		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	A. BU	A. BUILDING CO			B) DATE SURVEY COMPLETED 05/20/2021	
	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130		1		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI		(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE	
E 0000								
Bldg	conducted by the Ir accordance with 42		E 00	000				
	Survey Date: 05/20/2021 Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760 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. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8.							
	Quality Review cor	mpleted on 06/02/21						
	The requirement at NOT MET as evide	42 CFR, Subpart 483.475 is enced by:						
E 0015		8.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1),						
Bldg	485.625(b)(1) Subsistence Need §403.748(b)(1), § §441.184(b)(1), § §483.73(b)(1), §4	ds for Staff and Patients						
	must develop and	l implement emergency icies and procedures, based						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G <u></u>	COM	(X3) DATE SURVEY COMPLETED 05/20/2021	
	PROVIDER OR SUPPLIEI	LTERNATIVES SE IN	402	EET ADDRESS, CITY, STATE, ZIP CO EWING LN FERSONVILLE, IN 47130	.	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC DEPUTIENT OF DEFORMATION	ID PREFIX	CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION
TAG	on the emergency (a) of this section, paragraph (a)(1) of communication pl section. The policite of be reviewed and of [annually for LTC of the policies and posterior the following: (1) The provision staff and patients shelter in place, in to the following: (i) Food, water, m supplies (ii) Alternate source the following: (A) Temperatures and safety and for storage of provision (B) Emergency lig (C) Fire detection systems. (D) Sewage and of *[For Inpatient Ho Policies and proce (6) The following: address the follow (iii) The provision hospice employee they evacuate or are not limited to (A) Food, water, r supplies.	shting. , extinguishing, and alarm waste disposal. spice at §418.113(b)(6)(iii):] edures. are additional requirements ted inpatient care facilities and procedures must ving: of subsistence needs for es and patients, whether shelter in place, include, but	TAG	DEFICIENCY)		DATE
	1		I	1		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 05/20/2021				
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION		
TAG	(1) Temperatures and safety and for storage of provision (2) Emergency lig (3) Fire detection, systems. (C) Sewage and was assed on record regarded to ensure emand procedures include, but are not accordance with deficient practice of Findings include: Based on record regarded for the findings include: Residential Manages and the first had not been repleted in the first had not been repleted in the first had not match the period for the first had for the first had not match the period for the first had not for the fi	waste disposal. view and interview, the facility ergency preparedness policies lude at a minimum, (1) The tence needs for staff and ey evacuate or shelter in place, climited to the following: (i) and, and pharmaceutical supplies 42 CFR 483.475(b)(1). This ould affect all occupants. view and interview on n 10:30 a.m. and 1:00 p.m. with utive Director (AEO) the dness plan did not adequately l needs of the facility. Based the time of review with the er (RM) the emergency aid kit were inadequate and hished. The RM retrieved the the content. The AEO the supplies in the first aid kit solicies and procedures for ritten in the Emergency	E 0015	1.The administrator will ensure the emergency plan policies and procedures includes the updated Shelter-In-Place policy which addresses 1) alternative sources of energy, 2) emergency lighting, 3) fire detection, extinguishing and alarms, and 4) proper disposal of sewage and waste. 2.The area supervisor and program manager will train all staff on the updated Shelter-In-Place policy and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The Administrator will update the emergency plan to include the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, to include sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). 4.The Administrator will update the emergency plan to include a plan for the temporary loss of or need during sheltering in place for sewage and waste disposal. 5.This information is located in section 21 of the Emergency	f -		

6.The corrective action will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15G442	B. WING		05/20/2021
	PROVIDER OR SUPPLIE	LTERNATIVES SE IN	402 E\	ADDRESS, CITY, STATE, ZIP COD WING LN ERSONVILLE, IN 47130	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				monitored and reviewed for	
				effectiveness at a minimum	
				bi-annual	
				7.The Program Manager wil	
				purchase needed materials fo First Aid Kit staff will be	ir trie
				in-serviced on the required ite	ime
				and during monthly managem	
				site review First Aid kit will be	
				inspected for required items,	
				replacement items will be orde	er as
				needed by the Program Mana	iger.
				8.The Quality Assurance	
				Manager will review and appro	ove
				the shelter in place policy the	
				quality assurance manager ar	
				program manager will ensure most current Shelter in Place	the
				policy is in the Emergency	
				Preparedness Manual.	
				r repareuriess Mariaur.	
				Persons Responsible: AED,	
				Program Manager, Area Supervisor, and Residential	
				Manager, DSP Koorsen Fire a	and
				Security Representative, Aran	
E 0020	400.740/-1\/0\-44	0.54(4)(0), 440,440(4)(0)			
E 0039		6.54(d)(2), 418.113(d)(2),			
Bldg		2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2),			
Diag	, , , ,	.727(d)(2), 465.625(d)(2), .727(d)(2), 485.920(d)(2),			
	` ' ' '	1.12(d)(2), 494.62(d)(2)			
	EP Testing Requi				
		18.113(d)(2), §441.184(d)(2),			
	. , , , -	82.15(d)(2), §483.73(d)(2),			
		484.102(d)(2), §485.68(d)(2),			
		485.727(d)(2), §485.920(d)			

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 $(2), \, \S 491.12(d)(2), \, \S 494.62(d)(2).$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED					
AND PLAN	OF CORRECTION	15G442	A. BUILDI B. WING	NG		05/20/	
		100772				00/20/	I
NAME OF F	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TA	.G	DEFICIENCE		DATE
TAG	*[For ASCs at §41 OPO, "Organization CMHCs at §485.9 §491.12, and ESF (2) Testing. The [for exercises to test the standard of	nunity-based exercise is nduct a facility-based e every 2 years; or lity] experiences an actual ade emergency that requires mergency plan, the [facility] gaging in its next required or individual, facility-based e following the onset of the ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based e; or er drill; or ercise or workshop that is and includes a group	TA	.G	DEFICIENCY)		DATE
	clinically-relevant set of problem sta	emergency scenario, and a tements, directed					
	•	pared questions designed					
	to challenge an er	-					
	(iii) Analyze the Ifa	acility's1 response to and		l			

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION	COMP	E SURVEY LETED 0/2021	
	OF PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130					
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TAG	maintain docume exercises, and en the [facility's] emet *[For Hospices at (2) Testing for he the patient's home conduct exercises plan at least annuthe following: (i) Participate in a community based (A) When a community based functional (B) If the hospice man-made emerged of the emergency exempt from engascale community-facility-based functional exercise of this section is of this section is of include, but is not (A) A second full community-based functional exercise (B) A mock disast (C) A tabletop exempt for the emergency of the emergency exempt from engascale community-based functional exercise of this section is of include, but is not (A) A second full community-based functional exercise (B) A mock disast (C) A tabletop exempt for the emergency exempt from the emergency exempt from engascale to the emergency exempt from engascale to exercise the emergency exempt from engascale to exercise the exercise of the emergency exempt from engascale to exercise the exer	espices that provide care in e. The hospice must is to test the emergency cally. The hospice must do a full-scale exercise that is devery 2 years; or munity based exercise is not fuct an individual facility exercise every 2 years; or experiences a natural or gency that requires activation or plan, the hospital is aging in its next required full chased exercise or individual ctional exercise following the regency event. In the difference of the year the full-scale or see under paragraph (d)(2)(i) conducted, that may the limited to the following: -scale exercise that is do r a facility based se; or ster drill; or the year the full-scale or see and includes a group a narrated, a emergency scenario, and a fatements, directed epared questions designed		TAG	District II		DATE	

