ospice's response to and ntation of all drills, tabletop nergency events and revise			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G127	A. BU B. W	JILDING		07/19/	
		15G127	B. W.	NG		07/19/	2021
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
DE0.045		LTERNATIVES OF IN			EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the hospice's eme	ergency plan, as needed.					
	*IFor DDETs at 8/	141.184(d), Hospitals at					
	§482.15(d), CAHs						
	. , ,	PRTF, Hospital, CAH] must					
		s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the						
	_	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a community-based exercise is not						
	accessible, conduct an annual individual,						
	1	ctional exercise; or					
	. ,	Hospital, CAH] experiences					
		or man-made emergency					
	-	ation of the emergency					
		is exempt from engaging in					
	1	ull-scale community based					
		ty-based functional exercise					
	_	et of the emergency event.					
		an [additional] annual at may include, but is not					
	limited to the follo	-					
		scale exercise that is					
	community-based						
		ctional exercise; or					
		ock disaster drill; or					
	, ,	exercise or workshop that					
	. , ,	or and includes a group					
	discussion, using						
	clinically-relevant	emergency scenario, and a					
	set of problem sta						
	messages, or pre	pared questions designed					
	to challenge an er						
	l ', '	he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
	I = =	cility's] emergency plan, as					
	needed		I				I

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	OF CORRECTION	IDENTIFICATION NUMBER 15G127	A. BUILE B. WING			COMPL 07/19/	ETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1	031 WE	DDRESS, CITY, STATE, ZIP COD EST ST BANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	conduct exercises plan at least annu organization must (i) Participate in a that is community. (A) When a commaccessible, condufacility-based function of the exempt from en full-scale community-based functional exercise of the emergiality-based functional exercise of this section is community-based functional exercise of this section is community-based based functional exercise of the exempt from en full-scale community-based functional exercise of this section is community-based based functional exercise functional exer	ACE organization must to test the emergency ally. The PACE do the following: an annual full-scale exercise abased; or annual individual, ational exercise; or aperiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required aity based or individual, ational exercise following the gency event. In additional exercise every he year the full-scale or a under paragraph (d)(2)(i) conducted that may include, to the following: scale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. PACE's response to and antation of all drills, tabletop mergency events and revise gency plan, as needed.					

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	COM	PLETED 9/2021
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	1031	CADDRESS, CITY, STATE, ZIP WEST ST ALBANY, IN 47150	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	to test the emerge year, including un the emergency pro ICF/IID] must do to to Participate in a that is community. (A) When a commaccessible, conduct facility-based functions and that is exercipated a full-scallity-based functional following the onse that may include, following: (A) A second full-community-based based functional following: (B) A mock disass (C) A tabletop exiled by a facilitator discussion, using clinically-relevant set of problem star messages, or present to challenge an ereconstitution of the community-based functional set of problem star messages, or present to challenge an ereconstitution of the community-based functional set of problem star messages, or present or challenge and ereconstitution of the community-based functional set of problem star messages, or present or challenge and ereconstitution of the community-based functional set of problem star messages, or present or challenge and ereconstitution of the community-based functional set of problem star messages, or present or challenge and ereconstitution of the community-based functional set of problem star messages, or present or challenge and ereconstitution of the community-based functional set of problem star messages, or present or challenge and ereconstitution of the community	an annual full-scale exercise abased; or unity-based exercise is not ct an annual individual, tional exercise. ility] facility experiences an nan-made emergency that of the emergency plan, the mpt from engaging its next le community-based or based functional exercise of the emergency event. Iditional annual exercise but is not limited to the scale exercise that is or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. TC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed.				
	1 ' '	ne emergency plan at least				

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	OF CORRECTION	IDENTIFICATION NUMBER 15G127	A. BUII B. WIN	LDING		COMPL 07/19/	ETED
NAME OF I	PROVIDER OR SUPPLIEF	\ \			DDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		1031 WE NEW AL	EST ST BANY, IN 47150		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	following:	e ICF/IID must do the					
	_	n annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	accessible, condu	ct an annual individual,					
		tional exercise; or.					
	(B) If the ICF/IID e	experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the ICF/IID					
	is exempt from en	gaging in its next required					
	full-scale community-based or individual,						
	facility-based functional exercise following the						
	onset of the emer	-					
	` '	ditional annual exercise					
	· ·	but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
	community-based						
		ctional exercise; or					
	(B) A mock disast						
	1 ' '	ercise or workshop that is					
	I	and includes a group					
	discussion, using						
	set of problem sta	emergency scenario, and a					
		pared questions designed					
	to challenge an er	•					
	· ·	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	*[For HHAs at §48	34.102]					
		e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COM	E SURVEY PLETED 9/2021
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	1031 W	ADDRESS, CITY, STATE, ZIP CO /EST ST LBANY, IN 47150	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	is not accessible, individual, facility-every 2 years; or. (B) If the HH natural or man-materization of the exempt from engatull-scale community-based functional exercise of this section is continued, but is not (A) A second community-based facility-based functional exercise of this section is continued, but is not (A) A second community-based facility-based functional exercise is led by a facilitate discussion, using clinically-relevant set of problem state messages, or prepared to challenge an erection (IIII) Analyze the Hemaintain documer exercises, and emaintain documer exercises, and emaintain documer exercises to test to OPO must do the (III) Conduct a paper or workshop at lease exercise is led by	ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, ctional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop inergency events, and revise ency plan, as needed. 36.360] e OPO must conduct the emergency plan. The				

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPL	
		15G127	B. WI	NG		07/19/	2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	relevant emergen	cy scenario, and a set of					
	problem statemen	its, directed messages, or					
	prepared question	ns designed to challenge an					
	emergency plan. I	f the OPO experiences an					
	actual natural or n	nan-made emergency that					
	-	n of the emergency plan, the					
		om engaging in its next					
		xercise following the onset					
	of the emergency						
	(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed.						
	needed.						
	exercises to test ti RNHCI must do th (i) Conduct a pape at least annually. I group discussion in narrated, clinically scenario, and a se directed message designed to challed (ii) Analyze the RI maintain documer exercises, and em	e RNHCI must conduct he emergency plan. The					
	Based on record rev failed to conduct an emergency plan at I had no documentati pandemic as an actu activation of the ex- must do the followi (ii) Conduct an add	view and interview, the facility additional exercise to test the least once per year. The facility ion of counting the COVID hal emergency that required isting EPP. The ICF/IID facility ng: itional exercise that may imited to the following:	E 00	39	1.The administrator will ensuthe emergency plan policies and procedures includes the participation in a full-scale community based exercise and table top exercise in accordant with CFR 483.475(d)(2) and present in the EPP manual. 2.The area supervisor and program manager will conduct	nd d a ce	08/18/2021

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	OF CORRECTION	IDENTIFICATION NUMBER 15G127	A. BUILDING B. WING	JNSTRUCTION 	COMPLETED 07/19/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
RES CAF	RE COMMUNITY AL	TERNATIVES SE IN		LBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0000	functional exercise. b. A mock disaster of c. A tabletop exercise facilitator that include a facilitator, using a emergency scenario statements, directed questions designed to plan. (iii) Analyze the ICI maintain documentate exercises, and emergicate ICF/IID facility's en accordance with 42 deficient practice constitution. Findings include: Based on record revelot/19/2021 between Area Supervisor and additional testing or Preparedness Plan with Based on interview determined that the additional testing or documentation. The this assessment. This deficiency was Supervisor after records.	see or workshop that is led by a des a group discussion led by narrated, clinically-relevant, and a set of problem messages, or prepared to challenge an emergency F/IID facility's response to and attion of all drills, tabletop gency events, and revise the mergency plan, as needed in CFR 483.475(d)(2). This hald affect all occupants. iew and interview on a 11:20 a.m. to 2:30 p.m. with the d D.S.P., documentation of activation of the Emergency was not available for review. during record review, it was EPP did not include scheduled		table top exercise and ensure documentation of the table top exercise and the community based exercise are present in Emergency Disaster Preparedness Manual for reference as needed. 1.The Program Manager will schedule a training event with community based services the Area Supervisor, and Residen Manager ensure the facility tal part in the training. 2.The Program Manager will contact local community base services to schedule a community based table top exercise before February 23, 2019. 3.Persons Responsible: Program Manager, Area Supervisor, and Residential Manager.	the I e e e e e e e e e e e e e e e e e
Bldg. 01	_	Recertification Survey was diana Department of Health in CFR 483.470(j).	K 0000		

