STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING -- B. WING	10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 10/10/19 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 At this Emergency Preparedness survey, Res Care Community Alternatives South Central was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey the census was 7. Quality Review completed on 10/15/19	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 10/10/19 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 At this Life Safety Code survey, Res Care Community Alternatives South Central was found	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building was not sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in common living areas and none in the resident bedrooms. The facility has a capacity of 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.4 Quality Review completed on 10/15/19			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to document maintenance at intervals of not more than one year for 2 of 2 portable fire extinguishers located in the facility. LSC 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level	K S100	**K0100:** General Requirements **Corrective Action:** ·Program Manager reached out to Aramark to ensure all extinguishers were inspected. ·Fire Extinguisher Inspections	10/25/2019

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	of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Home Manager during a tour of the facility from 1:55 p.m. to 2:10 p.m. on 10/10/19, the portable fire extinguisher located in the kitchen by the hallway door and the portable fire extinguisher located in the hallway by the exit door each had an affixed maintenance tag documenting annual maintenance was most recently performed by the fire extinguisher contractor in September 2018 which was not within the most recent twelve month period. Based on interview at the time of the observations, the Home Manager stated the fire extinguisher contractor is scheduled to be here to preform annual maintenance but agreed documentation of annual maintenance performed for the aforementioned portable fire extinguishers within the most recent twelve month period was not available for review.		were completed on 10/25/19 by Johnson Controls. **(Attachment A)** ·Area Supervisor completes weekly check to ensure fire extinguishers are checked monthly and inspected annually. **(Attachment B)** ·ResCare Administration will conduct monthly site reviews to ensure all fire extinguishers are inspected and operable. (**Attachment C)** **Monitoring of Corrective Action:** ·Program Manager will ensure the Area Supervisor has completed the weekly check to inspect the fire extinguishers. ·Maintenance technician will send monthly check of the emergency lights to the Program Director for monitoring and to ensure completion. ·Program Manager will contact Aramark for all issues with the fire extinguishers. ·ResCare Administration will enter site reviews into the database to ensure completion and monitoring that all fire extinguishers are inspected and operable at the facility. **Completion Date: 10/25/19**	

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K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review with the Home Manager from 1:00 p.m. to 1:55 p.m. on 10/10/19, documentation of testing all fire alarm system	K S345	**K0345:** Testing and Maintenance **Corrective Action:** ·Program Manager contacted Aramark to set up a fire alarm inspection at the facility. Aramark contracted Johnson Controls to complete the inspection. ·Johnson Controls performed the fire alarm inspection including sensitivity testing on 10/26/19. **(Attachment D)** ·Program Manager will follow up with Aramark and Johnson Controls to ensure all documents are received as completed and all inspections are completed as scheduled. **Monitoring of Corrective Action:** ·Program Manager will stay in communication with Aramark to ensure they are scheduling all inspections at the facility.	10/26/2019

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	initiating devices within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Home Manager stated fire alarm system inspection documentation is located off-site and is with the Program Coordinator. Based on telephone interview with the Program Coordinator at 1:30 p.m. on 10/10/19, the Program Coordinator stated ownership of the facility changed within the last year and inspection documentation is sent to the new owners by the inspection contractor. The Program Coordinator has specifically requested that inspection documentation be sent to Res Care but the request has not been met. Based on observations with the Home Manager during a tour of the facility from 1:55 p.m. to 2:10 p.m. on 10/10/19, the facility has fire alarm system with smoke detectors and manual pull stations in the facility. 2. Based on record review and interview, the facility failed to ensure all facility smoke detectors were within their listed and marked sensitivity range. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In		**Completion Date: 10/26/19**	

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	zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review with the Home Manager from 1:00 p.m. to 1:55 p.m. on 10/10/19, documentation of an itemized list of the location and results of sensitivity testing all fire alarm system smoke detectors in the facility within the most recent two year period was not available for review. Based on interview at the time of record review, the Home Manager stated fire alarm system inspection documentation is located off-site and is with the Program Coordinator. Based on telephone interview with the Program Coordinator 1:30 p.m. on 10/10/19, the Program			

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	Coordinator stated ownership of the facility changed within the last year and inspection documentation is sent to the new owners by the inspection contractor. The Program Coordinator has specifically requested that inspection documentation be sent to Res Care but the request has not been met.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure corridor doors to 1 of 5 client bedrooms had no impediment to closing and latched into the door frame. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Home Manager during a tour of the facility from 1:55 p.m. to 2:10 p.m. on 10/10/19, the corridor door to the southwest bedroom by the hallway exit door failed to latch into the door frame after repeated	K S363	**K0363:** Fire Alarm System-Out of Service **Corrective Action:** ·Program Manager reported to Aramark (maintenance company for Rescare) that the corridor door to the southwest bedroom needs adjusted/repaired so it will latch properly. **(Attachment E)** **Monitoring of Corrective**	10/28/2019

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	attempts to close and latch the door into the door frame. The latching mechanism failed to protrude into the latching plate. Based on interview at the time of the observations, the Home Manager agreed the bedroom door had an impediment to closing and latching into the door frame.		**Action:** ·All maintenance requests are called in to Aramark for repair and follow up is completed by the Program Manager. **Completion Date: 10/28/19**	