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2021		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP COD WING LN ERSONVILLE, IN 47130	•
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TAG	care directly. The exercises to test the per year. The hose (i) Participate in a that is community. (A) When a commaccessible, conduct facility-based functions of the emergency exempt from engated full-scale community. (ii) Conduct an activate may include, following: (A) A second full-community-based functional exercises (B) A mock disassication (C) A tabletop exemptication of the emergency scenarior of the exercises (B) A mock disassication of the exercise (B) A mock disassication	cunity-based exercise is not ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the dittional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion	TAG		DATE
	§482.15(d), CAHs (2) Testing. The [F conduct exercises	41.184(d), Hospitals at at §485.625(d):] PRTF, Hospital, CAH] must to test the emergency r. The [PRTF, Hospital,			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER RES CARE COMMUNITY ALTERNATIVES SE IN OCA-JD SIMMARY STATEMENT OF DEPICINCIE PREFIX (CA-JD CA-H) MUST do the following: (i) Participate in an annual full-scale exercise that is community-based functional exercise following: (a) the [Facility] is exempt from engaging in its next required activation of the emergency that requires activation of the emergency event. (ii) Conduct an inaliadional amnual exercise or and that may include, but is not limited to the following: (i) A ascond full-scale community based or individual, a facility-based functional exercise following: (i) Conduct an individual, facility-based functional exercise following the onset of the emergency event. (iii) Conduct an individual, a facility-based functional exercise following: (i) A) A second full-scale community based or individual, a facility-based functional exercise following: (i) A) a second full-scale exercise that is community-based functional exercise following: (i) A) a second full-scale exercise that is community-based functional exercise or (ii) A and the may include, but is not limited to the following: (ii) A mock disaster drift, or (iii) Conduct an annual full-scale exercise that is community-based functional exercise; or (iii) A mock disaster drift, or (iii) Conduct an annual full-scale exercise that is community-based functional exercise; or (iii) A mock disaster drift, or (iii) A mock disaster, and an annual full-scale exercise to and maintain documentation of all drifts, tabletop exercises, and emergency events and revise the facility's penergency plan, as needed. **Teor PACE al §460.84(d): (ii) Participate in an annual full-scale exercise	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
RES CARE COMMUNITY ALTERNATIVES SE IN RES CARE COMMUNITY ALTERNATIVES SE IN SIMMARY STATEMENT OF DEFICIENCIE PREFIX GEACH DEFICIENCY MUST BE PRECEDED BY PULL TAG CAHT must do the following: (i) Participate in an annual full-scale exercise that is community-based, or (a) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise, or (b) If the [PRTF, hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency event. (ii) Conduct an individual, facility-based functional exercise following the onset of the emergency event. (iii) Conduct an individual, a facility-based functional exercise following the onset of the emergency event. (iii) Conduct an individual, a facility-based functional exercise following the onset of the emergency event. (iii) Conduct an individual, a facility-based functional exercise or and that may include, but is not limited to the following: (A) A second full-based functional exercise or (B) If most requires exclavation of the emergency event. (iii) Conduct an exercise or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 flacility's) response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the (facility's) response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the facility's) response to and maintain documentation of all drills, tabletop exercises to test the emergency plan, as needed. "(For PACE at §460.84(d).] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organiza	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
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that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabeltop exercise or workshop that is led by a facilitator and includes a group discussion, 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 [facilitys] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facilitys] emergency plan, as needed. **IFor PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:		_	_					
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and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:		and maintain doc	umentation of all drills,					
needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:		tabletop exercises	s, and emergency events					
*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:		and revise the [fac	cility's] emergency plan, as					
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:		needed.						
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:		*(=== DAO= =+ 0.4)	CO 04/4\.1					
conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:		-	• • =					
plan at least annually. The PACE organization must do the following:			_					
organization must do the following:			0 2					
			-					
(i) Farticipate in an annual fun-scale exercise		_	-					
that is community-based; or								

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Event ID:

9FM521

Facility ID: 000956

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PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE C A. BUILDING B. WING	e survey pleted 0/2021			
NAME OF P	PROVIDER OR SUPPLIER	•		ADDRESS, CITY, STATE, ZIP CO	DD	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		WING LN RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE PROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	1 ' '	nunity-based exercise is not				
		ct an annual individual,				
	1	ctional exercise; or reperiences an actual natural				
	1 ' '	ergency that requires				
		mergency plan, the PACE				
		gaging in its next required				
	-	nity based or individual,				
		tional exercise following the				
	onset of the emer	_				
	(ii) Conduct a	n additional exercise every				
	2 years opposite t	he year the full-scale or				
	functional exercise	e under paragraph (d)(2)(i)				
	of this section is c	onducted that may include,				
	but is not limited to					
	(A) A second full-	scale exercise that is				
	1	or individual, a facility				
	based functional e					
	(B) A mock disast					
	1 ' '	ercise or workshop that is				
	· -	and includes a group				
	discussion, using					
	I -	emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er					
	1 ' '	ACE's response to and nation of all drills, tabletop				
		nergency events and revise				
		gency plan, as needed.				
		joiney plant, as necucu.				
	*[For LTC Facilitie	es at §483.73(d):1				
	_	ty] must conduct exercises				
	· · ·	ency plan at least twice per				
	_	announced staff drills using				
	• •	ocedures. The [LTC facility,				
	ICF/IID] must do t	= -				
	-	n annual full-scale exercise				
	that is community-	-based; or				
	1	nunity-based exercise is not				

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Event ID:

9FM521 Facility ID: 000956

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PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	ì	UILDING	NSTRUCTION	(X3) DATE COMPI 05/20	LETED
	PROVIDER OR SUPPLIE	LTERNATIVES SE IN		402 EW	DDRESS, CITY, STATE, ZIP COD ING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE
	facility-based fund (B) If the [LTC facility actual natural or requires activation LTC facility is exerequired a full-scalind individual, facility-following the onset (ii) Conduct an actual may include, following: (A) A second full-community-based based functional (B) A mock disast (C) A tabletop exled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the [I response to and rall drills, tabletop events, and revise emergency plan, and that is community (A) Testing. The lease of the community (A) When a community (B) the conduction of the community (B) the conduction of the community (B) the community (C) t	cility] facility experiences an man-made emergency that an of the emergency plan, the empt from engaging its next alle community-based or based functional exercise et of the emergency event. In the exercise but is not limited to the exercise or the an individual, facility exercise; or the dillipse or workshop that is includes a group a narrated, emergency scenario, and a exements, directed pared questions designed emergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed. S483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the					