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	OF CORRECTION	IDENTIFICATION NUMBER 15G127	A. BUILD B. WING		01	COMPL 07/19/	ETED
	RE COMMUNITY AL	TERNATIVES SE IN	10	31 WE	DDRESS, CITY, STATE, ZIP COD EST ST BANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	II PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Survey Date: 07/19	/2021					
	Facility Number: 00 Provider Number: 1002 AIM Number: 1002	15G127					
	Community Alterna compliance with Re Medicaid, 42 CFR S from Fire and the 20 Protection Associati	Code survey, Res Care tives SE IN was found not in quirements for Participation in Subpart 483.470(j), Life Safety D12 Edition of the National Fire fon (NFPA) 101, Life Safety er 33, Existing Residential supancies.					
	fully sprinklered. T system with smoke and all living areas. and had a census of The attic of the facil purposes, storage, or	ling was determined to be he facility has a fire alarm detection in sleeping rooms The facility has a capacity of 8 6 at the time of this survey. lity is not used for living fuel-fired equipment. The ng a heat detection system e alarm system.					
	(E-Score) using NF	vacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the n E-Score of 1.8.					
14 0400	Quality Review con	npleted on 07/26/21					
K S100 Bldg. 01	Section 33.1 or 33						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/19/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1031	ET ADDRESS, CITY, STATE, ZIP COD WEST ST ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	K-tags, but are de along with the app NFPA standard cit on Form CMS-256 1. Based on observ facility failed to ensextinguisher located at least monthly and documented including person performing the states the provisions apply. LSC 4.6.12 obvious to the public to be either maintain Standard for Portab Edition, Section 7.2 shall be inspected ean electronic monitor minimum of 30-day manual inspections manual inspections manual inspections manual inspection work the person performed. Where manual conducted, records to be kept on a tag or lextinguisher, on an maintained on file, and Records shall be kept the last 12 monthly performed. This deficients, staff and visible findings include: Based on observation of the position of the position and the positions include:	ficient. This information, blicable Life Safety Code or tation, should be included 67. Vation and interview, the care 3 of 3 portable fire 1 in the facility were inspected 1 the inspections were 1 in the inspections were 1 in the facility were inspected 1 the inspections were 1 in the facility were inspected 1 in the facility were inspection shall be an unal inspections are for manual inspections are for manual inspections shall abel attached to the fire inspection checklist or by an electronic method. Put demonstrating that at least inspections have been facility were inspected 1 in the facility were inspections have been facility of the facility were inspected 1 in the facility wer		CROSS-REFERENCED TO THE APPROPE	DATE O8/31/2021 e will s of all De nance sCare ugust hecks act by ea ager to e being Dle the anager vice e e the t of s and atation. visits the
	1	0	1		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		15G127	B. WI	B. WING		07/19/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE		ID		ı	(Y5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1/10		ire and Safety System		1/10	maintaining proper documenta	ation	DATE
		r the sprinkler riser during the			6. The Administrator will	auon.	
	-	9/2021 between 2:30 p.m. to			ensure the 3 of 3 portable fire		
	•	D.S.P., the monthly fire			extinguisher is inspected annu	ıal	
	-	tion was only documented			along with all portable fire	ıaı	
		9. The inspections for April,			extinguisher in the facility.		
	May, and June (of 2				-		
		tag or the "Monthly Fire and			7. The Program Manager contacted Aramark scheduling	,	
		' Based on interview at the			work order to have the portable		
		, the D.S.P. indicated that			extinguisher in the living room		
		s were being done by			hung by a bracket supplied by		
					manufacturer approved for su		
individuals with the company but not recorded on the tags. No other form of a record of monthly				1	CII		
inspections was provided for review.				purpose. 8. The Program Manager	اانيم		
	hispections was pro	vided for review.] -	WIII	
	This deficiency was	s reviewed with the D.S.P.			insure all portable fire	st oll	
		aference held on 07/07/2021.			extinguishers are accessible a	it all	
	during the Exit Con	merence neid on 07/07/2021.			times and random monthly	by	
	2 Rosed on record	I review and interview; the			inspections will be conducted	-	
		sure 2 of 2 battery operated			the management team to verif 9. The Program Manager	y.	
	•	the facility were maintained in			The Program Manager contacted Aramark to schedul		
		C 7.9. LSC 7.9.3, Periodic					
		acy Lighting Equipment,			the repair of the cross corridor		
		il test to be conducted for 30			door to repair the latching mechanism, upon repair rando	om.	
	-	ntervals and an annual test to			monthly inspection will be	וווע	
		ery required battery powered			conducted by a member of the		
		system for not less than a 1 ½			management team to insure	-	
		ipment shall be fully			proper functionality.		
	_	duration of the test. Written			10. The Program Manager		
	-	spections and tests shall be			contacted Aramark to schedul		
		or inspection by the authority			the repair of 1 of 2 interior	٠	
		This deficient practice could			emergency lights, upon repair		
	affect all occupants	-			random monthly inspection wi		
	arreet arr occupants	•			conducted by a member of the		
	Findings include:				management team to insure	_	
	i mamgo metade.				proper functionality.		
	Based on record rev	view of the log entitled			11. Concerning annual		
	Based on record review of the log entitled "Monthly Fire and Safety System Checks" posted				maintenance of Fire Extinguis	her	
		ser during the facility tour on			The Associate Executive Direction		
	_	n 2:30 p.m. to 3:30 p.m. with the					
	0 // 1 3/ 20 2 1 DELWEEL	1 2.50 p.m. to 5.50 p.m. with the			contacted Eric Grey with Koor	3CII	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE C A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/19/2021		
NAME OF P	ROVIDER OR SUPPLIER		STREET	T ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF P	KOVIDEK OK SUPPLIER	C	1031 \	WEST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	NEW /	ALBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION PRIATE	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	-	battery operated emergency		Fire and Security on August	t 3,	
		s only documented until		2021 to schedule annual		
		documentation of testing from		maintenance for all the facil		
		ths was available for review.		Fire Extinguisher. The Sco	•	
		at the time of observation, the		work has been updated to e	ensure	
		ed lack of documentation but		the inclusion of annual		
	checked the operation	came on a regular basis and		maintenance for portable fir	e	
	checked the operation	on of the fights.		extinguishers and required		
	This definionary was	s reviewed with the D.S.P.		documentation. The Progra		
	-	ference held on 07/07/2021.		Manager, Area Supervisor a Direct Support Lead have b	l l	
	during the Exit Con	nerence held on 07/07/2021.				
	2 Pagad on abgam	votion and interview the		in-serviced on the requirem	ent and	
3. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers in			if a deficiency is noted the			
	the living room was protected. NFPA 10, Standard			Program Manager, Area Supervisor or Direct Support	t Lood	
	_	stinguishers, 6.1.3.4 requires		· · · · · · · · · · · · · · · · · ·		
		tinguishers types shall be (1)		will contact (844) ResCare to create a service order. The	.0	
	_	(2) in the bracket supplied by		Associate Executive Director		
	_) in a listed bracket approved		contacted Aramark Services		
	·) in cabinets or wall recesses.		June 25, 2021 the Facilities		
		ice could affect all occupants.		maintenance vendor to ensure the		
	This deficient pract	ice could affect all occupants.		scope of work for Koorsen F		
	Findings include:			and Security included the a		
	i manigs merade.			maintenance of portable fire		
	Based on observation	on during the facility tour on		extinguishers and required	,	
		n 2:30 p.m. to 3:30 p.m. with the		documentation will be made	_	
		uisher located in the Cleaning		available for review.		
	_	n the floor unsupported.		12. The Facility will ensure	e	
		at the time of observation, the		interior emergency lights are		
		ed that the portable fire		tested, maintained, and rec		
		the floor and appeared to be		testing are maintained.		
	-	interview at the time of		13. The Facility will ensure	e l	
	_	S.P. stated that she did not		interior emergency lights are	l l	
		ble fire extinguisher was there.		tested at a minimum of 3 we		
	•			and a maximum of 5 weeks		
	This deficiency was	s reviewed with the D.S.P.		less than 30 seconds, recor		
	•	ference held on 07/07/2021.		test will be maintained by th	l l	
	-			facility.		
	4. Based on observ	vation and interview, the		14. The facility will ensure	a	
	facility failed to ens	sure 1 of 3 fire extinguishers		functional test is conducted		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/19/2021	
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	1031 V	ADDRESS, CITY, STATE, ZIP COD VEST ST ALBANY, IN 47150	
	SUMMARY: (EACH DEFICIEN REGULATORY OR was accessible at al Portable Fire Exting states fire extinguis: located where they immediately available deficient practice of Findings include: Based on observation 07/19/2021 between D.S.P., one fire extinguisher. Based observation, the D.S. extinguisher was not This deficiency was during the Exit Con 5. Based on observation for the Exit Con 5. Based on observation stringuisher was not consider the stringuisher was not the deficiency was during the Exit Con 5. Based on observation stringuisher was not considered to self close alarm system activate released by the hold states the provisions apply. LSC 4.6.12.		1031 V	VEST ST	DATE /2 Interior che will acy
	be either maintained practice could affect Findings include: Based on observation 07/19/2021 between	ed to the fire alarm system, to d or removed. This deficient t all clients, staff and visitors. on during the facility tour on a 2:30 p.m. to 3:30 p.m. with the rridor door did not latch into			
		closed in the event of			

