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	08/09/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 08/09/18 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 At this Emergency Preparedness survey, Res Care Community Alternatives Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey the census was 7. Quality Review completed on 08/13/18 - DA	E 0000		
E 0007 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice could affect all occupants. Findings include:	E 0007	**E007:** The facility must develop an emergency preparedness plan that must be reviewed and updated at least annually. **Corrective Action:** ·Program Manager updated the Emergency Preparedness Manual call list to include detailed instruction as to who would call who in the event of a disaster. (**Attachment A**)	08/25/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Based on record review on 08/09/18 at 12:30 p.m. with the Residential Manager the emergency preparedness plan (EPP) did not address: a. what services the facility would be able to provide, b. continuity of operations and c. delegations of authority and succession plans. Based on interview concurrent with record review it was acknowledged by the Residential Manager the EPP did not address items a, b and c above.		·Program Manager will update the Emergency plans annually and as needed. ·Rescare has a program called ROC (Rescare On Call) that would provide the needed staffing to ensure all needs of our consumers are met and their Active Treatment would not be affected. **(Attachment B)** ·Annual Mock drills are ran to ensure all staff are trained and are aware of the emergency plans and procedures in the event of a disaster. **Monitoring of Corrective Action:** ·Area Supervisor will train all staff on the Emergency Preparedness Manual updates to the call procedure. ·ROC employees are trained on the Emergency Preparedness plan annually and as needed for updates as they are all currently Rescare employees. ·Emergency Preparedness Plans are updated monthly and as needed to ensure the most accurate information in the event of an emergency. ·Annual Mock Drills are run yearly to ensure all staff are trained and aware of the emergency plans and procedures during a disaster.	

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			Completion Date: 8-25-18	
E 0024 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review on 08/09/18 at 11:56 a.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not address the use of volunteers in an emergency. Based on interview at the time of record review with the RM it was confirmed the plan did not address use of volunteers.	E 0024	**E024:** The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be updated at least annually. **Corrective Action:** ·Rescare has a program called ROC (Rescare On Call) that would provide the needed staffing to ensure all needs of our consumers are met and their Active Treatment would not be affected. **(Attachment B)** ·ROC employees are trained on the Emergency Preparedness plan annually and as needed for updates as they are all currently Rescare employees. ·Program Manager ensures Emergency plans are updated monthly to ensure the most accurate contact information is included. ·Area Supervisor ensures all staff are trained annually and as needed on the Emergency Preparedness Plan. **Monitoring of Corrective Action:** ·Program Manager will notify the	08/25/2018

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			Program Director and the Executive Director in the event of an emergency to initiate the call to the ROC staff members to assist. ·Program Manager updates emergency preparedness manual monthly and as needed. ·Area Supervisor trains all staff on the Emergency Preparedness plan and submits training to the Program Manager and HR. **Completion Date: 8-25-18**	
E 0025 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants. Findings include: Based on record review on 08/09/18 at 11:50 a.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not include contractual arrangements with other facilities to receive clients. Based on interview concurrent with record review with the RM it was acknowledged the EPP did not include arrangements with other facilities to receive	E 0025	**E025:** The facility must develop and implement emergency preparedness policies and procedures. **Corrective Action:** ·Program Manager updated the Emergency Preparedness Manual to include applying for the 1135 Waiver for this location in case of an emergency or disaster that would require us to relocate to a facility outside of the Indiana. (**Attachment C**) ·In the event of an emergency or disaster Rescare would follow the plan as written to go to the identified location if an evacuation was ordered or needed. Rescare has facilities across the US in the	08/25/2018

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	clients to ensure continuity of care.		event we had to move to a different facility we would have the option of a Rescare facility where continuity of care would remain the same. ·Program Manager will update the Emergency plans annually and as needed. **Monitoring of Corrective Action:** ·The Program Manager will follow up with CMS to ensure approval is obtained for the 1135 Waiver in the event of a disaster requiring evacuation out of state. ·Emergency Preparedness Plans are updated monthly and as needed to ensure the most accurate information in the event of an emergency. ·Annual Mock Drills are run yearly to ensure all staff are trained and aware of the emergency plans and procedures during a disaster. **Completion Date: 8-25-18**	
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services	E 0037	**E037:** The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be updated at least annually.	08/25/2018

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	under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/09/18 at 11:59 a.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include staff demonstrating their knowledge of the emergency preparedness program by taking a test on the subject. Based on interview concurrent with record review with the RM it was stated tests may be available at the main office, but was unable to produce any documentation at the time of the survey.		**Corrective Action:** ·Area Supervisor trains all staff on the Emergency Preparedness Manual. **(Attachment D)** ·All staff sign acknowledgement of the training on the Emergency Preparedness Manual**. (Attachment E)** ·All staff are given a test to ensure they understand and are knowledgeable of the Emergency Preparedness Plan. **(Attachment F)** ·Mock Drills are ran annually to ensure all staff are trained and aware of the emergency plans and procedures in the event of a disaster. ·Program Manager ensures Emergency plans are updated monthly to ensure the most accurate contact information is included. **Monitoring of Corrective Action:** ·Program Manager updates emergency preparedness manual monthly and as needed. ·Copies of the Mock Drill are sent to the Program Manager and a copy remains in the Emergency Preparedness Manual. ·Area Supervisor trains all staff on the Emergency Preparedness plan and submits training and test to the Program Manager and HR. **Completion Date: 8-25-18**	

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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: 08/09/18 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 At this Life Safety Code survey, Res Care Community Alternatives Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story 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 Slow with an E-Score of 1.56. Quality Review completed on 08/13/18 - DA	K 0000		
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING			

