STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING -- B. WING	01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL DR JEFFERSONVILLE, IN 47130

(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: 01/24/19 Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810 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. The facility has 8 certified beds. At the time of the survey, the census was 8. Quality Review completed on 01/29/19 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0018 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location	E 0018	1.The administrator will ensure the emergency plan policies and procedures addresses the tracking of staff and clients, whether they evacuate or shelter in place. Including the consideration of care and treatment needs of evacuees, staff responsibilities; transportation;	02/23/2019

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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	in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 01/24/19 between 2:15 p.m. and 2:50 p.m., no policies and procedures which include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency was available to review. Based on interview at the time of record review, the Program Manager confirmed no such documentation was available to review.		identification of evacuation locations; and primary and means of communication with external assistance. 2.The area supervisor and program manager will train all staff on the 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	
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 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 01/24/19 between 2:15 p.m. and 2:50 p.m., no policies and procedures which include	E 0024	1.The emergency plan policies and procedures will be updated to include volunteers in an emergency or other emergency staffing strategies including the integration of State and Federal designated healthcare professionals to address surge needs during an emergency. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for	02/23/2019

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	the use of volunteers in an emergency or other emergency staffing strategies was available for review. Based on interview at the time of record review, the Program Manager confirmed no such documentation was available for review.		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	
E 0026 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 01/24/19 between 2:15 p.m. and 2:50 p.m., no policies and procedures which include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was available for review. Based on interview at the time of record review, the Program Manager confirmed no such documentation was available for review.	E 0026	1.The administrator will ensure the table of contents for the emergency disaster preparedness manual is updated to include the location of the policy on the Roles of the facility Under a Waiver declared by Secretary is in the emergency preparedness manual. 2.The area supervisor and program manager will train all staff on the table of contents, the policy and procedure, where to locate the policy, and the policy 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 4.The persons responsible will be the Executive Director, Associate Executive Director, Program Manager, Area Supervisor, and Residential Manager.	02/23/2019

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E 0034 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 01/24/19 between 2:15 p.m. and 2:50 p.m., the facility was unable to provide documentation for a communication plan including a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee. Based on interview at the time of record review, the Program Manager confirmed no documentation was available for review.	E 0034	1.The administrator will ensure the emergency plan policies and procedures will be updated to include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction. 2.The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction is 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 4.The persons responsible will be the Executive Director, Associate Executive Director, Program Manager, Area Supervisor, and Residential Manager.	02/23/2019
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is	E 0039	1.The administrator will ensure the emergency plan policies and procedures includes the participation in a full-scale community based exercise and a table top exercise in accordance	02/23/2019

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	community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 01/24/19 between 2:15 p.m. and 2:50 p.m., no documentation was available for either a community-based or tabletop exercise drill. Based on interview at the time of record review, the Program Manager confirmed that no drill documentation was available for review.		with CFR 483.475(d)(2) and present in the EPP manual. 2.The area supervisor and program manager will conduct the table top exercise and ensure documentation of the table top exercise and the community based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed. 3.The Program Manager will schedule a training event with community based services the Area Supervisor, and Residential Manager ensure the facility takes part in the training. 4.The Program Manager will contact local community based services to schedule a community based table top exercise before February 23, 2019. 5.Persons Responsible: Program Manager, Area Supervisor, and Residential Manager.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of	K 0000		

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	Health in accordance with 42 CFR 483.470(j). Survey Date: 01/24/19 Facility Number: 000769 Certification Number: 15G247 AIM Number: 100248810 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 with a basement was not sprinkled. The facility has a fire alarm system with smoke detection on all levels including the corridors, common living areas and basement. The facility has a capacity of 8 and had a census of 8 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 01/29/19			
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			