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	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN		1031 W	DDRESS, CITY, STATE, ZIP COD EST ST BANY, IN 47150		
	ı			L	·		775
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
	^	to fire. The door was equipped					
		ld open device arranged to self					
		close with fire alarm system n interview at the time of					
		S.P. acknowledged that the					
		provided some degree of					
		rent of an emergency and that					
	_	gage the strike on the frame.					
	the fater did not en	gage the strike on the frame.					
	This deficiency was	s reviewed with the D.S.P.					
		nference held on 07/07/2021.					
	8						
	6. Based on observation and interview, the						
	facility failed to ensure 1 of 2 interior emergency						
		ng order. LSC 33. 1.1.3 states					
	the provisions of C	hapter 4, General, shall apply.					
	LSC 4.6.12.3 states	s existing life safety features					
	obvious to the publ	ic, if not required by the Code,					
	shall either be main	ntained or removed. LSC					
	7.9.3.1.1 testing of	required emergency lighting					
	systems shall be pe	rmitted to be conducted as					
	follows:						
		ng shall be conducted monthly,					
		3 weeks and a maximum of 5					
	weeks between test	s, for not less than 30					
	seconds.						
	` '	l shall be permitted to be					
		0 days with approval of the					
	authority having ju						
		ng shall be conducted annually					
		½ hours if the emergency					
	lighting is battery p						
		lighting equipment shall be					
		or the duration of the test.					
		of visual inspections and tests					
	authority having ju	e owner for inspection for the					
		tice could affect occupants on					
		the facility were required to					
	-	rgency during a loss of normal					
	evacuate III all cille	igency during a loss of normal					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		A. BUILI B. WING	DING	01	COMPL 07/19/	ETED	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		1031 WE	DDRESS, CITY, STATE, ZIP COD EST ST BANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	power. Findings include:						
	Based on observation of 07/19/2021 between D.S.P., 1 of 2 of the lights failed to light interview at the tim	on during the facility tour on a 2:30 p.m. to 3:30 p.m. with the battery operated emergency during testing. Based on e of observation, the D.S.P. no aware how long the d not been working.					
	1	s reviewed with the D.S.P. ference held on 07/07/2021.					
	facility failed to doc extinguishers located maintenance at intenance	entifies the person performing ifies the name of the agency k. This deficient practice could					

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/19/2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1031 V	ADDRESS, CITY, STATE, ZIP COD VEST ST ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K S211 Bldg. 01	07/19/2021 between D.S.P., the portable Cleaning Closet had documenting mainted than one year ago. of observation, the extinguisher in the not being used. She extinguisher was not This deficiency was during the Exit Con NFPA 101 Means of Egress - Means of Escape 2012 EXISTING Designated means continuously main	reviewed with the D.S.P. ference held on 07/07/2021. General General s of escape shall be tained clear of obstructions			
	case of fire or eme 33.2.2 1. Based on observ facility failed to ma of escape on the firs maintained clear of to full instant use in This deficient pract on the first story inc the staff and visitors means of escape thr Findings include: Based on observation	to full instant use in the ergency. vation and interview, the intain 1 of 3 designated means st story be continuously obstructions and impediments the case of fire or emergency. It is could affect all consumers eluding 2 of 7 sleeping rooms so on the first story requiring ough the Med. Room.	K S211	1.The administrator will ensure Designated means of escape be continuously maintained cloud of obstructions and impediment to full instant use in the case of fire or emergency. 2.The administrator will ensure the removal of boxes obstruct the exterior door of the med rooms. upon removal random monthly inspection will be conducted by a member of the management team to insure proper functionality.	shall ear nts of ure ing

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G127	B. W	ING		07/19/	2021
				CTREET	ADDRESS STEW STATE ZID SOD		
NAME OF F	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
DEC OA		TEDNIATIVES OF IN			EST ST		
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	rc	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	D.S.P., the exterior	door from the Med. Room was			3.Staff will be in-serviced on	the	
	obstructed by boxes	s of supplies waiting to be			daily inspection of all doors us	ed	
		s obstructed the opening of			for evacuation and if a deficier		
		or door by 14" and did not			is found they are to immediate	-	
		pen fully. The emergency			report any issues to ResCare	.,	
		an for the first story of the			Maintenance.		
		exterior door from the Office			4.The Residential Manager v	will	
		e. Based on interview at the			check all doors used for		
	•	, the D.S.P., the supplies where			evacuation weekly and if a		
		rt time until they are picked up.			deficiency is found they are to		
		cted the operation of the door			immediately report any issues	to	
	the entire time of th				ResCare Maintenance.		
	the of the of the survey				5.The Management team wil	ı	
	This deficiency was reviewed with the D.S.P.				conduct monthly inspections for		
	during the Exit Conference held on 07/07/2021.				proper function of all doors use		
	1				for evacuation and if a deficier		
	2. Based on observ	vation and interview, the			is found they are to immediate	-	
		intain 1 of 1 designated means			report any issues to ResCare	·y	
	•	second story be continuously			Maintenance.		
	-	obstructions and impediments			6.The Program Manager will		
		the case of fire or emergency.			in-service the staff on blocking		
		le stairs are classified as a			doors with lawn chairs upon re		
	-	o not having the required			random monthly inspection wil	-	
		neans of escape. This deficient			conducted by a member of the		
		t 5 consumers in their sleeping			management team to insure e		
	_	d story and staff attending to			doors remain unobstructed.	ΛIL	
	them.	a story and starr attending to			doors remain unobstructed.		
	them.				Persons Responsible: AED,		
	Findings include:				Program Manager, Area		
	i manigs merade.				Supervisor, and Residential		
	Based on observation	on during the facility tour on			Manager, DSP. Aramark, Res	Care	
		n 2:30 p.m. to 3:30 p.m. with the			Maintenance.	Jaie	
		nairs, used by the consumers			ivialitelialice.		
		een placed immediately outside					
		com the interior stairs from the					
		hairs obstruct the means of					
	-						
	-	ond story of the house. Based					
		time of the observation, the					
	_	knowledged that the chairs					
	blocked the path of	escape. He also noted that the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		15G127	B. WING		07/19/2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1031 V	ADDRESS, CITY, STATE, ZIP COD WEST ST ALBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S BLANGE CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	chairs are not alway location.	s located in their current			
		s reviewed with the D.S.P. ference held on 07/07/2021.			
K S222	NFPA 101				
Bldg. 01	escape shall not be Bathroom doors so inches. Doors are closet door latch so the inside in case bathroom door shadopening from the demergency when means of escape egress when the be Delayed egress lo	of travel to a means of the less than 28 inches. Thall not be less than 24 swinging or sliding. Every shall be readily opened from of an emergency. Every all be designed to allow butside during an locked. No door in any shall be locked against building is occupied. cks complying with			
	only. Access-contromplying with 7.2 Forces to open do 7.2.1.4.5. Door-latching devi 7.2.1.5.10. Corrido positive latching hare prohibited. Door assemblies for required to swing travel shall be inspettion.	permitted on exterior doors rolled egress locks 2.1.6.2 shall be permitted. For shall comply with sides shall comply with or doors are provided with ardware, and roller latches for which the door leaf is in the direction of egress pected and tested not less occordance with 7.2.1.15.			
	483.470(j)(1)(ii) 1. Based on obser facility failed to ma	vation and interview, the intain 1 of 3 designated means t story be continuously	K S222	1.The administrator submitte work order Aramark for the ex	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>			ETED
		15G127	B. W	ING		07/19/	2021
			<u> </u>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			EST ST		
DES CVE		I TEDNIATIVES SE INI			LBANY, IN 47150		
KES CAP	RE COMMUNITY A	LTERNATIVES SE IN		INEVV A	LDAN1, IN 47 150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	maintained clear of	obstructions and impediments			office door for the removal of t	he	
		the case of fire or emergency.			dead bolt lock, upon repair rar	ıdom	
		of the LSC states: no door in			monthly inspection will be		
	-	e, other than those meeting			conducted by a member of the	;	
	-	33.2.2.5.5.1 or 33.2.2.5.5.2, shall			management team to insure		
	-	gress when the building is			proper functionality.		
	-	cient practice could affect all			2.Staff will be in-serviced on	the	
		rst story including 3 of 7			daily inspection of all doors us		
	sleeping rooms the	staff and visitors on the first			for evacuation and if a deficier	· 1	
	story.				is found they are to immediate	:ly	
					report any issues to ResCare		
	Findings include:				Maintenance.		
					3.The Residential Manager	will	
		on during the facility tour on			check all doors used for		
		n 2:30 p.m. to 3:30 p.m. with the			evacuation weekly and if a		
		door from the Office is			deficiency is found they are to		
		y-operated dead-bolt lock. The			immediately report any issues	to	
		ion route plan for the first			ResCare Maintenance.		
		llustrates the exterior door			4.The Management team wi		
		means of escape. This device			conduct monthly inspections for		
	_	g the door in the means of			proper function of all doors us		
	-	terview at the time of			for evacuation and if a deficier	-	
	· ·	S.P., a key for the dead-bolt			is found they are to immediate	:ly	
		ble to verify the mechanical			report any issues to ResCare		
	operation of the cyl	inder.			Maintenance.		
	TEL: 1 (° '	: 1 :4 4 B C B			5.The program manger]	
		s reviewed with the D.S.P.			contacted Aramark to remove		
	during the Exit Con	ference held on 07/07/2021.			bathroom keyed lock and repla	ace	
	2 D1 1	and in and industrial of			it with an easy access lock to		
		vation and interview, the			ensure access will not be dela	yea,	
	•	intain 1 of 3 designated means			upon repair random monthly		
	-	st story be continuously			inspection will be conducted b	-	
		obstructions and impediments			member of the management to	∍am	
		the case of fire or emergency.			to insure proper functionality.		
		of the LSC states: no door in					
		e, other than those meeting			Devene Beenengthie AED		
	_	33.2.2.5.5.1 or 33.2.2.5.5.2, shall			Persons Responsible: AED,		
	-	gress when the building is			Program Manager, Area		
	_	cient practice could affect all			Supervisor, and Residential		
	consumers on the fi	rst story including 3 of 7			Manager, DSP		