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Event ID:

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PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	
		15G442	B. WI	NG		05/20/	/2021
NAME OF I	DROVIDED OD GUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEF	C		402 EW	/ING LN		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		ade emergency that requires					
		mergency plan, the ICF/IID					
	is exempt from engaging in its next required						
	full-scale community-based or individual,						
	facility-based functional exercise following the						
	onset of the emergency event. (ii) Conduct an additional annual exercise						
	that may include, but is not limited to the						
	following:	peole eversion that is					
	community-based	scale exercise that is					
	I						
	facility-based functional exercise; or (B) A mock disaster drill; or						
	(C) A tabletop exercise or workshop that is						
	, ,	and includes a group					
	discussion, using	- ·					
		emergency scenario, and a					
	set of problem sta						
	1	pared questions designed					
	to challenge an er	·					
	_	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	*FF	24.4003					
	*[For HHAs at §48						
		e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:	full cools aversion that is					
		full-scale exercise that is					
	community-based						
	, ,	ommunity-based exercise					
		conduct an annual					
		based functional exercise					
	every 2 years; or.	A ovnorionada ar astual					
	` '	A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
	i exempl from enga	aging in its next required	ı				I

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Event ID:

9FM521 Facility ID: 000956

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PRINTED: 06/17/2021 FORM APPROVED OMB NO. 0938-039

	AN OF CORRECTION	IDENTIFICATION NUMBER 15G442	 JILDING	NSTRUCTION	COMPL 05/20	ETED
	OF PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EW	NDDRESS, CITY, STATE, ZIP COD I'ING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility based fundonset of the emericii) Conduct an adyears, opposite the functional exercise of this section is conclude, but is not (A) A second community-based facility-based fundonsity-based fundonsity-based facility-based fundonsity-based fundonsity-	ditional exercise every 2 le year the full-scale or le under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is lor an individual, ctional exercise; or lisaster drill; or lo exercise or workshop that for and includes a group la narrated, lemergency scenario, and a litements, directed lipared questions designed limergency plan. HA's response to and lintation of all drills, tabletop linergency events, and revise lency plan, as needed. 86.360] le OPO must conduct line designed mergency plan. The				

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Event ID:

9FM521

Facility ID: 000956

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	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 	(X3) DATE SURVEY COMPLETED 05/20/2021		
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	maintain docume exercises, and er the [RNHCl's and needed. *[RNCHIs at §40 (d)(2) Testing. The exercises to test. RNHCl must do t (i) Conduct a papat least annually. group discussion narrated, clinicall scenario, and a standard diescreted message designed to chall (ii) Analyze the R maintain docume exercises, and er the RNHCl's emet 1. Based on record facility failed to en COVID pandemic required activation Preparedness Plan ICF/IID facility mit (i) Participate in ar is community-base a. When a community-	PO's response to and ntation of all tabletop nergency events, and revise I OPO's] emergency plan, as 3.748]: e RNHCI must conduct the emergency plan. The he following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a y-relevant emergency et of problem statements, es, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise ergency plan, as needed. I review and interview, the sure its documentation of the as an actual emergency that of the existing Emergency (EPP) was complete. The last do the following: a annual full-scale exercise that d; or nity-based exercise is not tan annual individual,	E 0039	1.The administrator will ensuthe participation in a full-scale community based exercise and table top exercise is present in EPP manual. 2.The area supervisor and program manager will ensure documentation of the table top exercise and the community based exercise are present in Emergency Disaster	d a n the		

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b. If the ICF/IID facility experiences an actual

natural or man-made emergency that requires

activation of the emergency plan, the ICF/IID

full-scale in a community-based or individual,

year following the onset of the actual event.

facility-based full-scale functional exercise for 1

facility is exempt from engaging its next required

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Preparedness Manual for

reference as needed. The

and is present. The safety

associate executive director will

review the training documentation

to ensure it has been completed

committee will review and update

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2021		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	•	402 EW	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	(ii) Conduct an add	R LSC IDENTIFYING INFORMATION itional exercise that may		TAG	annually as needed. 3.This information is located		DATE
	a. A second full-sca	imited to the following: ale exercise that is or an individual, facility-based			section 22 of the Emergency Disaster Preparedness Manua		
	functional exercise. b. A mock disaster				4.Dated Documentation will provided showing the complet	be	
	c. A tabletop exerci	c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by			of a tabletop exercise 5.The AED will in service the		
	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				Program Manager, Area Supervisor and Residential	•	
					Manager on the requirement of conducting an annual commun		
	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				based exercise and maintainir documentation	-	
		CFR 483.475(d)(2). ice could affect all occupants.			Persons Responsible: AED, Program Manager, Area Supervisor, and Residential		
	Findings include:				Manager, DSP.		
	05/20/2021 between the Associate Exect facility failed to matacility as required for COVID-19 of the Disaster Preparation during record reviet policy requiring months as no longer in ef- that records of clear review. The AEO at assessment of the p	view and interview on in 10:30 a.m. and 1:00 p.m. with putive Director (AED), the contain records of cleaning the by the policies and procedures are RES CARE Emergency/ in Manual. Based on interview aw, the AED indicated that the porning and evening cleaning fect. The AEO acknowledged ming were not available for cknowledged that an olicy and procedure and the change to the policy were view.					
		ewed with the AED during the 5/20/2021 at 2:30 p.m.					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/20/2021	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		402 EW	ADDRESS, CITY, STATE, ZIP COD I'ING LN RSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE	
	facility failed to come emergency plan at ICF/IID facility mu (ii) Conduct an addinclude, but is not a. A second full-secommunity-based of functional exercises b. A mock disaster c. A tabletop exercise facilitator that inches a facilitator, using emergency scenaristatements, directed questions designed plan. (iii) Analyze the IC maintain document exercises, and emergency scenaries accordance with 42 deficient practice of Findings include: Based on record resume Emergency/Disasted documentation with Director (AED) be documentation of a the Emergency Preserview, in word include schedulactivation documentation d	drill; or ise or workshop that is led by a lades a group discussion led by a lades a group discussion led by a narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency CF/IID facility's response to and lation of all drills, tabletop regency events, and revise the mergency plan, as needed in a CFR 483.475(d)(2). This ould affect all occupants. View of RES CARE or Preparation Manual the he Associate Executive tween 10:30 a.m. and 1:00 p.m., an additional or activation of paredness Plan was not w. Based on interview during was determined that the EPP did led testing or an actual						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G442			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED B. WING 05/20/2021				LETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR The deficiency was	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION reviewed with the AED during		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	FION LD BE KOPRIATE	(X5) COMPLETION DATE
K 0000	the Exit Conference	e on 05/20/2021 at 2:30 p.m.					
Bldg. 01	conducted by the In accordance with 42 Survey Date: 05/20 Facility Number: 0 Provider Number: 100 At this Life Safety 0 Community Alterna compliance with Re Medicaid, 42 CFR 3 from Fire and the 20 Protection Associat Code (LSC), Chapte Board and Care Occ This one story build sprinklered. The att detection connected panel. The facility has a ca of 8 at the time of the Calculation of the E (E-Score) using NF	200956 15G442 244760 Code survey, RES CARE atives SE IN was found not in Equirements for Participation in Subpart 483.470(j), Life Safety 012 Edition of the National Fire ion (NFPA) 101, Life Safety er 33, Existing Residential cupancies. Ling was determined to be fully ic is protected by heat I to the fire alarm control has a fire alarm system with corridors and all living areas. Apacity of 8 and had a census his survey. Evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the han E-Score of 0.6.	K 0	000			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		A. BU	A. BUILDING <u>01</u> CON			SURVEY LETED /2021	
	PROVIDER OR SUPPLIE	L LTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
K S211 Bldg. 01	continuously mair and impediments case of fire or em 33.2.2 Based on observatifailed to maintain 1 exterior doors) of e impediments to full or emergency. This all occupants needit escape from the Be Findings include: Based on record refevacuation Drill" rare used to exit the emergency. Based facility tour on 05/2:00 p.m. with the (AED), Front Pation because the door has an interview at the acknowledged that to be drilled during on an interview at the AED acknowledged opened. The AED immediately to hav	- General s of escape shall be stained clear of obstructions to full instant use in the ergency. ion and interview, the facility of 2 primary means (1 of 5 scape clear of obstructions and l instant use in the case of fire deficient practice could affect ng to use the primary means of	K S	211	1.The administrator will ensure Designated means of escape be continuously maintained cloof obstructions and impediment to full instant use in the case of fire or emergency. 2.The administrator submitted work order Aramark for the extended door used for the front pation of the extended door used for the front pation of all doors used for evacuation and if a deficient is found they are to immediate report any issues to ResCare Maintenance. 4.The Residential Manager of the Re	shall ear ints of ed a itterior oor ithe sed incy ely will itto iill or ed incy	06/19/2021

