STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G167	A. BUILDING 01 B. WING	10/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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: 10/31/17 Facility Number: 000701 Provider Number: 15G167 AIM Number: 100248800 At this Life Safety Code survey, Res Care Community Alternatives SE IN 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 facility was not sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and common living areas. The facility has a capacity of seven and had a census of five at the time of this survey. Calculation of the Evacuation Difficulty	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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.2. Quality Review completed on 11/02/17 - DA			
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. 1. Based on observation and interview, the facility failed to ensure 2 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 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.	K S100	1.All staff will be retrained on completing monthly 30 second testing of emergency lighting and annual 90 minute testing of the emergency lighting. All staff will be retrained on proper documentation of emergency lighting testing as well. The residential manager and the area supervisor will monitor monthly to ensure inspections and documentation is completed as required. 2.All staff will be retrained on completing monthly fire	11/30/2017

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	(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 observations on 10/31/17 between 9:45 a.m. and 10:45 a.m. during a tour of the facility with Direct Care Staff #1, the facility had two battery powered emergency light units. Based on record review between 9:45 a.m. and 10:45 a.m., there was no documentation available to show the two battery powered emergency lights were tested for 30 seconds monthly, furthermore, there was no documentation available to show the facility performed an annually 90		extinguisher inspections and proper documentation of the inspections. The residential manager and the area supervisor will monitor monthly to ensure inspections and documentation is completed as required.	

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	minute test on the two battery powered emergency light units. Based on interview at the time of record review, Direct Care Staff #1 said she did not know if there was documentation available to show a 30 second monthly test and a 90 minute annual test available for the two battery emergency lights. 2. Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label			

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	attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations on 10/31/17 between 9:45 a.m. and 10:45 a.m. during a tour of the facility with Direct Care Staff #1, the portable fire extinguisher located in the kitchen/dining room area had an affixed inspection and maintenance tag and label lacking a monthly inspection for March, May, June and July of 2017, furthermore, the portable fire extinguisher located in the sleeping room hall had an affixed inspection and maintenance tag and label lacking a monthly inspection for June and July of 2017. Based on interview at the time of the observations, Direct Care Staff #1 stated no other documentation of monthly fire extinguisher inspections was available for review and acknowledged documentation of monthly inspections for the portable fire extinguisher for the aforementioned months was not available for review.			
K S511	NFPA 101			

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Bldg. 01	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 client safety in 1 of 2 bathrooms where light bulbs were not provided in light sockets. This deficient practice could affect all clients. Findings include: Based on observation on 10/31/17 at 10:40 a.m. during a tour of the facility with Direct Care Staff #1, two of four light sockets in the light fixture above the vanity in the bathroom on the left side of the client sleeping room hall were not provided with light bulbs, which left an open light socket within arms reach. Based on interview at the time of observation, Direct Care Staff #1 said she didn't know light bulbs were missing from the light fixture.	K S511	All staff will be retrained on proper reporting of maintenance needs and ensuring there are light bulbs in all fixtures to prevent risks of client safety. The residential manager will complete monthly environmental inspections to ensure all maintenance needs are addressed and the area supervisor will review the inspections for accuracy and follow up.	11/30/2017
K S711 Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan The administration of every resident board and care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in the event of fire, for keeping persons in			

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	place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility. All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk. 32.7.1, 32.7.2, 33.7.1, 33.7.2			
	Based on record review and interview, the facility failed to ensure there was a complete fire safety plan in place to ensure the safety of 5 of 5 clients. This deficient practice could affect all clients, as well as staff and visitors. Findings include: Based on record review on 10/31/17 at 10:30 a.m. with Direct Care Staff #1	K S711	The fire plan will be updated to include facility staff use of the fire extinguishers, activation of the alarm to notify all occupants in the event of a fire, calling 911, and, evacuation of the facility including primary and secondary exits and the outside parking lot location	11/30/2017

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	present, the facility's "Addendum to Fire Drill Procedure" was not a complete and accurately fire safety plan. The fire plan did not address the use of the pull stations to activate the alarm to notify all occupants in the event of a fire, plus calling the fire department (911) in the event of a fire emergency regardless of the size of a fire. The "Addendum to Fire Drill Procedure" at B. Suppression at 1. it states "If you have any doubt that you can fight the fire for any reason, call 911 immediately and evacuate the home.", furthermore, at 2. it states "If the fire is large, call 911 and leave the home," Based on interview at the time of record review, Direct Care Staff #1 agreed it was not a complete fire safety plan.		used as a congregation point during a fire. All staff at the home will be trained on the updated fire plan.	