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15G127 B. WING 07/19/2021 STREET ADDRESS, CITY, STATE, ZIP COD	
STREET ADDRESS, CITY, STATE, ZIP COD	_
NAME OF PROVIDER OR SUPPLIER 1031 WEST ST	
RES CARE COMMUNITY ALTERNATIVES SE IN NEW ALBANY, IN 47150	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG: PEGLII ATORY OR LSC IDENTIFYING INFORMATION TAG DATE	1
TAG REGULATOR OR ESCIDENTIFIED INFORMATION TAG DATE	
sleeping rooms the staff and visitors on the first story.	
Story.	
Findings include:	
Based on observation during the facility tour on	
07/19/2021 between 2:30 p.m. to 3:30 p.m. with the	
D.S.P., the exterior door to the Med. Room from	
the hallway is equipped with a key-operated	
lockset. The emergency evacuation route plan for the first story of the house illustrates the interior	
door to the Med. Room on a means of escape	
route. This device is capable of locking the door	
in the means of escape. Based on interview at the	
time of observation, the D.S.P., a key for the	
lockset is carried by a staff person on duty at all	
times. In the event of an emergency when the staff	
is elsewhere in the house, access through the	
Med. Room is not available to the occupants of	
Bedroom #2 and #3 on the first story.	
This deficiency was reviewed with the D.S.P.	
during the Exit Conference held on 07/07/2021.	
2. Deced on shear ration and interview the	
3. Based on observation and interview, the facility failed to maintain the Med. Room	
bathroom door be continuously maintained clear	
of obstructions and impediments to full instant	
use in the case of fire or emergency. Section	
33.2.2.5.4 of the LSC states: every bathroom door	
shall be designed to allow opening from the	
outside during an emergency when locked. This	
deficient practice could affect consumers on the	
first story including 2 of 7 sleeping rooms the staff	
and visitors on the first story.	
Findings include:	ļ
Based on observation during the facility tour on	
07/19/2021 between 2:30 p.m. to 3:30 p.m. with the	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(x3) date survey COMPLETED 07/19/2021
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	1031 V	ADDRESS, CITY, STATE, ZIP COD VEST ST LBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K S345	Bathroom has a priv not open from the o on interview at the t made every attempt keys available. This deficiency was	n door to the Med. Room vacy lockset that staff could utside during the tour. Based ime of observation, the D.S.P., to open the door with the reviewed with the D.S.P. ference held on 07/07/2021.			
Bldg. 01	Maintenance Fire Alarm System Maintenance 2012 EXISTING (I A fire alarm syster in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are rea 9.7.5, 9.7.7, 9.7.8,	Prompt) In a Testing and Prompt) In is tested and maintained In an approved program It requirements of NFPA 70, It code, and NFPA 72, In and Signaling Code. In acceptance, maintenance It is a signal of the signal			
	failed to ensure 1 of maintained in accor Fire Alarm and Sign Edition, 14.2.1.2.1 s Section 10.19 shall impaired. Section 1 and malfunctions shapractice could affect Findings include: Based on observation 10.7/19/2021 between D.S.P., the smoke dispersion of the maintained in accordance in the maintained in the	on and interview; the facility I fire alarm systems was dance with NFPA 72, National naling Code. NFPA 72, 2010 states the requirements of be applicable when a system is 4.2.1.2.2 states system defects all be corrected. This deficient t all clients, staff, and visitors. on during the facility tour on a 2:30 p.m. to 3:30 p.m. with the etector in the Dining Room is ectrical box in the ceiling by	K S345	1. The administrator will ensurannual functional testing for initiating devices such as smol detectors, heat detectors, release devices, and fire alarm boxes in performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available the facility for review. 2. The administrator will ensurance sensitivity testing of the fire alarm system is completed by Koorse Fire and Security every alternative after install and that report of the tests/inspections are	ke ase is d em in ire arm en ate

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/19/2021	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		WEST ST ALBANY, IN 47150	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
1110		Based on interview at the time		available in the facility for rev	
		D.S.P. stated she did not know		Koorsen Fire and Security wil	I
	I -	e detector had been loose from		also forward inspection repor	
	the ceiling.			the QA Manager for monitoring	ng of
	This deficiency was	s reviewed with the D.S.P.		completion. 3.The Program Manager wi	u
	I -	ference held on 07/07/2021.		meet with a representative from	
				Koorsen Fire and Security, a	
				tentative date has been set for	or
				August 16, 2021 The Facility	
				require schedule required tes	9
				and request copies of inspect	
				and testing mailed to the prog manager upon completion to	·
				Program Manager at 4341	uiic
				Security PKWY Suite 101 Ne	w
				Albany IN 47150.	
				4.The Program Manager sp	
				with the Kris Carney from Koo	orsen
				Fire and Security effective	
				immediately all sites will have annual functional fire alarm	an
				inspection in the Month of	
				February and a semiannual fi	re
				alarm visual inspection comp	
				in August. Repair of the device	
				that failed the sensitivity test	
				been scheduled to be comple	
				no later than August 31,2021 Access to the device will be	•
				made available and that device	ce will
				be tested no later than Augus	
				2021. Koorsen Fire and Sec	
				was notified of ResCare's "In	
				Scope Services Agreement"	hat
				automatically authorizes	
				repair/service of fire systems.	
				Koorsen will notify the Progra Manger upon completion of a	
				inspections to ensure any	"