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	-		T ADDRESS, CITY, STATE, ZIP COD EWING LN	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		ERSONVILLE, IN 47130	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
				Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP. Aramark, Res Maintenance.	-Care
K S222	NFPA 101				
Bldg. 01	escape shall not be Bathroom doors so inches. Doors are closet door latch so the inside in case bathroom door shall be opening from the demergency when means of escape egress when the bedayed egress to 7.2.1.6.1 shall be only. Access-controcomplying with 7.2 Forces to open do 7.2.1.4.5. Door-latching devit 7.2.1.5.10. Corridopositive latching hare prohibited. Door assemblies for required to swing travel shall be inspectionally in access.	of travel to a means of the less than 28 inches. Thall not be less than 24 swinging or sliding. Every Thall be readily opened from of an emergency. Every all be designed to allow			
	failed to ensure 1 of	on and interview, the facility 5 5 exterior exit doors were eccurity mechanism to release	K S222	1.The administrator submitt work order Aramark for the ex	terior

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G442	B. W	ING _		05/20/	2021
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	1			/ING LN		
DES CVE		LTERNATIVES SE IN			RSONVILLE, IN 47130		
INES CAI	AL COMMONTT A	ETERNATIVES SE IN		JEI I EI	COUNTELL, IN 47 130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the door and open.	33.2.2 states designated means			to be repair and or replaced.		
	of escape shall be co	ontinuously maintained free of			2.Staff will be in-serviced on	the	
	all obstruction or in	npediments to full instant use			daily inspection of all doors us	ed	
	in the case of fire or	emergency. This deficient			for evacuation and if a deficier	тсу	
	practice could affec	t occupants in Bedrooms #1-5			is found they are to immediate	ely	
	in the facility.				report any issues to ResCare	-	
					Maintenance.		
	Findings include:				3.The Residential Manager	will	
	-				check all doors used for		
	Based record review	v of the Emergency Evacuation			evacuation weekly and if a		
	Drill reports on 05/2	20/2021 between 10:30 a.m. and			deficiency is found they are to		
	1:00 p.m. with the A	Associate Executive Director			immediately report any issues		
	(AED), the "front patio" door is considered the primary exit from Bedrooms #1-5. Based on				ResCare Maintenance.		
					4.The Management team wi	II	
	observation during	the facility tour on 05/20/2021			conduct monthly inspections for		
	between 1:00 p.m. a	and 2:00 p.m. with the AED, the			proper function of all doors us		
	-	ould not be opened due to			for evacuation and if a deficier		
	-	hardware. The AED was not			is found they are to immediate	-	
	aware of the fact tha	at the door could not be			report any issues to ResCare	•	
	opened in the direct	ion of escape. The AED			Maintenance.		
	immediately called	for service on the door					
	hardware at the time	e of observation.					
					Persons Responsible: AED,		
	The deficiency was	reviewed with the AED during			Program Manager, Area		
	_	e on 05/20/2021 at 2:30 p.m.			Supervisor, and Residential		
		•			Manager, DSP		
K S300	NFPA 101						
	Protection - Other						
Bldg. 01	Protection - Other						
	2012 EXISTING						
	List in the REMAR	RKS section any LSC					
	Section 33.2.3 Pro	otection requirements that					
	are not addressed	by the provided K-tags, but					
	are deficient. This	information, along with the					
	applicable Life Sa	fety Code or NFPA					
	standard citation,	should be included on					
	Form CMS-2567.						
	Based on observation and interview, the facility		K S	300	1.The facility will ensure the		06/19/2021
	failed to ensure the	closing to latch of a door			door between the living room	and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		15G442	B. Wl	ING		05/20/	2021
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	S.			/ING LN		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	equipped with sprin	g-loaded hinges and a			front hallway that is equipped	with	
		device activated by the fire			a closing to latch of door equip	pped	
	alarm system. NFPA 101 in 4.6.12.3 states existing				with spring-loaded hinges and	а	
	· ·	obvious to the public, if not			magnetic hold-open device		
		le, shall be maintained. NFPA			activated by the fire alarm sys		
		nce and Tests. Fire-warning			NFPA 101 in 4.6.12.3 required	•	
		maintained and tested in			the Code, shall be maintained		
		e manufacturer's published			following NFPA 72, 29.10		
		the requirements of Chapter			Maintenance and Tests.		
	·	1.1.1 Inspection, testing, and			2.The maintenance coordina		
	maintenance progra	_			will ensure all doors will positive	/ely	
	_	Code and conform to the			latch as required.		
	equipment manufacturer's published instructions.				3.The Program Manager		
	This deficient practice could affect all clients,				scheduled a service order with	1	
	staff, and visitors.				Aramark for the repair or		
	Findings in ded.				preplacement of the door betw		
	Findings include:			the living room and front hallway and will be repaired by ResCare			
	Pasad on observative	on with the Associate					
		on 05/20/2021 between 1:00			Maintenance before July 1, 20 A delay in repair may occur d		
		the door between the living			to scheduling limitations based		
		hallway did not close and latch			vendor supply.	1 011	
		the hold-open device. Based			4.The Residential Manager	will	
		he time of the observation, the			inspect house weekly to latchi		
		why the door was required or if			doors operate properly Area	9	
		ke barrier. No Life Safety			Manager will preform random		
		g wall fire rating requirements			monthly inspections and Progr	ram	
	_	locument review. The AED			Manager will provide quarterly		
		the door did not fully close			inspections to ensure doors		
	_	ased from the hold-open			positively latch to frame as		
	device.	-			required and function as requi	red.	
					5.Staff will notify ResCare		
	The deficiency was	reviewed with the AED during			Maintenance upon discovery o	of	
	the Exit Conference	e on 05/20/2021 at 2:30 p.m.			any deficiency that prevents		
					Clients Bedroom Doors from		
					positively latching to the frame	as	
					required by calling 844-ResCa	ıre.	
					_		
					Persons Responsible: Prograr	n	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		r í	ILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/20/2021		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE
					Manager, Area Supervisor, Residential Manager, DSP. Aramark, ResCare Maintenan	ıce.	
K S345	NFPA 101						
	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance Fire Alarm System Maintenance	n - Testing and					
	2012 EXISTING (Prompt)						
	A fire alarm system is tested and maintained						
		n an approved program e requirements of NFPA 70,					
		Code, and NFPA 72,					
		n and Signaling Code.					
	_	n acceptance, maintenance					
	and testing are rea	-					
	9.7.5, 9.7.7, 9.7.8,	review, observation and	K S	3/15	1.The administrator will ens	ure	06/19/2021
		ty failed to ensure all fire alarm	K S.	343	annual functional testing for		00/19/2021
	system initiating de	-			initiating devices such as smo	ke	
		schedules for testing			detectors, heat detectors, rele	ase	
		72. LSC Section 33.2.3.4.1			devices, and fire alarm boxes		
		alarm system shall be			performed by Koorsen Fire an		
	-	nce with Section 9.6, unless .2.3.4.1.1 or 33.2.3.4.1.2 are			Security on the fire alarm syst and that reports of the	em	
	_	0.6.1.3 states a fire alarm system			tests/inspections are available	in	
		ety shall be installed, tested,			the facility for review.		
		ccordance with the applicable			2.The administrator will ensi	ure	
	_	PA 70, National Electric Code			sensitivity testing of the fire al		
	· ·	onal Fire Alarm and Signaling			system is completed by Koors		
		010 Edition, Section 14.4.5 be performed in accordance			Fire and Security every alterny year after install and that repo		
		n Table 14.4.5. Table 14.4.5 at			of the tests/inspections are	113	
		airements of 14.4.5.5 shall			available in the facility for revi	ew.	
		ors. Section 14.4.5.5 states			Koorsen Fire and Security will		
		perature, spot-type heat			also forward inspection report		
		sted in accordance with			the QA Manager for monitorin	g of	
	I -	4.4.5.5.4. Two or more			completion. 3 The Program Manager wil	.	
i e	 detectors shall be fe 	sted on each initiating circuit	1		I 3 The Program Manager will	. 1	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPL	ETED
		15G442	B. W	ING		05/20/	/2021
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			/ING LN		
RES CAE		LTERNATIVES SE IN			RSONVILLE, IN 47130		
INLO OAI	L COMMONTT A	ETERIVATIVEO OL IIV		ا ا ا	TOOMVILLE, IN 47 100		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	1	t detectors shall be tested each			meet with a representative fro	m	
	1 -	l be kept by the building owner			Koorsen Fire and Security, a		
		etectors have been tested.			tentative date has been set fo		
	I -	h detector shall have been			June 16, 2021 The Facility wil		
		nt practice could affect all			require schedule required test	-	
	clients, staff, and visitors.				and request copies of inspecti		
	The state of the s				and testing mailed to the prog		
	Findings include:				manager upon completion to t	he	
	D 1				Program Manager at 4341		
	Based on record review on 05/20/2021 between				Security PKWY Suite 101 Nev	N	
	10:30 a.m. and 1:00 p.m. with the Associate				Albany IN 47150.		
	Executive Director, documentation of heat				4.The Program Manager sp		
	detector testing for two devices located in the				with the Kris Carney from Koo	rsen	
		ble for review. The most recent			Fire and Security effective		
	1 -	ting Report dated August 4,			immediately all sites will have	an	
		the two heat detectors in the			annual functional fire alarm		
		ded in the report. Survey of the			inspection in the Month of		
		ble because no ladder was			February and a semiannual fir		
		interview at the time of record			alarm visual inspection compl		
		ated the fire alarm system			in August. Repair of the device		
	_	ow include the inspection and			that failed the sensitivity test h		
	_	ctors or the wiring connecting			been scheduled to be complete		
	the devices to the fa	aire alarm control panel.			no later than July 1,2021. Acc	cess	
					to the device will be made		
	I	reviewed with the AED during			available and that device will be		
	the Exit Conference	e on 05/20/2021 at 2:30 p.m.			tested no later than July 1, 20		
					Koorsen Fire and Security wa		
		review and interview, the			notified of ResCare's "In Scop	e	
	1	sure all facility smoke detectors			Services Agreement" that		
		sted and marked sensitivity			automatically authorizes		
	_	n 33.2.3.4.1 states a manual fire			repair/service of fire systems.		
		be provided in accordance with			Koorsen will notify the Prograi		
		n 9.6.1.3 states a fire alarm			Manger upon completion of al	I	
	i i	talled, tested and maintained in			inspections to ensure any		
	accordance with the applicable requirements of				deficiencies are properly track		
	NFPA 72, National Fire Alarm Code. NFPA 72,				and repaired. Koorsen will ser		
	2010 Edition, Section 14.4.5.3.1 states detector				documentation of all inspectio		
	I	checked within 1 year of			services and repair to ResCar	e	
		.4.5.3.2 states every alternate			main office at 4341 Security		
	year thereafter. Aft	ter the second required			Parkway STE. 101 New Albar	ıv IN	I

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		15G442	B. WING		05/20/2021
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	402 E\	ADDRESS, CITY, STATE, ZIP COD WING LN ERSONVILLE, IN 47130	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1710		ensitivity tests indicate that	ING	47150 within 30 days of comp	
		nained within its listed and		1	
				service. The Program Manage	ar will
		range, the length of time		follow up to ensure work is	
		tests shall be permitted to be		completed and documented a	S
		mum of 5 years. If the		required.	
		led, records of detector caused			
		d subsequent trends of these			
		intained. In zones or areas		Persons Responsible: AED,	
		rms show an increase over the		Program Manager, Area	
		pration tests shall be performed.		Supervisor, and Residential	
		smoke detector is within its		Manager, DSP Koorsen Fire a	and
	listed and marked s	sensitivity range, it shall be		Security Representative.	
	tested using any of	the methods:			
	(1) Calibrated test 1	method.			
	(2) Manufacturer's	calibrated sensitivity test			
	instrument.				
	(3) Listed control e	equipment arranged for the			
	purpose.				
	(4) Smoke detector	/fire alarm control unit			
	arrangement where	by the detector causes a signal			
	-	where its sensitivity is outside			
	its listed sensitivity	-			
	-	d sensitivity method acceptable			
	to the authority hav	-			
	1	have sensitivity outside the			
		sensitivity range shall be			
	cleaned and recalib	· -			
		ivity cannot be tested or			
		y spray device that administers			
		centration of aerosol into the			
		cient practice could affect all			
	clients, staff, and v	isitors.			
	Findings include:				
		view with the Associate			
	Executive Director	(AED) on 05/20/2021 between			
	10:30 a.m. and 1:00	0 p.m., documentation of smoke			
		testing within the most recent			

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two year period was not available for review.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		 JILDING	01	COMPL 05/20/	ETED	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EW	DDRESS, CITY, STATE, ZIP COD ING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	те	(X5) COMPLETION DATE
K S351	the Area Director ac of smoke detector so most recent two year review and that no could indicate that so were available. The deficiency was the Exit Conference	at the time of record review, eknowledged documentation ensitivity testing within the period was not available for other documentation that sensitivity testing and results reviewed with the AED during on 05/20/2021 at 2:30 p.m.				
Bldg. 01	installed, for either building coverage, accordance with S shall initiate the fir accordance with S modified below. The supply shall be do In Prompt Evacuar sprinkler system in with NFPA 13D, S of Sprinkler System and two Family Down Homes, shall be part Automatic sprinkler closets not exceed feet and in bathrous square feet, provides paces are finished materials providing thermal barrier. In Prompt Evacuar where an automat system is in according the standard for the Irrigation of t	Installation tic sprinkler system is r total or partial the system shall be in Section 9.7 and e alarm system in Section 9.6, as the adequacy of the water cumented. tion facilities, an automatic of accordance trandard for the Installation ms in One wellings and Manufactured termitted. ers shall not be required in ding 24 square toms not exceeding 55 ded that such the d with lath and plaster or tion Capability facilities tic sprinkler dance with NFPA 13,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		15G442	B. WI	NG		05/20/	/2021
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹		1	/ING LN		
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
1120 0711	(E GOIMMONT) / (1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	not be required in closets not						
		are feet and in bathrooms					
	not exceeding 55	· ·					
	•	n spaces are finished with					
	lath and plaster or						
		nute thermal barrier. ition Capability facilities in					
	buildings four or fe						
	•	e, systems in accordance					
	with NFPA 13R, S						
	Installation of Spri						
	Residential Occup						
	·	ories in Height, shall be					
	permitted.						
	· .	e alarm system shall not be					
	required for existing						
		cordance with 33.2.3.5.6.					
	Where an automa	tic sprinkler is installed,					
	attics used for livir	ng purposes,					
	storage, or fuel-fir	ed equipment are sprinkler					
	protected by July	5, 2019. Attics not used for					
		torage, or fuel-fired					
		one of the following:					
		eat detection system to					
	activate the fire al	arm system					
	according to 9.6.						
	· ·	ıtomatic sprinkler system					
	according to 9.7.						
		noncombustible or					
	limited-combustible						
	-	fire-retardant-treated wood					
	according to NFP						
		.5.3.1, 33.2.3.5.3.3, .3.5.3.6, 33.2.3.5.7					
	· ·	ration and interview, the	KS	251	1.The Facility will ensure the	<u>,</u>	06/19/2021
		ce sprinkler protection	1 2 2	JJ 1	installation an additional auton		00/17/2021
		yout of Bedroom #5 in a fully			sprinkle head to adequately	iidiio	
		ome. This deficient practice			protect the bedroom #5.		
		dents, staff, and visitors within			2.The Facility will ensure the)	
	the facility.	•			installation an additional auton		
			1		Ī		i e

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. Building <u>01</u>			COMPLETED	
		15G442	B. WI	NG _		05/20/	/2021
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹					
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130				
	L COMMONT A		ı		T T T T T T T T T T T T T T T T T T T		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	TO 11 1 1 1				sprinkle head to adequately		
	Findings include:				protect the bedroom #4.		
		ear ar a second			3.The Facility will ensure the		
		on with the Associate			installation an additional auton	natic	
		on 05/20/2021 during a tour of			sprinkle head to adequately		
		1:00 p.m. and 2:00 p.m., the			protect the Pantry.		
		enclosure for a pantry has			4.The Facility will ensure the		
		y pattern of the existing			installation an additional auton	natic	
	_	m #5 including the floor area			sprinkle head to adequately		
		of the closet. Based on an			protect the bathroom #1.		
		AED at the time of observation,			5.The Facility will ensure the		
		t the pantry was not new			installation an additional auton	natic	
		AED acknowledged that the			sprinkle head to adequately		
		tibles in and near the closet			protect the bathroom #2.		
	_	rmal and that the sprinkler			6.Koorsen Fire and Security		
	does not appear to a	adequately protect the area.			was notified by the Program		
	יים ו מיי	' 1 'd d AFD			Manager on Mat 20, 2021 to		
	-	s reviewed with the AED			schedule the installation of an		
	_	nference on 05/20/2021 at 2:30			additional automatic sprinkler		
	p.m.				the bathroom and are added to	o tne	
	2 D 1 1				inspection and testing of the		
		ration and interview, the			Sprinkler System.		
		ice sprinkler protection			7.The Program Manager		
	-	el load in Bedroom #4 in a fully			contacted Aramark on May 20		
		ome. This deficient practice			2021 and submitted a work or		
	the facility.	nts, staff, and visitors within			to have ResCare Maintenance	;	
	me facility.				verify install the installation		
	Findings include:				required by LSC and add the inspection and testing to		
	i manigs include:				Koorsen's scope of work.		
	Rased on observativ	on with the Associate			8.The Associate Executive		
		on 05/20/2021 during a tour of			Director contacted Joe Moore	with	
		1:00 p.m. and 2:00 p.m., the			Aramark Services on June 11,		
		tibles in Bedroom #4 exceeds			2021 the Facilities maintenance		
		droom. Stuffed animals filled			vendor to ensure the scope of		
		l, and flat surfaces of dressers			work for Koorsen Fire and Sec		
		on an interview with the AED			for the installation of additiona	-	
		vation, the AED acknowledged			sprinkler heads are included. I		
		as higher than normal and that			completion no later than July 1	-	
		ne sprinkler system designer			2021 documentation will be m		
	an assessment by th	is aprimited by brein debigner				aac	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/20/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP COD WING LN RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION eted to verify that the existing	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) available for review.	(X5) COMPLETION DATE
	sprinkler design wa load in the room.	s adequate for the combustible			
	1	reviewed with the AED ference on 05/20/2021 at 2:30		Persons Responsible: Koors Fire and Security, Aramark Maintenance Manager, Progr Manager, Area Supervisor, a	ram
	facility failed to pla a fully sprinklered g	Based on observation and interview, the acility failed to place sprinklers in 1 of 1 Pantry in fully sprinklered group home. This deficient ractice could affect all residents and staff within the facility.		Residential Manager, DSP.	
	Findings include:				
	Executive Director tour of the facility be there was no sprink Pantry enclosure ap from space formerly the room was created modified to protect combustibles and patto be greater than not The lack of sprinkle acknowledged by the observations.	on with the Associate (AED) on 05/20/2021 during a setween 1:00 p.m. and 2:00 p.m., der located in the Pantry. The pears to have been created a part of Bedroom #5. When ad, sprinkler protection was not the Pantry. The quantity of ackaging in the Pantry appears formally found in a residence.			
	1	reviewed with the AED ference on 05/20/2021 at 2:30			
	facility failed to pla bathrooms with floo feet in a fully sprink	ation and interview, the ce sprinklers in 1 of 2 or areas greater than 55 square clered group home. This ould affect all residents and lity.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/20/2021			
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	402 EV	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPE DEFICIENCY)	LD BE COMPLETION		
	Findings include:						
	Executive Director tour of the facility there was no sprint The floor area of the square feet. The lad and the area of the square feet was act times of the observed This deficiency was during the Exit Corp.m. 5. Based on observed facility failed to plate 10 spaces without opattern. This deficients and staff with Findings include: Based on observation of the facility the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventation of the facility water closet and variation and staff with the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are closet and variations are consequently the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are closet and variations are consequently the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are consequently the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are consequently the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are consequently the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are consequently the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are consequently the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are consequently the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are consequently the sprinkler in Bath of the bath/shower the ceiling. The best deflector and preventations are consequently the sprinkler in Bath of the bath of the bath of the sprinkler in Bath of the bath	s reviewed with the AED inference on 05/20/2021 at 2:30 vation and interview, the ace sprinklers in 1 of more than obstructions to the spray ent practice could affect all					
	-	s reviewed with the AED nference on 05/20/2021 at 2:30					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		A. BUILDING B. WING	01	COM	COMPLETED 05/20/2021	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	402 EW	ADDRESS, CITY, STATE, ZIP C VING LN RSONVILLE, IN 47130	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR. (EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE ADEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	p.m.					
K S353	NFPA 101 Sprinkler System -	Maintenance and Testing				
Bldg. 01	Sprinkler System - 2012 EXISTING (F NFPA 13 and 13R All sprinkler system with NFPA 13, Sta Sprinkler Systems for the Installation Residential Occup Four Stories in He and maintained in Standard for Inspendintenance of W System. NFPA 13D System Sprinkler systems with NFPA 13D, S of Sprinkler System Dwellings and Mainspected, tested a accordance with the NFPA 25: 1. Control valves 25, section 13.2.71). 3. Alarm devices (NFPA 25, section 4. Alarm devices (NFPA 25, section 5. Valve supervisemiannually (NFPA 25, section 7. Visible pipe in 25, section 5.2.2).	Maintenance and Testing Prompt) Systems Installed in accordance Indard for the Installation of Indard for the Installation of Indard for Sprinkler Systems in Indices Up To and Including Indices Up To and Including Indices Up To and Including Indices Up To Indices Up T				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` ′	ULTIPLE CO	,	3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED		
		15G442	B. W.	ING		05/20/	05/20/2021	
NAME OF I	PROVIDER OR SUPPLIER	- }			ADDRESS, CITY, STATE, ZIP COD			
					VING LN			
RES CARE COMMUNITY ALTERNATIVES SE IN				JEFFEI	RSONVILLE, IN 47130			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL				TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
	(NFPA 25, section	oected annually prior to						
		for adequate heat for water						
	_	A 25, section 5.2.5).						
		ative sample of fast						
	· ·	rs are tested at 20 years						
	(NFPA 25, section	_						
		ative sample of dry pendant						
	sprinklers are test	ted at 10 years (NFPA 25,						
	section 5.3.1.1.15	5).						
	12. Antifreeze s	olutions are tested annually						
	(NFPA 25, section							
		es are operated through						
		d returned to normal						
		5, section 13.3.3.1).						
		tems of OS&Y valves are						
		y (NFPA 25, section						
	13.3.4).	stome extending into						
		stems extending into s of the building are						
		and maintained (NFPA 25,						
	section 13.4.4).	and maintained (WTT 77 25,						
		system last checked and						
	necessary mainte							
	B. Show who prov	vided the service.						
		e of the water supply for the						
	automatic sprinkle	er system.						
	(Provide in REMA	RKS information on						
	,	non-required or partial						
	automatic sprinkle							
	l '	.5.8, 9.7.5, 9.7.7, 9.7.8,						
	and NFPA 25	,						
	Based on observ	vation and interview, the	KS	353	1.The Facility will ensure the	:	06/19/2021	
	facility failed to ens	sure 1 of more than 10 sprinkler			installation of an escutcheon p			
	· ·	were maintained. NFPA 13,			in the office for the automatic			
		stallation of Sprinkler Systems,			sprinkler head in accordance v	with		
	2010 Edition, Secti	on 6.2.7.1 states plates,			NFPA 13, Standard for the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		15G442	B. WI	ING		05/20/	/2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	3			/ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	·	er devices used to cover the			Installation of Sprinkler Syster	ns,	
	-	nd a sprinkler shall be metallic			2010 Edition, Section 6.2.7.1.		
		r use around a sprinkler. This			2.Sprinkler head location on	the	
	-	ould affect all clients and staff			ceiling in bedroom #8 will be		
	in the facility.				inspected by Koorsen Fire and		
					Security Before July 1, 2021. I		
	Findings include:				needed the Sprinkler Head wil	l be	
					cleaned or replaced.		
		on with the Associate			3.The Program Manager, Ar		
		(AED) during a tour of the			Supervisor and Direct Support		
		o.m. to 2:30 p.m. on 05/20/2021,			Lead have been in-serviced or	n the	
	_	sing its escutcheon plate at the			requirement of monthly visual		
	•	. Based on interview at the time			inspections for all Fire alarm a		
		AED stated that he has			Sprinkler components and if a		
		escutcheon earlier the same			deficiency is noted the Progra	m	
		nowledged the sprinkler was			Manager, Area Supervisor or		
	missing an escutche	eon plate.			Direct Support Lead will conta		
					(844) ResCare to create a ser	vice	
	_	s reviewed with the AED			order.		
	during the Exit Cor	nference on 05/20/2021 at 2:30			4.The Associate Executive		
	p.m.				Director contacted Joe Moore		
					Aramark Services on June 11		
		ration and interview, the			2021 the Facilities maintenant		
	-	sure 1 of more than 10			vendor to ensure the scope of		
	_	s would activate properly due			work for Koorsen Fire and Sec	•	
	_	gases at the ceiling. This			for the installation of the missi	•	
	-	ould affect all clients, as well as			escutcheon plate and replace		
	staff and visitors in	the facility.			of dirty sprinkler head is includ		
					Upon completion no later than	-	
	Findings include:				1, 2021 documentation will be		
		1 1 0 11			made available for review.		
		on during the facility tour on					
		n 1:00 p.m. and 2:00 p.m. with					
		utive Director, there was an			Persons Responsible: AED,		
		tration of the ceiling in the			Program Manager, Area		
		er location) in Bedroom #8. The			Supervisor, and Residential		
	_	d that the ceiling penetration			Manager, DSP Koorsen Fire a	ind	
	was unsealed.				Security Representative		
	This deficiency	s reviewed with the AFD					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442			JILDING	01	COMPI 05/20	LETED	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN		402 EW	DDRESS, CITY, STATE, ZIP COD ING LN RSONVILLE, IN 47130		
				<u> </u>			,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		ATE	(X5) COMPLETION DATE
1710		ference on 05/20/2021 at 2:30		mo			DATE
	p.m.						
	facility failed to ens automatic sprinklers material that might a sprinkler. This defic	ation and interview, the ure 1 of more than 10 sclean and free of foreign affect the operation of the ient practice could affect all aff and visitors in the facility.					
	Findings include:						
	O5/20/2021 between Associate Executive in Bedroom #8 was might affect the pro- in the event of a fire build-up of material the time of observat This deficiency was	on during the facility tour on a 1: p.m. and 2:00 p.m. with the Director (AED), the sprinkler covered with dust and dirt that per activation of the sprinkler. The AED acknowledged the on the bulb of the sprinkler at ion. The reviewed with the AED ference on 05/20/2021 at 2:30					
	p.m.						
K S363 Bldg. 01	other mechanisms door closed. 2. No doors shat the occupant from 3. Doors shall b automatic-closing	e provided with latches or suitable for keeping the libe arranged to prevent closing the door. e self-closing or in accordance with 7.2.1.8					
	throughout by an a	han those protected approved automatic accordance with 33.2.3.5.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/20/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
K S712	Door assemblies of swing in the direct inspected and test 33.2.3.6.4, 33.7.7 Based on observation failed to ensure 1 of no impediment to the door. This deficient client. Findings include: Based on observation the Associate Execution of the Associate Execution of the Associate Execution of the AED stated that prevent the door from oxygen tube that the continuously and is concentrator in Bed acknowledged that the occupant from occupant from the deficiency was	with leaves required to ion of egress travel are ted annually per 7.2.1.15. on and interview, the facility is 8 resident rooms doors had be occupant from closing the practice could affect one on during a facility tour with attive Director (AED) on in 1:00 p.m. and 2:00 p.m., a door red under the door to Bedroom iew at the time of observation, the door stop was there to the pinching closing the exercise to the oxygen	KS	3363	1.The Program Manager wensure clients bedroom doors positively latch to the frame. 2.Bedroom #8 door stop was removed by the Program Manand staff has been in-service about not leaving doors propopen. DSP's will check all do to ensure no client doors are propped open. 3.The Residential Manager inspect house weekly to ensubedroom doors are not proppopen. Area Manager will prefor random monthly inspections. Program Manager will provid quarterly inspections to ensubedroom doors positively late frame as required. 4.Staff will notify ResCare Maintenance upon discovery any damage that prevents CI Bedroom Doors from positive latching to the frame as required by calling 844-ResCare. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP.	as nager d ped poors will ure ped form and e re ch to of iients ely ired	06/19/2021
	Fire Drills						
Bldg. 01	1	t hold evacuation drills at each shift of personnel and					

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STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>01</u>	COMPI	ETED	
		15G442	B. WI	NG		05/20	/2021	
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			/ING LN			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	under varied cond							
	a. Ensure that all personnel on all shifts are trained to perform assigned tasks;							
		all personnel on all shifts are						
	familiar with the u							
	emergency and d	isaster plans and						
	procedures.							
	2. The facility mus							
		cuate clients during at least						
	one drill each yea							
	evacuation of clie	provisions for the						
	disabilities;	nts with physical						
		and evaluation on each drill;						
		Il problems with evacuation						
		cidents and take corrective						
	action; and	ordenia and take corrective						
		ills, clients may be						
		afe area in facilities certified						
		Care Occupancies Chapter						
	of the Life Safety							
		meet the requirements of						
		and (2) of this section for						
	any live-in and rel	lief staff that they utilize.						
	42 CFR 483.470(i	i)						
		view and interview, the facility	K S'	712	1.All staff at the Facility will	be	06/19/2021	
		re drills quarterly on each shift			re-trained on conducting fire d	Irills		
		alendar quarters and 1 of 3			quarterly on all shifts. The			
	_	year. This deficient practice			Residential Manager will revie			
	could affect all clie	nts.			drills to ensure all required dri			
					area conducted. The Progran	n		
	Findings include:				Manager will train the Area			
	D 1 .	CE			Supervisor and the Area			
		of Emergency Evacuation Drill			Supervisor will train all facility			
	_	021 between 10:30 a.m. and 1:00			staff.			
	-	ciate Executive Director (AED),			4 The Area Comments :::	.:_:4		
		of a fire drill conducted on			1.The Area Supervisor will v	risit		
		cond quarter of 2020. Based on			the home at least monthly to			
		he AED at the time of record			ensure the drills are in the hor	ne		
	review, there was n	o other documentation			and up to date.		I	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/17/2021 FORM APPROVED OMB NO 0938-039

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	<u>01</u>	COMPLETED 05/20/2021			
		15G442	B. WIN	IG					
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	available for review	to indicate the missed drill had							
	been conducted.				1.The Residential Manager v	vill			
					submit monthly drills to the QA	L			
	This deficiency was reviewed with the AED				Department upon completion.	The			
	during the Exit Conference on 05/20/2021 at 2:30				QA Department will notify the	Area			
	p.m.			Manager and Program manual the facility has not perform					
					monthly drills as required.				
					1.The Area supervisor will				
					ensure drills are completed as				
					required.				
					1.The program manager will conduct random monthly inspections to ensure drills are being completed as required.				
					Persons Responsible: Progra Manager, Area Supervisor, Residential Manager, DSP	m			

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