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	NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to ensure at least 1 of 1 Front Entry fire extinguisher was maintained. This deficient practice could affect all occupants. This deficient practice could affect all occupants. Findings include: Based on observation with the Program Manager on 01/24/19 at 2:51 p.m., the Front Entry fire extinguisher gauge indicated the fire extinguisher was undercharged. Based on interview at the time of observation, the Program Manager confirmed the fire extinguisher was undercharged. 2. Based on observation and interview, the facility failed to protect 3 of 3 oxygen cylinders in the office. 2012 NFPA 99, Health Care Facilities Code, 11.6.2.3(11) requires freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect all occupants. Findings include: Based on observation with the Program Manager on 01/24/19 at 2:56 p.m., the office had three oxygen cylinders that were freestanding on the floor. Based on interview at the time of observation, the Program Manager acknowledged the unprotected cylinders.	K S100	Fire extinguisher by front door was replaced by Koorsen Fire and Security on February 15,2019 Oxygen cylinders will be properly stored in a cylinder stand that was ordered and installed by ResCare Maintenance on February 18 ,2019. Staff will be trained on proper storage of oxygen cylinders by Area Supervisor. Random inspections of oxygen cylinder storage will be preformed by Residential Manager Weekly, Area Supervisor Monthly and by Program Manager quarterly. Persons Responsible: Program Manager, Area Supervisor, and Residential Manager.	02/23/2019
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches.			

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	Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation, the facility failed to ensure 1 of 1 Dining room exit was provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. LSC 33.2.2.5.7 requires compliance with LSC 7.2.1.5.10. LSC 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could affect all occupants. Findings include: Based on observation with the Program Manager on 01/24/19 at 2:58 p.m., the Dining room exit door contained two separate locks. Based on interview	K S222	The facility will ensure the Dining Room Exit door containing two separate locks will be modified and the second lock removed by ResCare Maintenance on February 18, 2019. The Program manager verified the removal of second lock on February 18, 2019. Persons Responsible: ResCare Maintenance, Program Manager.	02/23/2019

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	at the time of observation, the Program Manager confirmed the exit door had two separate locks on the Dining room door.			
K S253 Bldg. 01	NFPA 101 Number of Exits - Patient Sleeping and Non-Sl Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Prompt) Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, each sleeping room shall have a second means of escape that consists of one of the following: 1. It shall be a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape. 2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape. 3. It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 square feet. The width shall be not less than 20 inches. The height shall be not less than 24 inches. The bottom of the opening shall be not more than 44 inches above the floor. Such means of escape shall be acceptable			

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	where one of the following criteria are met: a. The window shall be within 20 feet of finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an exterior balcony. 4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following: 1. The ladder or steps do not extend more than 6 inches into the well. 2. The ladder or steps are not obstructed by the window. 5. If the sleeping room has a door leading directly to the outside of the building with access to finished ground level or to a stairway that meets the requirements of exterior stairs in 33.2.2.2.2, that means of escape shall be considered as meeting all the escape requirements for the sleeping room. a. A second means of escape from each sleeping room shall not be required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5. b. Existing approved means of escape shall be permitted to continue to be used.			

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	33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through 33.2.2.3.4 Based on observation and interview, the facility failed to ensure 3 of 6 clients sleeping rooms was provided with an unobstructed secondary means of escape in accordance with 33.2.2.3. This deficient practice could affect at least 3 clients. Findings include: Based on observation with the Program Manager on 01/24/19 between 2:54 p.m. and 3:00 p.m., the following was discovered: a) bedroom #3 secondary escape window was obstructed with a dresser b) bedroom #5 secondary escape window was obstructed with a desk c) bedroom #6 secondary escape window was obstructed with a bed Based on interview at the time of each observation, the Program Manager confirmed each window obstruction.	K S253	The facility will ensure access to secondary escape windows is maintained in all sleeping areas. Staff will be trained on the standard of maintaining unobstructed secondary means of escape in sleeping rooms. Random inspections of sleeping rooms will be preformed by Residential Manager Weekly, Area Supervisor Monthly and by Program Manager quarterly.	02/23/2019
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 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3	K S345	1.The administrator will ensure annual functional testing for initiating devices such as smoke	02/23/2019

