STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING -- B. WING	06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW 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	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 Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/20/22 Facility Number: 000664 Provider Number: 15G127 AIM Number: 100234310 At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 8 certified beds, with a current census of 6. Quality Review completed on 06/23/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 06/20/22 Facility Number: 000664 Provider Number: 15G127 AIM Number: 100234310 At this Life Safety Code survey, Res Care Community Alternatives SE IN was found not in	K 0000		

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

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	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 was a two story fully sprinklered facility. The facility has a fire alarm system with hard wired smoke detectors in the corridors, common living areas, and all client sleeping rooms. It could not be determined if the attic was equipped with heat detection connected to the fire alarm system. The facility has a capacity of 8 and had a census of 6 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 0.45. Quality Review completed on 06/23/22			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure 1 of 2 interior emergency lights were tested, maintained, 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	K S100	To correct deficient practice, the emergency light will be repaired by the service provider. All site staff will be trained to complete the monthly inspection and ensure the unit is in working order. Additional	07/20/2022

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	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 in the facility. Findings include: Based on observations on 06/20/22 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Lead, the facility had two battery powered emergency light units. The battery powered emergency light unit on the second floor west stairway was not working when tested. Based on interview at the time of observation, the Lead confirmed the emergency battery backup light did not work when tested. Based on record review between 10:00 a.m. and 12:00 p.m. with the Lead present, the most recent monthly 30 second report was dated 05/09/22. This finding was reviewed with the Lead and Area Supervisor during the exit conference.		monitoring will be completed through weekly inspections for two months to be completed by the Area Supervisor and Maintenance Tech. Ongoing monitoring will be achieved through a monthly LSC inspection to ensure all life safety features are in working order completed by the Area Supervisor and Maintenance tech.	

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K S311 Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING (Prompt) Vertical openings shall be protected so as not to expose a primary means of escape. Vertical openings shall be considered protected if separated by smoke partitions in accordance with 8.2.4 that resist the passage of smoke from one story to any primary means of escape on another story. Smoke partitions shall have a fire resistance rating on not less than 1/2 hour. Any doors or openings to the vertical opening shall be capable of resisting fire for not less than 20 minutes. Stairs shall be permitted to be open where complying with sections 33.2.2.4.6 or 33.2.2.7. 33.2.3.1.1 through 33.2.3.1.4 Based on observation and interview, the facility failed to ensure 2 of 2 interior stairway doors were not held open with items that would resist the passage of smoke from the main level to the second floor, or for clients needing to exit from the second floor to the outside using these two stairways. This deficient practice could affect all occupants. Findings include: Based on an observations on 06/20/22 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Lead, the main level stairway door from the dining room was held wide open with a table top cabinet, furthermore, the main level stairway door from the first floor southeast bedroom was held open with a golf club. In the event of a fire on the main level these doors would not automatically close and resist the passage of	K S311	To correct the deficient practice, staff will be trained on not propping doors open and purpose for keeping doors open. Additional monitoring will be implemented by the Area supervisor completing weekly checks to ensure the doors are not propped open. Ongoing monitoring will be achieved through a monthly LSC inspection to ensure all life safety features are in working order completed by the Area Supervisor and maintenance tech.	07/20/2022

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	smoke to the second floor due to being held wide open with items. Based on interview at the time of each observation, the Lead acknowledged the two stairway doors being held wide open with items. This finding was reviewed with the Lead and Area Supervisor during the exit conference.			
K S341 Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 15 hard wired smoke detectors were secured to the ceiling surface. NFPA 72, 2010 edition, at 17.4.4 states Initiating devices shall be supported independently of their attachment to the circuit conductors. This deficient practice could affect all occupants. Findings include: Based on observations on 06/20/22 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Lead, there was a ceiling mounted smoke detector in the dining room hanging from the ceiling by its wires. Based on interview at the time of observation, the Lead agreed the smoke detector in the dining room was hanging from the ceiling and not secured. This finding was reviewed with the Lead and Area	K S341	To correct the deficient practice, the smoke detector will be repaired and secured appropriately. All staff will be trained to report any maintenance issues regarding the home or life safety features. Ongoing monitoring will be achieved through a monthly LSC inspection to ensure all life safety features are in working order completed by the Area Supervisor and maintenance tech.	07/20/2022

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	Supervisor during the exit conference.			
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 observation, record review, and interview; the facility failed to ensure 1 of 1 fire alarm system was continuously in proper operating condition. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation of the fire alarm control panel (FACP) on 06/20/22 at 10:41 a.m. during a tour of the facility with the Area Supervisor and Lead, the following was illuminated on the FACP: a. "System Alarm" with red light b. "Zone 1" with red light c. " Alarm Silenced" with yellow light During an interview at the time of observation, the Area Supervisor and Lead acknowledged the lights which were illuminated at the FACP, furthermore, the Area Supervisor pushed the System Reset button and the system reset. Based on record review between 10:00 a.m. and 12:00 p.m., the most recent fire drill performed was dated 05/03/22 which the Lead said was probably the last time the fire alarm system was activated as far	K S345	To correct the deficient practice the heat detectors will be inspected and documented. Additionally, the fire alarm panel was found to be in working order, but not reset after a drill. All staff will be re-trained how to appropriately reset the fire alarm panel. All supervisors will be re-trained to ensure all life safety features are in working order and as required, inspections completed within the timeline. Ongoing monitoring will be achieved through a monthly LSC inspection to ensure all life safety features are in working order completed by the Area Supervisor and maintenance tech.	07/20/2022

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	as she knew. This finding was reviewed with the Lead and Area Supervisor during the exit conference. 2. Based on record review, observation, and interview; the facility failed to provide complete documentation to ensure heat detectors were provided in the attic space and connected to 1 of 1 fire alarm system in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. This deficient practice could affect all clients and staff. Findings include: Based on record review on 06/20/22 between 10:00 a.m. and 12:00 p.m. with the Lead present, there was no documentation available for any fire alarm system inspection and testing. This was confirmed by the Lead at the time of record review. There was no means of inspecting the attic while touring the facility. An annual fire alarm system inspection and testing report dated 02/21/22 was sent via email within three hours after exit from the facility. This report did not include the inspection of heat detection in the attic. This finding was not reviewed with any staff during the exit conference since the annual fire alarm system report was not available while at the facility.			
K S353	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5).			