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	OF CORRECTION	IDENTIFICATION NUMBER 15G127	A. BUILDING B. WING	01	COMPLETED 07/19/2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1031 W	ADDRESS, CITY, STATE, ZIP COD VEST ST ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				deficiencies are properly track and repaired. Koorsen will ser documentation of all inspection services and repair to ResCarmain office at 4341 Security Parkway STE. 101 New Albart 47150 within 30 days of composervice. The Program Manager follow up to ensure work is completed and documented a required. 5.The Program Manager contacted Aramark to schedule the repair of the smoke detect the dining room repair will be made no later than August 31 2021. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire a Security Representative.	nd ons, re ny IN oleted er will as
K S353 Bldg. 01	Sprinkler System 2012 EXISTING (INFPA 13 and 13R All sprinkler system with NFPA 13, State Sprinkler Systems for the Installation Residential Occup Four Stories in Heand maintained in Standard for Inspec	- ·			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COMP	E SURVEY PLETED 9/2021
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP C	OD	
				VEST ST		
RES CAI	RE COMMUNITY AI	LTERNATIVES SE IN	NEVV A	ALBANY, IN 47150		_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORI		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE PPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	NFPA 13D System					
	_ ·	installed in accordance tandard for the Installation				
		ms in One- and Two-Family				
	· ·	nufactured Homes, are				
	inspected, tested					
		ne following requirements of				
	NFPA 25:	3 .				
	1. Control valves	s inspected monthly (NFPA				
	25, section 13.3.2).				
	2. Gauges inspe	cted monthly (NFPA 25,				
	section 13.2.71).					
	Alarm devices inspected quarterly					
	(NFPA 25, section 5.2.6).					
		s tested semiannually				
	(NFPA 25, section	•				
		sory switches tested				
	- '	PA 25, section 13.3.3.5).				
	((NFPA 25, section	ers inspected annually				
		spected annually (NFPA				
	25, section 5.2.2).					
		angers inspected annually				
	(NFPA 25, section					
	9. Buildings insp	ected annually prior to				
	•	or adequate heat for water				
		A 25, section 5.2.5).				
	•	ative sample of fast				
		rs are tested at 20 years				
	(NFPA 25, section					
		ative sample of dry pendant				
	section 5.3.1.1.15	ed at 10 years (NFPA 25,				
). Dolutions are tested annually				
	(NFPA 25, section					
	,	es are operated through				
		d returned to normal				
	_	5, section 13.3.3.1).				
		ems of OS&Y valves are				
		y (NFPA 25, section				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		15G127	B. WI	NG		07/19/	2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD VEST ST LBANY, IN 47150	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	unheated portions inspected, tested section 13.4.4). A. Date sprinkler section 13.4.4). A. Date sprinkler sections are cessary mainter. B. Show who prove the source automatic sprinkles. (Provide in REMA coverage for any reautomatic sprinkles) and NFPA 25. 1. Based on record facility failed to do and quarterly sprinkles accordance with NF the Inspection, Test Water-Based Fire Pedeficient practice of facility. Findings include: Based on record reverse of the section of includes for review. The system - quarterly of 5/06/2021 indicated inspection and testing individual within the reached on the desired section of the section	e of the water supply for the er system. RKS information on non-required or partial	K S.	353	1.Sprinkler head location on pantry will be relocated by Koorsen Fire and Security Bel October 31, 2022. 2.Sprinkler head location in Bedroom #1 will be relocated Koorsen Fire and Security Bel October 31, 2022. 3.The Program Manager, Ar Supervisor and Direct Support Lead have been in-serviced or requirement of monthly visual inspections for all Fire alarm a Sprinkler components and if a deficiency is noted the Program Manager, Area Supervisor or Direct Support Lead will contain (844) ResCare to create a ser order. 4.The Associate Executive Director contacted Joe Moore Aramark Services on June 11	by fore rea t n the and m act vice	10/31/2021

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	ì í	JILDING	onstruction 01	(X3) DATE COMPL 07/19 /	ETED
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD VEST ST LBANY, IN 47150	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	between 2:30 p.m. were found at the syservice work was pon interview at the and the Area Super the recipient of the provide documentar. This deficiency was during the Exit Cordinary t	to 3:30 p.m. with the D.S.P., tags or		TAG	2021 the Facilities maintenand vendor to ensure the scope of work for Koorsen Fire and Sec for the installation of the missi escutcheon plate and replaced of dirty sprinkler head is included Upon completion no later than 1, 2021 documentation will be made available for review. 5.An Additional Meeting with Aramark we held on Thursday August 19, 2021 to discuss the streamlining of bid and contral process, in conjunction with Koorsen Fire and security. The requirements for collecting 3 competitive bids has been removed and the approval for payment has been submitted. Work will be completed no late than October 31, 2021 howeved the expectation is for work to be complete as soon as possible Upon completions all documentation will be made available for review. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire as Security Representative	ce curity ng ment ded. i July n e cting	DATE
	07/19/2021 between Area Supervisor an was available for re	view and interview on n 11:20 a.m. to 2:30 p.m. with the d D.S.P., no documentation view. Based on record review our on 07/19/2021 between 2:30					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COM	TE SURVEY IPLETED 19/2021
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	1031 V	ADDRESS, CITY, STATE, ZIP C VEST ST ALBANY, IN 47150	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		(X5) COMPLETION DATE
	"Monthly Fire and indicated that sprint inspections were m documentation of n December 20219 w review. Based on ir observation, the D.3 the organization did regular basis without their service. This deficiency was during the Exit Cord. 3. Based on observation of the did to ensure the sprinkler head were in accordance with edition, Section 8.7 located a minimum wall. Findings include: Based on observation of the construction of the construction of the at the time of observacion of the at the time of observacion wall of the wall and Pantry she began working years ago. This deficiency was according to the deficiency was according to the section of the according to the section of the wall and Pantry she began working years ago.	ith the D.S.P., a log entitled Safety System Checks" kler valve and gauge ade until December of 2019. No nonthly inspections after ere made available for record atterview at the time of S.P. stated that someone from a inspect the system on a att providing documentation of serviewed with the D.S.P. afterence held on 07/07/2021. In vation and interview, the sure the spray pattern for a senot obstructed in the Pantry 33.2.3.5. NFPA 13, 2010 In J.S.P. after shall be of 4 in. (102 mm) from an end on during the facility tour on a 2:30 p.m. to 3:30 p.m. with the sprinkler has been obstructed of the front wall of the pantry. The pantry is only 1.5 inches from a deflector. Based on interview vation, the D.S.P. aprinkler was less than 4" from a pantry. The D.S.P. stated that had been as is since before at the house more than two				
	aaring the Exit Con	110101100 1101d 011 0 // 0 // 2021.				1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		A. BUIL B. WING	DING	01	COMPL 07/19/	ETED	
	RE COMMUNITY AL	TERNATIVES SE IN		1031 WE	DDRESS, CITY, STATE, ZIP COD EST ST BANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
	facility failed to ens sprinkler heads were story Bedroom #1 in NFPA 13, 2010 edit sprinklers shall be le obstructions to discl 8.5.5.3 or additional ensure adequate cov deficient practice coefficient practice coefficie	ration and interview, the ure the spray pattern for e not obstructed in the first in accordance with 33.2.3.5. ion, Section 8.5.5.1, states ocated so as to minimize marge as defined in 8.5.5.2 and sprinklers shall be provided to serage of the hazard. This hald affect all clients. In during the facility tour on a 2:30 p.m. to 3:30 p.m. with the been constructed in the room spray pattern from the located in the room from mer. Based on interview at the the D.S.P. stated that closet before she began working at two years ago. The reviewed with the D.S.P. ference held on 07/07/2021.					
K S356		Supervisory Signals					,
Bldg. 01	2012 EXISTING (S In Slow Evacuation an automatic sprin either total or parti system shall be in 9.7 and shall initial accordance with 9 adequacy of the w documented.	Supervisory Signals Slow) n Capability facilities where kler system is installed, for al building coverage, the accordance with Section te the fire alarm system in .6, as modified below. The ater supply shall be					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	l í	UILDING	onstruction 01	(X3) DATE COMPI 07/19	LETED
NAME OF I	PROVIDER OR SUPPLIEF	₹	_		ADDRESS, CITY, STATE, ZIP COD EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION DATE
		er system in accordance					
	with NFPA 13D, S	Standard for the Installation					
	of Sprinkler Syste	ms in One and two Family					
	I -	inufactured Homes, shall be					
	I -	atic sprinklers shall not be					
	1	s not exceeding 24 square					
		oms not exceeding 55					
		ded that such spaces are					
		and plaster or materials					
		nute thermal barrier.					
	In Slow Evacuation Capability facilities, where an automatic sprinkler system is in						
	accordance with NFPA 13, Standard for the						
	Installation of Sprinkler Systems, automatic						
	sprinklers shall not be required in closets not						
		are feet and in bathrooms					
		square feet, provided that					
	such spaces are f	inished with lath and					
	plaster or materia	l providing a 15-minute					
	thermal barrier.						
		on Capability facilities, in					
	_	ewer stories above grade					
	1 '	accordance with NFPA					
		the Installation of Sprinkler					
	l -	ential Occupancies up to					
		ır Stories in Height, shall be					
	permitted.	e alarm system shall not be					
	required for existing	•					
	accordance with 3	_					
		atic sprinkler is installed,					
		ng purposes, storage, or					
		ent are sprinkler protected.					
		r living purposes, storage,					
		ment meet one of the					
	following:						
		heat detection system to					
		arm system according to					
	9.6.						
	2. Protected by	automatic sprinkler system					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G127		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/19/2021	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	1031	T ADDRESS, CITY, STATE, ZIP COD WEST ST ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
	limited-combustib 4. Constructed of wood according to 33.2.3.5.3, 33.2.3 33.2.3.5.3.6	of fire-retardant-treated	K S356	ResCare Maintenance conduct monthly inspections	00/01/2021
	failed to document supply shall be doc having jurisdiction. states: where an autinstalled, for either coverage the adequ be documented to tijurisdiction. Standa and Maintenance of Systems. This deficients in the facility. Findings include: Based on record revolved and Supervisor and documentation of the supply. Based on retour on 07/19/2021 with the D.S.P., doconly was recorded and Safety Systems. This deficiency was reprovide documentation.	the adequacy of the water umented to the authority Section 33.2.3.5.3 of the LSC comatic sprinkler system is total or partial building acy of the water supply shall me authority having and for the Inspection, Testing, and Water-Based Fire Protection ient practice could affect all y. Wiew and interview on an 11:20 a.m. to 2:30 p.m. with the d D.S.P., there was no ne adequacy of the water record review during the facility between 2:30 p.m. to 3:30 p.m. cumentation of the pressure on the log entitled "Monthly tem Checks" and only until used on interview at the time of S.P. and the Area Supervisor ach the recipient of the ports but were unable to		the facility sprinkler system. Documented test dates will be kept onsite and with mainter manager for review. 2. The AED met with Residential Manager, Area Supervisor and Residential Manager, Area Supervisor or Residential Min service Program Manager, Area Supervisor or Residential Min spections are completed as required and available for review. If documentation is not available Program Manager, Area Supervisor or Residential Min will contact Aramark (844)-RESCARE and create a service or and follow up to ensure completion within 5 days. 4. The AED will in service Program Manager, Area Supervisor and Residential Manager on the requirement inspecting Fire Extinguishers maintaining proper documer Persons Responsible: AED Program Manager, Area	coe nance sCare ugust hecks ct by ea ager to e being cle the anager vice e e the t of s and ntation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		A. BUILDING B. WING	01	COMPI 07/19	LETED	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	1031 W	ADDRESS, CITY, STATE, ZIP COD /EST ST ILBANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
				Supervisor, and Residentia Manager, DSP	I	
K S358	NFPA 101 Sprinkler System -	Installation				
Bldg. 01	Sprinkler System - 2012 EXISTING (SIn Slow Evacuation an automatic sprine either total or partisystem shall be in 9.7 and shall initiar accordance with 9 adequacy of the widocumented. In Slow Evacuation automatic sprinkle with NFPA 13D, Sof Sprinkler System Dwellings and Marpermitted. Automarequired in closets feet and in bathroosquare feet, providing a 15-min In Slow Evacuation an automatic sprinkler shall not exceeding 24 square feet and in sprinklers shall not exceeding 24 square feet and in Sprinklers shall not exceeding 24 square feet and in Sprinklers shall not exceeding 25 such spaces are finglaster or material thermal barrier. In Slow Evacuation buildings four or feet plane, systems in a square feet and sprinklers are finglaster or material thermal barrier.	Installation Slow) In Capability facilities where kler system is installed, for all building coverage, the accordance with Section te the fire alarm system in .6, as modified below. The atter supply shall be In Capability facilities, an ar system in accordance tandard for the Installation ms in One and two Family hufactured Homes, shall be tic sprinklers shall not be not exceeding 24 square oms not exceeding 55 led that such spaces are and plaster or materials the termal barrier. In Capability facilities, where				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G127	B. W	ING		07/19/	2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	<u>, </u>	1031 W	ADDRESS, CITY, STATE, ZIP COD /EST ST LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	NEOVIDERIC N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and including Four permitted. Initiation of the fire required for existir accordance with 3 Where an automa attics used for livir fuel-fired equipme Attics not used for or fuel-fired equipme following: 1. Protected by activate the fire also. 2. Protected by according to 9.7. 3. Constructed of limited-combustible 4. Constructed of wood according to 33.2.3.5.3, 33.2.3.33.2.3.5.3.6 Based on record reversal failed to document a supply shall be documented to the documented to	tic sprinkler is installed, and purposes, storage, or ent are sprinkler protected. Viving purposes, storage, ment meet one of the heat detection system to arm system according to automatic sprinkler system of noncombustible or le construction; or of fire-retardant-treated of NFPA 703. 5.3.2 through 33.2.3.5.3.4, when and interview, the facility the adequacy of the water umented to the authority Section 33.2.3.5.3 of the LSC comatic sprinkler system is total or partial building acy of the water supply shall the authority having and for the Inspection, Testing, if Water-Based Fire Protection lient practice could affect all	KS	358	1. ResCare Maintenance we conduct monthly inspections of the facility sprinkler system. Documented test dates will be kept onsite and with maintenant manager for review. 2. The AED met with ResC Maintenance Manager on Aug 3, 2021 to ensure monthly cheare being performed. 3. The Facility will conduct random monthly inspections be the Residential Manager, Area Supervisor or Program Managensure documentation of Fire Extinguisher Inspections are be completed as required and	f nce are ust ecks y n er to	08/18/2021