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	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. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NPFA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Program Manager on 01/24/19 at 2:54 p.m., the annual fire alarm and biannual sensitivity test was available for review. Based on interview at the time of record review, the Program Manager acknowledged the aforementioned condition and confirmed no other documentation was available for review.		detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. **3.The Program Manager met with Eric Gray with Koorsen Fire and Security, on Feburary 4, 2019 to schedule required testing and request copies of inspections and testing are emailed to the program manager upon completion.**	
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			

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	15G247	A. BUILDING 01 B. WING	01/24/2019

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RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL DR JEFFERSONVILLE, IN 47130

(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
	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 6 client rooms doors had no impediment to closing and positively latched into the frame. This deficient practice could affect all occupants. Findings include: Based on observation with the Program Manager on 01/24/19 at 3:00 p.m., bedroom #6 contained a door stop. Bedroom #6 failed to latch into the frame when tested. Based on interview at the time of each observation, the Program Manager confirmed the bedroom door was propped open and failed to latch when tested.	K S363	1.The administrator will ensure clients bedroom doors have self-closing or automatic-closing devices installed, and the door latches to the frame. 2.Staff will be trained on the standard of not propping open self closing bedroom doors. The administrator will ensure clients bedroom doors have self-closing or automatic-closing devices installed. 3.The maintenance coordinator will ensure all clients bedroom doors have self-closing or automatic-closing devices installed. 4.All corridor doors had self closing latches installed by ResCare Maintenance and doors positively latch to frame installation and repair on February 18, 2019. 5.Self closing doors will be tested monthly by staff to ensure doors positively latch to frame. If a defective door is found it will be reported through the ResCare Maintenance form and repairs scheduled. Area Supervisor and Program Manager will inspect door closers quarterly to ensure proper operation.	02/23/2019

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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. 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) 1. Based on record review and interview, the facility failed to ensure 8 of 8 clients utilized all exits during fire drills and were able to choose an alternative route if the primary exit were blocked. LSC 33.7.2.2 requires resident training to include actions to be taken if the primary escape route is blocked. LSC 33.7.3.3 requires that drills shall involve the actual evacuation of all clients to an assembly point, as specified in the emergency plan, and shall provide clients with experience in	K S712	1.All staff at the home will be re-trained on conducting fire drills quarterly on all shifts. Fire drills will be conducted under varied conditions. Drill will also include a secondary egress once a year. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train	02/23/2019

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	egressing through all exits and means of escape required by this Code. LSC 33.7.3.5 Actual exiting from windows shall not be required to comply with 33.7.3; opening the window and signaling for help shall be an acceptable alternative. Finally, LSC 33.7.3.4 requires exits and means of escape not used in any drill shall not be credited in meeting the requirements of this Code for board and care facilities. This deficient practice affects all occupants. Findings include: Based on record review of the "Emergency Evacuations Drill" form with the Program Manager on 01/24/19 at 2:42 p.m., none of the last twelve fire drills indicated secondary egress was practiced in the nonsprinklered home. Based on interview at the time of record review, the Program Manager acknowledged there was no other documentation available to demonstrate secondary egress was practiced during fire drills within the past year. 2. Based on record review and interview, the facility failed to conduct evacuation drills under varied conditions on each shift for 4 of the last 4 calendar quarters in accordance with 42 CFR 483.470(i). 42 CFR 483.470(i) Standard: Evacuation drills. This deficient practice affects all staff and clients. Findings include: Based on record review of the fire drill reports titled "Emergency Evacuations Drill" with the Program Manager on 01/24/19 at 2:42 p.m., four sequential third shift fire drills took place between 3:00 a.m. and 4:00 a.m. for four of the last four quarters. Based on interview at the time of record review, the Program Manager acknowledged the		the Area Supervisor and the Area Supervisor will train all facility staff. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date.	

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	lack of documentation.			