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	10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to ensure the ceiling on 1 of 2 sprinklered levels of the facility was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect all clients, as well as staff and visitors. Findings include:	K S353	To correct the deficient practice, the ceiling will be prepared. All staff will be trained to all maintenance issues regarding the home or life safety features. Ongoing monitoring will be achieved through a monthly LSC inspection to ensure all LSC features are in working order	07/20/2022

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	Based on observations on 06/20/22 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Lead, there was a two foot by two foot section of the drywall ceiling missing in the laundry room/fire alarm panel room on the first floor of the house. In the event of a fire in this area, it could not be assured the sprinkler head in this room would function to its full capability. Based on interview at the time of observation, the Lead said the section of drywall ceiling had been missing for about two weeks or more. This finding was reviewed with the Lead and Area Supervisor during the exit conference.		completed by the Area Supervisor and maintenance tech.	
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 1 of 8 client sleeping room doors would close completely and latch into its door frame. This deficient practice could affect four clients on the second floor.	K S363	To correct the deficient practice, the door will be repaired and made to latch. All staff will be trained to all maintenance issues regarding the home or life safety features. Ongoing monitoring will be	07/20/2022

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	Findings include: Based on observations on 06/20/22 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Lead, client bedroom door #8 (second floor, southeast corner bedroom) would not close completely and latch into its door frame when tested several times. The door was heavily damaged. Based on interview at the time of observation, the Lead agreed bedroom door #8 was damaged and prevented it from closing completely and latching. This finding was reviewed with the Lead and Area Supervisor during the exit conference.		achieved through a monthly LSC inspection to ensure all life safety features are in working order completed by the Area Supervisor and maintenance tech.	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 5 wet locations was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt,	K S511	To correct the deficient practice, GFCI will be repaired and inspected for proper working condition. All staff will be trained to all maintenance issues regarding the home or life safety features. Ongoing monitoring will be achieved through a monthly LSC inspection to ensure all life safety features are in working order completed by the Area Supervisor and maintenance tech.	07/20/2022

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	single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where			

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RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

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	electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one client or staff . Findings include: Based on observation on 06/20/22 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Lead, there was one electric receptacle in the Utility Room/Sprinkler Riser Room that was within one foot of the hand washing sink. The receptacle was not provided with GFCI protection. When tested with a GFCI tester it did not break the electrical circuit. Based on interview at the time of observation, the Lead agreed the electric receptacle in the Utility Room/Sprinkler Riser Room was not provided with GFCI protection. This finding was reviewed with the Lead and Area Supervisor during the exit conference.			
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING 01 B. WING	06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

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	2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to ensure a fire drill was conducted quarterly on 2 of 3 shifts during 4 of 4 quarters during the past 12 months. This deficient practice could affect all clients. Findings include: Based on record review on 06/20/22 between 10:00 a.m. and 12:00 p.m. with the Lead present, there were no fire drill reports available for review for the following shifts and quarters: a. Second shift (evening) of the fourth quarter (October, November, and December) of 2021, and second quarter (April, May, and June) of 2021 and so far in 2022. b. Third shift (night) of the third quarter (July, August, and September) of 2021, and first quarter (January, February, and March) 2022. Based on interview at the time of record review, the Lead said there were no other fire drill reports available to review.	K S712	To correct the deficient practice, a 2022 Fire drill calendar has been created to include two drills per shift per quarter. All staff responsible for maintaining drills have been trained on the calendar. All supervisory staff responsible for maintaining drills have been re-trained to ensure each group home drills per LSC. Ongoing monitoring will be achieved through a monthly LSC inspection form to ensure all LSC requirements are completed accurately and timely completed by the AS.	07/20/2022

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	This finding was reviewed with the Lead and Area Supervisor during the exit conference.			
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 area where cigarettes were smoked. This deficient practice could affect clients and staff that smoke. Findings include: Based on observation on 06/20/22 between 10:00 a.m. and 12:00 p.m. during a tour of the facility with the Lead, the smoking area at the side yard had two open ashtrays with cigarette butts, plus a smoke tower that was missing the tower portion of the unit and not functioning as designed. Furthermore, there were at least 10 cigarette butts on the ground around the smoking area. Based on interview at the time of observation, the Lead agreed cigarette butts were not properly disposed of at the side yard smoking area. This finding was reviewed with the Lead and Area Supervisor during the exit conference.	K S741	To correct the deficient practice, an appropriate cigarette butt receptacle with a lock has been provided to the home. All staff have been trained the smoking area at and the use of an appropriate receptacle. All staff have been trained to help the individuals dispose of their butts appropriately. Ongoing monitoring will be achieved by weekly grounds inspections for appropriate cigarette butt disposal completed by the AS and site lead.	07/20/2022