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		15G127	B. W	ING		07/19/	2021
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	•	1031 W	ADDRESS, CITY, STATE, ZIP COD IEST ST LBANY, IN 47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
	Area Supervisor and	d D.S.P., there was no			available for review. If		
		e adequacy of the water			documentation is not available	the	
	supply. Based on re	cord review during the facility			Program Manager, Area		
		between 2:30 p.m. to 3:30 p.m.			Supervisor or Residential Man	ager	
		rumentation of the pressure			will contact Aramark (844)-		
		on the log entitled "Monthly			RESCARE and create a service	ce	
	Fire and Safety System Checks" and only until				order and follow up to ensure		
	December 2019. Based on interview at the time of				completion within 5 days.		
	observation, the D.S.P. and the Area Supervisor				4. The AED will in service t	he	
	made attempts to reach the recipient of the				Program Manager, Area		
	sprinkler system reports but were unable to provide documentation for review. This deficiency was not reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.				Supervisor and Residential		
					Manager on the requirement of		
					inspecting Fire Extinguishers		
					maintaining proper documenta	auon.	
					Persons Responsible: AED,		
					Program Manager, Area		
					Supervisor, and Residential		
					Manager, DSP		
					3 ,		
K S362	NFPA 101						
	Corridors - Constr	uction of Walls					
Bldg. 01	Corridors - Constr						
	2012 EXISTING (F	• *					
		ndicated below, corridor					
	walls shall meet al	•					
		ng sleeping rooms have a					
		fire resistance rating,					
		ed to be achieved if the					
		hed on both sides with lath					
	and plaster or mat thermal barrier.	erials providing a 15-minute					
		doors are substantial					
		ose of 1-3/4 inch thick,					
		d-core construction or other					
		ual or greater stability and					
	fire integrity.	uai oi gi catei stability allu					
		els are fixed fire window					
		ordance with 8.3.4 or are					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G127	B. W	NG _		07/19/	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	R			/EST ST		
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150		
1120 0/11	· · · · · · · · · · · · · · · · · · ·			I IVEVV /			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ceeding 9 square feet each					
		ed in approved frames.					
	1	shall not apply to corridor					
	walls that are smoke partitions in accordance						
		are protected by automatic					
	sprinklers in accordance with 33.2.3.5 on						
	both sides of the wall and door. In such						
	instances, there shall be no limitation on the						
	type or size of gla						
	1	ition facilities, all sleeping					
	rooms shall be separated from the escape						
	route by smoke partitions in accordance with						
	8.2.4. Sleeping arrangements that are not located in						
		nall be permitted for					
		members, provided that the					
		arm in the sleeping area is					
	1	en staff that might be					
	sleeping.	en stan that might be					
		oved facilities, where the					
	l	n E-score of three or less					
		nd care methodology of					
	NFPA 101A, Guid						
		e Safety, sleeping rooms					
	1	d from escape routes by					
	•	nat are smoke resistant.					
	33.2.3.6						
		vation and interview, the	KS	362			10/31/2021
		sure 1 of 7 sleeping room doors			1.The AED met with ResCar	·e	
	were smoke-resistar	nt construction. This deficient			Maintenance Manager on Aug	ust	
	practice could affec	et all clients, staff and visitors.			3, 2021 to ensure all doors in	the	
					facility meet or exceed LSC		
	Findings include:				8.3.3.1 states openings require	ed	
					to have a fire protection rating	by	
	Based on observation	on during the facility tour on			Table 8.3.4.2 shall be protecte	d by	
	07/19/2021 between	n 2:30 p.m. to 3:30 p.m. with the			approved, listed, labeled fire d	oor	
		the second story Bedroom #2			assemblies and fire window		
		h/lockset which left a 3" hole			assemblies and their		
	_	ise smoke-resistant door.			accompanying hardware, inclu	ıding	
	Based on interview	at the time of observation, the			all frames, closing devices,		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		15G127	B. WING		07/19/2021
			CTREET	CADDRECC CITY STATE ZIR COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD	
DE0 041	DE OOMANALINIETY A	1 TEDNIA TIV (EQ. QE IN)		WEST ST	
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN	NEW /	ALBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVINER'S DI AN OF CODRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	D.S.P. stated the do	oor had been recently replaced		anchorage, and sills in	
	because of damage	caused by the consumer. The		accordance with the requirem	ents
	door was replaced i	more than a week ago.		of NFPA 80, Standard for Fire	:
				Doors and Other Opening	
	This deficiency was	s reviewed with the D.S.P.		Protectives, except as otherw	ise
	during the Exit Cor	nference held on 07/07/2021.		specified in this Code. NFPA	
				Standard for Fire Doors and C	Other
	2. Based on obser	vation and interview, the		Opening Protectives, 2010 Ed	l l
	facility failed to ensure 1 of 7 sleeping room doors			Section 4.8.4.2 states the	,
	were smoke-resista	nt construction. This deficient		clearance under the bottom of	fa
	practice could affect	et all clients, staff and visitors.		door shall be a maximum of 3	/4
				inch.	
	Findings include:			2.The AED met with ResCa	re
				Maintenance Manager on Aug	gust
	Based on observation during the facility tour on			3, 2021 to schedule the repair	of
	07/19/2021 between	n 2:30 p.m. to 3:30 p.m. with the		the latch lock set for bedroom	#2.
	D.S.P., the door to	the second story Bedroom #1		Upon repair random monthly	
	had a gap larger tha	an 1/8" at the top of the		inspections for a member of	
	opening. Based on	interview at the time of		ResCare Management team v	vill
	observation, the D.	S.P. acknowledged the gap		be conducted to ensure prope	;r
	was larger than 1/8	".		functionality.	
				3.The AED contacted Aram	ark
	This deficiency was	s reviewed with the D.S.P.		on 8/03/2021 and submitted a	į.
	during the Exit Cor	nference held on 07/07/2021.		work order to have ResCare	
				Maintenance noncompliant do	
				will be removed and complian	t
				door will be installed by Octob	er
				31, 2021.	
				4.The AED will meet with	
				ResCare Maintenance Manag	jer on
				August 3, 2021 to schedule th	
				replacement of sleeping room	
				doors. Aramark Maintenance	has
				collected measurements for	
				sleeping room doors. An orde	
				has been placed and the vend	
				has given a tentative delivery	
				between 6 and 12 weeks due	
				supply chain issues. Upon de	ivery
				door will be installed with in 2	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/19/2021	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				weeks. Estimated install date be no later than October 31, 2 5.The program manager will verify the installation upon completion	2021.
				Persons Responsible: AED, Aramark Program Manager, A Supervisor, and Residential Manager, DSP	vrea
K S363	NFPA 101				
Bldg. 01	other mechanisms door closed. 2. No doors shat the occupant from 3. Doors shall be automatic-closing in buildings other throughout by an a sprinkler system in Door assemblies was swing in the direct inspected and test 33.2.3.6.4, 33.7.7	the provided with latches or a suitable for keeping the closing the door. The self-closing or in accordance with 7.2.1.8 than those protected approved automatic an accordance with 33.2.3.5. With leaves required to ion of egress travel are ted annually per 7.2.1.15.			
	failed to ensure 1 of capable of resisting mechanisms suitabl	on and interview, the facility 7 sleeping room doors were smoke and provided with e for keeping the doors closed. ice affects 5 of 6 clients who d story.	K S363	1.The Program Manager will ensure clients bedroom doors positively latch to the frame. 2.The maintenance coordina will ensure all clients bedroom doors will positively latch as required. 3.The #2 Second Story Bedroom Door will be repaired.	ator

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		15G127	B. W	NG		07/19/	/2021
NAME OF P	ROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
550.045	SE SOLM (IN UE) (A	. TED. (4 T) (50 OF IN			EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
	Based on observation	on during the facility tour on			ResCare Maintenance before		
	07/19/2021 between	n 2:30 p.m. to 3:30 p.m. with the			August 31, 2021.		
	D.S.P., the corridor	doors to consumer sleeping			4.The Residential Manager	will	
	room, Second Story	Bedroom #2, was not			inspect house weekly to ensur		
	equipped with latch	ing hardware. Based on			bedroom Area Manager will		
	interview at the tim	e of observation, the D.S.P.			preform random monthly		
	stated the door had been recently replaced because of damage caused by the consumer. The				inspections and Program Man	ager	
					will provide quarterly inspectio	ns	
	door was replaced r	nore than a week ago.			to ensure bedroom doors		
					positively latch to frame as		
	This deficiency was	s reviewed with the D.S.P.			required.		
during the Exit Conference held on 07/07/2021.				5.Staff will notify ResCare			
				Maintenance upon discovery of	of		
				any damage that prevents Clie	ents		
					Bedroom Doors from positively	y	
					latching to the frame as require	ed	
					by calling 844-ResCare.		
					Persons Responsible: Prograr	n	
					Manager, Area Supervisor,		
					Residential Manager, DSP.		
K S364	NFPA 101						
	Corridor - Opening	-					
Bldg. 01	Corridor - Opening	-					
	2012 EXISTING (- · ·					
	-	rable transoms or other air					
		enetrate the wall, except					
	properly installed	•					
		than transfer grilles.					
	Transfer grilles sh	iall be prohibited.					
	33.2.3.6.3		17. ~	264	4.Th- AED : 1 11 D . 0		01/01/2022
		on and interview, the facility	KS	364	1.The AED met with ResCar		01/01/2022
		f 11 (corridor) doors were			Maintenance Manager on Aug		
		smoke within the means of			3, 2021 to ensure all doors in	ıne	
	_	ome. This deficient practice			facility meet or exceed LSC	a d	
		inicis who reside on the first			8.3.3.1 states openings require		
	story.				to have a fire protection rating	-	
					Table 8.3.4.2 shall be protecte	a by	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
15G127		B. WING 07/19/2021			2021		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	_	NEW A	LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	Findings include:				approved, listed, labeled fire d	oor	
	Dagad on observative	on during the facility tour on			assemblies and fire window assemblies and their		
		1 2:30 p.m. to 3:30 p.m. with the				ıdina	
		closet (corridor) doors are			accompanying hardware, inclual frames, closing devices,	laing	
		ers and the Pantry door is a			anchorage, and sills in		
		The louvers appear to be			accordance with the requirement	ente	
		combustion air to the HVAC			of NFPA 80, Standard for Fire		
	•	of the louvers creates a			Doors and Other Opening		
	_	air is drawn through the			Protectives, except as otherwi	se I	
		interview at the time of			specified in this Code. NFPA 8		
		S.P. stated the doors had been			Standard for Fire Doors and C		
	as is since she arrived at the home more than two				Opening Protectives, 2010 Ed		
	years ago.				Section 4.8.4.2 states the	·	
					clearance under the bottom of	а	
	This deficiency was reviewed with the D.S.P.				door shall be a maximum of 3/	' 4	
	during the Exit Conference held on 07/07/2021.				inch.		
					2.The AED met with ResCar	re e	
					Maintenance Manager on Aug	ust	
					3, 2021 to schedule the remov	⁄al	
					and replacement of two closet		
					doors. Upon repair random		
					monthly inspections for a men		
					of ResCare Management tean		
					be conducted to ensure prope	r	
					functionality.		
					3.The Residential Manager		
					inspect house weekly to ensur	е	
					bedroom Area Manager will		
					preform random monthly	agor	
					inspections and Program Man will provide quarterly inspection	-	
					to ensure bedroom doors	113	
					positively latch to frame as		
					required.		
					4.The January 1st date was		
					incorrectly selected the correct	ted	
					estimated date is the same as		
					sleeping room doors. All door		
					the facility have been ordered		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 01 B. WING		01	COMPLETED 07/19/2021	
15G127		B. W.	ING		07/19/	2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG		DEFICIENCY)	\\	DATE		
K S712	NFPA 101				the same time. Replacement expected sooner than projected date, but supply chain issues labor shortages has extended expected completion date. The AED will meet with ResCare Maintenance Manager on Aug. 3, 2021 to schedule the replacement of sleeping room doors. Aramark Maintenance collected measurements for sleeping room doors. An order has been placed and the venchas given a tentative delivery between 6 and 12 weeks due supply chain issues. Upon del door will be installed with in 2 weeks. Estimated install date be no later than October 31, 2021. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP.	ed and ne gust has er dor date to livery will	
1.0712	Fire Drills						
Bldg. 01	least quarterly for under varied cond a. Ensure that al trained to perform b. Ensure that al familiar with the usemergency and diprocedures. 2. The facility mus	I personnel on all shifts are assigned tasks; I personnel on all shifts are se of the facility's saster plans and					

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		IDENTIFICATION NUMBER 15G127	A. BUILDING B. WING	01	COMPLETED 07/19/2021		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	evacuation of clier disabilities; c. File a report a d. Investigate all drills, including accation; and e. During fire dri evacuated to a satunder the Health (of the Life Safety (3. Facilities must r paragraphs (i) (1) any live-in and reli 42 CFR 483.470(i) Based on record reversaled to conduct fir for 4 of the last 12 cover the past year. The affect all consumers affect all consumers affect all consumers affect all consumers by the same of the second 2020 and there was conducted on third squarters of the year the time of observatives and other documentation of notice the missed documentation of notice and the same of the second coumentation of notice the missed documentation of notice the second coumentation of notice the second coumentation of notice the missed documentation of notice the second coumentation of notice the second council the seco	provisions for the hts with physical and evaluation on each drill; problems with evacuation cidents and take corrective area in facilities certified care Occupancies Chapter Code. The enter equirements of and (2) of this section for ef staff that they utilize. The drills quarterly on each shift calendar quarters and 3 shifts this deficient practice could	K S712	1.All staff at the Facility will re-trained on conducting fire of quarterly on all shifts. The Residential Manager will revied drills to ensure all required dri area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff. 1.The Area Supervisor will the home at least monthly to ensure the drills are in the home and up to date. 1.The Residential Manager submit monthly drills to the Quinciple Department upon completion. QA Department will notify the Manager and Program manages the facility has not performed monthly drills as required.	drills ew all ills n visit me will A The Area		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		15G127	B. WING			07/19/	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				1031 W	/EST ST		
RES CARE COMMUNITY ALTERNATIVES SE IN				NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	COMPLETION
TAG		terence held on 07/07/2021.		IAU			DATE
	during the Exit Con	nerence held on 0//0//2021.			1.The Area supervisor will ensure drills are completed as	,	
					required.	,	
					required.		
					1.The program manager will		
					conduct random monthly		
					inspections to ensure drills are	e	
					being completed as required.		
					Persons Responsible: Progra	am	
					Manager, Area Supervisor,		
					Residential Manager, DSP		
K S741	NFPA 101						
	Smoking Regulati						
Bldg. 01	Smoking Regulation						
		ns shall be adopted by the					
	administration of b						
	-	ere smoking is permitted, afety type ashtrays or					
		pe provided in convenient					
	locations.	be provided in convenient					
		, 33.7.4.1, 33.7.4.2					
		view, observation and	KS	741	1.All staff at the home will be	e	08/18/2021
		ty failed to provide a smoking	11 5	, 11	re-trained the Facilities smoking		00/10/2021
		allowing client and staff			policy, and use of the designa	_	
	smoking. The facili	ty failed to provide cigarette			smoking area.		
	butt waste container	rs at the smoking area. This			2.The Facility will in service	staff	
	deficient practice at	fects all clients, staff and			on the use of the smoking tow	er er	
	visitors.				used to dispensing cigarette b	utts.	
					3.All staff in the facility will b	е	
	Findings include:				inserviced on ensure smoking		
					materials are deposited into		
		view and interview on			ashtrays and metal containers		
		11:20 a.m. to 2:30 p.m. with the			with self-closing cover devices		
		d D.S.P., documentation of a			which ashtrays can be emptie		
		licy was not available for			noncombustible material and	sate	
		terview at the time of record			design	_	
		tated that two consumers			4. The Facility will ensure the		
	smoked cigarettes. Efforts to obtain a copy of the		ı		smoking area is cleaned and a	all	I

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AND PLAN OF CORRECTION IDENTIFICATION 1		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING O O O O O O O O O O O O O		(X3) DATE SURVEY COMPLETED	
15G127		B. WING		07/19/2021		
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	1031	ET ADDRESS, CITY, STATE, ZIP COD WEST ST / ALBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	policy were not successful. Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., cigarette butts were found at the front door landing in a plastic container with other trash. Based on interview at the time of the observations, the D.S.P. acknowledged a non-combustible safety container was not provided at the landing for smokers and that cigarette butts were mixed with trash in the plastic container. This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.			cigarette butts are removed from the ground and disposed of properly 5. The Program Manager, Area Supervisor, and Residential Manager will randomly inspect the facility monthly to ensure the proper use of the smoking tower and that cigarette butts are not being thrown on the ground. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance Manager.		
K S761						
Bldg. 01 Based on observation and interview, the facility failed to maintain annual testing of 2 of 2 fire doors in accordance of NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants in the dining room.		K S761	1.The administrator will ens annual functional testing and inspections for fire doors is performed by Koorsen Fire ar Security on the fire alarm syst and that reports of the tests/inspections are available the facility for review. 2.The Program Manager w meet with a representative from Koorsen Fire and Security, a tentative date has been set for August 23, 2021 The Facility will require schedule required testing ar request copies of inspection and testing mailed to the	ad eem iill s		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/19/2021		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				1031 W	ADDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		TE	(X5) COMPLETION DATE	
	Findings include: Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., no documentation of fire door annual inspections was provided for review. Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the tag on the doors to the interior stair enclosure indicates that the two doors are fire-rated assemblies listed for 90-minutes. Based on interview at the time of observation, the D.S.P. the fire-rated door assemblies had not been inspected in the last year or since their installation. This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.				program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany 47150. Persons Responsible: Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative.	n	

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