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	List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	Based on record review and interview, the facility failed to ensure 2 of 2 interior emergency lights were tested and the records of the testing maintained. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. (2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the test. (5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction. This deficient practice could affect all occupants if the facility were required to evacuate in an emergency during a loss of normal power. Findings include: Based on record review on 08/09/18 at 12:13 p.m., with the Residential Manager (RM) there were two	K S100	**K0100:** The facility failed to ensure 2 of 2 interior emergency lights were tested and recorded. **Corrective Action:** ·Program Manager created a form for the Maintenance Technician from Rescare to test the emergency lights monthly for 30 seconds and yearly for 90 minutes. **(Attachment G)** ·Program Manager informed the Maintenance Technician of the need for him to test the emergency lights for 30 seconds every month as well as a 90 minute test annually. **Monitoring of Corrective Action:** ·Program Manager will ensure the Area Supervisor has completed the weekly check to inspect the emergency lights. ·Maintenance technician will send monthly check of the emergency lights to the Program Director for monitoring and to ensure completion. ·Program Manager will contact Simplex Grinnell for all issues with	08/31/2018

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	battery power emergency lights observed, one in the living room and one in the main hall. During record review there was no documentation for the 30 second monthly test or the 90 minute annual test of the two battery powered lights. Based on interview with the RM at the time of record review, it was confirmed the facility did not have written records of a monthly or annual functional test. The RM further acknowledged a functional test was done monthly, but he not not realize this had to be documented for 30 seconds monthly with a 90 minute annual test.		the emergency lights at the facility. ·ResCare Administration will conduct monthly site reviews to ensure all emergency lights are inspected and operable. (**Attachment H**) **Completion Date: 8-31-18**	
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 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 14.4.5.3.2 states every alternate year thereafter. After the second required	K S345	**K0345:** Testing and Maintenance **Corrective Action:** ·Program Manager contacted Simplex Grinnell to have documents of system inspections sent to Rescare to have them placed in the facility. (Attachment M) ·Program Manager received documentation of the sensitivity testing that was completed on 10-12-17. **(Attachment L)**	09/04/2018

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	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 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 on 08/09/18 at 12:19 p.m. with the Residential Manager (RM) the last documentation of smoke detector sensitivity testing within the past two year period was dated 02/03/16. Based on interview at the time of record		·Program Manager will follow up with Simplex Grinnell to ensure all documents are received as completed and all inspections are completed as scheduled. **Monitoring of Corrective Action:** ·Rescare Administration will complete monthly Site Reviews and send to the Program Director and Executive Director for monitoring of completion. ·Program Director will follow up on issues noted on the Site review and submit to the Program Manager for follow up on the issues. **Completion Date: 9-4-18**	

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	review, the RM acknowledged documentation of smoke detector sensitivity testing within the most recent two year period was past due.			
K S346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 Based on record review and interview, the facility failed to provide a written fire watch policy for when the fire alarm system is out of service for more than 4 hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Maintenance Director on 08/09/18 at 12:07 p.m., the facility provided fire watch plan documentation but it was incomplete. The plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. and make a return call to all entities notified confirming the fire alarm system is functioning properly. Based on interview during record review, the Residential	K S346	**K0346:** Fire Alarm System-Out of Service **Corrective Action:** ·Program Manager updated the Fire Watch policy to include the gateway link to ISDH. **(Attachment I)** ·Program Manager will send the correct Fire Watch Policy and Procedure to the Area Supervisor to place in the facility. ·Area Supervisor will train all staff on the updated Fire Watch Policy. **(Attachment J)** **Monitoring of Corrective Action:** ·Area Supervisor will train all staff on the Fire Watch Policy. ·Area Supervisor will send all training on the Fire Watch Policy	08/31/2018

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	Manager (RM) acknowledged the fire watch policy stated to contact the Indiana State Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above and there was no mention of a return call verifying conditions were back to normal.		and send to the Program Manager to ensure completion. ·ResCare Administration will conduct monthly site reviews to ensure all systems are operable, inspections are complete and fire watch is implemented as needed. (**Attachment H**) **Completion Date: 8-31-18**	
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 2 of 4 sleeping room doors were capable of resisting smoke and provided with mechanisms suitable for keeping the doors closed and the doors had no impediment to closing and positively latched into the frame. This deficient practice could affect all occupants. . .	K S363	**K0363:** Fire Alarm System-Out of Service **Corrective Action:** ·Program Manager contacted Simplex Grinnell to have them come to the facility for repair of the 2 self closing doors not operating	08/25/2018

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	Findings include: Based on observations on 08/09/18 during the tour from 12:45 p.m. to 1:05 p.m. with the Residential Manager (RM), resident room # 3 corridor door with a self closing device would not self close and latch into its door frame when tested. Furthermore, during a test of resident room # 4 corridor door it could not self close and latch because the door was out of alignment and hit the outside of the door jam which prevented it from latching and resisting the passage of smoke. This was verified by the RM at the time of observations.		properly. **(Attachment K)** ·**Program Manager spoke with Simplex and determined the doors were functioning properly on their end. Program Manager reached out to Rescare Maintenance Technician for repair of the 2 self closing doors.** ·Maintenance Technician went to the home and was able to adjust the hinges and replace one closure on the 2 self closing doors and they will now shut properly when the alarm is activated**.** **(Attachment M)** ·Rescare Administration conducts Site reviews 2 times monthly to ensure all systems are working properly. **(Attachment H)** **Monitoring of Corrective Action:** ·Program Manager will follow up with the facility and Simplex Grinnell for completion of the repairs. ·Site reviews will be sent to the Program Director for monitoring of noted issues and to ensure completion. **Completion Date: 9-4-18**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING 01 B. WING	08/09/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE