PRINTED: 08/27/2021 OVED

OMB NO. 0938-039

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

Е

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]	FORM	APPR

(X3) DATE SURVEY

AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER 15G442	A. BUILDING B. WING	<u></u>	COMPLETED 08/03/2021
	ROVIDER OR SUPPLIEI	LTERNATIVES SE IN	402 EW	ADDRESS, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0000					
Bldg	Preparedness Surve	isit (PSR) to the Emergency ey conducted on 05/20/21 was adiana Department of Health in CFR 483.475.	E 0000		
	Survey Date: 08/03	3/2021			
	Community Alterna compliance with En Requirements for M	15G442			
		ertified beds. All 8 beds are aid. At the time of the survey,			
	Quality Review cor	npleted on 08/05/21			
	The requirement at NOT MET as evide	42 CFR, Subpart 483.475 is enced by:			
E 0039 Bldg	441.184(d)(2), 48 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 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)			

(X2) MULTIPLE CONSTRUCTION

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

TITLE

000956

(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.

Event ID: 9FM522

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

TATEMENT OF DE	FICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CON	ISTRUCTION	(X3) D.	ATE SURVEY
ND PLAN OF CORR	ECTION	IDENTIFICATION NUMBER	A. BU	ILDING		СО	MPLETED
		15G442	B. WI	NG		08	/03/2021
AME OF PROVIDE	P OP SUPPLIEI	}		STREET AI	DDRESS, CITY, STATE, 2	ZIP COD	
AME OF TROVIDE.	K OK SOLI LIEI	Υ.		402 EWI			
ES CARE CON	MUNITY A	LTERNATIVES SE IN		JEFFER	SONVILLE, IN 471	30	
(4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN O		(X5)
		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	COMPLETIC
		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENC	UY)	DATE
(2), §4	191.12(d)(2)	, §494.62(d)(2).					
*[For	ASCs at 841	16.54, CORFs at §485.68,					
-	-	ons" under §485.727,					
	-	020, RHCs/FQHCs at					
	-	RD Facilities at §494.62]:					
		facility] must conduct					
		he emergency plan					
		sility] must do all of the					
follow	ing:						
(i) Pa	ticipate in a	full-scale exercise that is					
		l every 2 years; or					
	-	nunity-based exercise is					
		onduct a facility-based					
		e every 2 years; or					
		ility] experiences an actual					
	, -	ade emergency that requires					
		mergency plan, the [facility]					
		igaging in its next required					
		l or individual, facility-based					
	-	e following the onset of the					
	event.						
		lditional exercise at least					
		posite the year the full-scale					
-		cise under paragraph (d)(2)					
		s conducted, that may					
		limited to the following:					
		scale exercise that is					
. ,		l or individual, facility-based					
	onal exercis	-					
	mock disast						
· ,	•	ercise or workshop that is					
-		and includes a group					
	ssion using a						
		emergency scenario, and a					
		tements, directed					
		pared questions designed					
I to cha	mende an ei	mergency plan.	1				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	 VILDING NG	INSTRUCTION		PLETED )3/2021
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			402 EW	ADDRESS, CITY, STATE, ZIP COD /ING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	N BE PRIATE	(X5) COMPLETIC DATE	
	maintain docume exercises, and e	facility's] response to and entation of all drills, tabletop mergency events, and revise ergency plan, as needed.				
	the patient's hom conduct exercises plan at least ann the following: (i) Participate in community base (A) When a com accessible, cond based functional (B) If the hospice man-made emer of the emergency exempt from eng scale community facility-based fun onset of the emer (ii) Conduct an a years, opposite t functional exercise of this section is include, but is no (A) A second ful community-base functional exercise (B) A mock disa (C) A tabletop e led by a facilitato discussion using clinically-relevan set of problem st	bespices that provide care in the. The hospice must is to test the emergency ually. The hospice must do a full-scale exercise that is d every 2 years; or munity based exercise is not uct an individual facility exercise every 2 years; or experiences a natural or gency that requires activation y plan, the hospital is aging in its next required full -based exercise or individual ctional exercise following the rgency event. idditional exercise every 2 he year the full-scale or se under paragraph (d)(2)(i) conducted, that may t limited to the following: I-scale exercise that is d or a facility based se; or ster drill; or kercise or workshop that is r and includes a group a narrated, t emergency scenario, and a atements, directed epared questions designed				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CON	ISTRUCTION	(X3) DA	TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER		ILDING			MPLETED
		15G442	B. WI				03/2021
		<u> </u>		STREET AI	DDRESS, CITY, STATE,	ZIP COD	
AME OF PR	ROVIDER OR SUPPLIEF	(		402 EWI	NG LN		
RES CAR	E COMMUNITY A	LTERNATIVES SE IN		JEFFER	SONVILLE, IN 471	30	
,		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN		(X5)
REFIX		CY MUST BE PRECEDED BY FULL	]	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	) THE APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIEN	CYI	DATE
	•	spices that provide inpatient					
	-	hospice must conduct					
		he emergency plan twice					
		spice must do the following:					
	., .	an annual full-scale exercise					
	that is community						
	. ,	nunity-based exercise is not					
		ct an annual individual					
	•	tional exercise; or					
		experiences a natural or					
	•	ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.						
	.,	dditional annual exercise					
	-	but is not limited to the					
	following:						
	. ,	scale exercise that is					
	-	or a facility based					
	functional exercise						
	(B) A mock disas						
	· / ·	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,	-					
		rio, and a set of problem					
		ed messages, or prepared					
	questions designe	ed to challenge an					
	emergency plan.						
	•	ospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	ine nospice's eme	ergency plan, as needed.					
		l41.184(d), Hospitals at					
	§482.15(d), CAHs						
	.,	PRTF, Hospital, CAH] must					
	conduct evercises	to test the emergency	1				1

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	A. BUI B. WIN	LDING G		CO 08/	ate survey Mpleted <b>/03/2021</b>
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				402 EWI	DDRESS, CITY, STATE, ZIP CO ING LN SONVILLE, IN 47130	D	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	F	ID REFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	plan twice per yet CAH] must do th (i) Participate in that is communit (A) When a comm accessible, cond facility-based fur (B) If the [PRTF, an actual natural that requires acti plan, the [facility] its next required or individual, faci following the ons (ii) Conduct exercise or and t limited to the follo (A) A second ful community-base facility-based fur (B) A m (C) A tableto is led by a facilita discussion, using clinically-relevan set of problem st messages, or pro- to challenge an e (iii) Analyze and maintain doo tabletop exercise and revise the [fa needed. *[For PACE at §4 (2) Testing. The conduct exercise plan at least ann organization must	ar. The [PRTF, Hospital, e following: an annual full-scale exercise y-based; or munity-based exercise is not uct an annual individual, ctional exercise; or Hospital, CAH] experiences or man-made emergency vation of the emergency is exempt from engaging in full-scale community based lity-based functional exercise et of the emergency event. an [additional] annual hat may include, but is not owing: I-scale exercise that is d or individual, a ctional exercise; or ock disaster drill; or op exercise or workshop that ator and includes a group g a narrated, t emergency scenario, and a atements, directed epared questions designed emergency plan. the [facility's] response to cumentation of all drills, es, and emergency events acility's] emergency plan, as					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	A. BUILI B. WING	DING	STRUCTION	CO	ATE SURVEY MPLETED <b>/03/2021</b>	
	NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		4	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID		STATEMENT OF DEFICIENCIE		ID FFIN	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		EFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE	
	accessible, condu facility-based fund (B) If the PACE ex- or man-made eme activation of the e is exempt from em full-scale commun facility-based fund onset of the emer (ii) Conduct a 2 years opposite f functional exercise of this section is of but is not limited t (A) A second full- community-based based functional ex- (B) A mock disas (C) A tabletop ex- led by a facilitator discussion, using clinically-relevant set of problem star messages, or pre- to challenge an en (iii) Analyze the F maintain documen exercises, and en the PACE's emerger year, including un the emergency pr ICF/IID] must do t	nunity-based exercise is not ct an annual individual, ctional exercise; or cperiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required ity based or individual, ctional exercise following the gency event. n additional exercise every he year the full-scale or e under paragraph (d)(2)(i) onducted that may include, o the following: scale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. PACE's response to and ntation of all drills, tabletop hergency events and revise gency plan, as needed. es at §483.73(d):] ty] must conduct exercises ency plan at least twice per announced staff drills using locedures. The [LTC facility, he following: an annual full-scale exercise						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	A. BUILDING B. WING	DNSTRUCTION	COM	te survey 1pleted 03/2021
	NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET A 402 EW JEFFEI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	RECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIO
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	AFROMATE	DATE
	<ul> <li>(A) When a commaccessible, conduting accessible, conduting accessible, conduting and the [LTC factor actual natural or marequires activation LTC facility is exerised a full-scalindividual, facility-following the onset (ii) Conduct an actual may include, following:</li> <li>(A) A second full-community-based based functional et (B) A mock disass (C) A tabletop exiled by a facilitator discussion, using clinically-relevant set of problem statises ages, or prept to challenge an er (iii) Analyze the [I response to and mall drills, tabletop exercises to test this community-following and revise emergency plan, at *[For ICF/IIDs at § (2) Testing. The IC exercises to test this community (A) When a commaccessible, condutive accessible, cond</li></ul>	unity-based exercise is not ct an annual individual, tional exercise. ility] facility experiences an nan-made emergency that of the emergency plan, the mpt from engaging its next le community-based or based functional exercise t of the emergency event. Iditional annual exercise but is not limited to the scale exercise that is or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a tements, directed bared questions designed nergency plan. _TC facility] facility's naintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. 483.475(d)]: CF/IID must conduct he emergency plan at least e ICF/IID must do the m annual full-scale exercise				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G442	A. BUILDING B. WING	ONSTRUCTION	CO	TE SURVEY MPLETED 03/2021		
	NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		402 EV	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWIDER'S DI AN OF CO	PRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION)	SHOULD BE	COMPLETIO		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE		
	natural or man-ma activation of the e is exempt from en full-scale commun facility-based func- onset of the emery (ii) Conduct an ad that may include, following: (A) A second full-s community-based facility-based func- (B) A mock disast (C) A tabletop exe- led by a facilitator discussion, using clinically-relevant set of problem sta messages, or pre- to challenge an er (iii) Analyze the IC maintain documer exercises, and err the ICF/IID's emer *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. Th following: (i) Participate in a community-based (A) When a c is not accessible, individual, facility- every 2 years; or. (B) If the HH natural or man-ma	ditional annual exercise but is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or rrcise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. F/IID's response to and tation of all drills, tabletop mergency events, and revise gency plan, as needed. 44.102] e HHA must conduct he emergency plan at e HHA must do the full-scale exercise that is						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CON	STRUCTION	(X3) DA	ATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING		CO	MPLETED
		15G442	B. WIN	G		08/	/03/2021
JAME OF	PROVIDER OR SUPPLIEI	3	<u> </u>	STREET AL	DDRESS, CITY, STATE	, ZIP COD	
				402 EWI			
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	SONVILLE, IN 47	130	
X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE AC CROSS-REFERENCED T	O THE APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIE	NCY)	DATE
		aging in its next required					
		nity-based or individual,					
	-	tional exercise following the					
	onset of the emer						
		lditional exercise every 2					
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c	•					
		limited to the following:					
		full-scale exercise that is					
	community-based						
		ctional exercise; or					
	. ,	isaster drill; or					
		p exercise or workshop that					
		tor and includes a group					
	discussion, using						
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze the H	HA's response to and					
	maintain docume	ntation of all drills, tabletop					
	exercises, and en	nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §4	86.360]					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the						
		er-based, tabletop exercise					
		ast annually. A tabletop					
	-	a facilitator and includes a					
		using a narrated, clinically					
		cy scenario, and a set of					
	•	nts, directed messages, or					
		ns designed to challenge an					
		If the OPO experiences an					
		nan-made emergency that					
		n of the emergency plan, the					
		om engaging in its next					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G442	(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/03/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			402 1	et address, city, state, zip cod EWING LN FERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE
	of the emergence (ii) Analyze the C maintain docume exercises, and e the [RNHCI's and needed. *[RNCHIs at §44 (d)(2) Testing. Th exercises to test RNHCI must do (i) Conduct a pap at least annually group discussion narrated, clinical scenario, and a s directed messag designed to chal (ii) Analyze the F maintain docume exercises, and e the RNHCI's eme Based on record re failed to conduct a emergency plan at ICF/IID facility m (ii) Conduct an ad include, but is not a. A second full-se community-based functional exercise b. A mock disaste c. A tabletop exer- facilitator that incl a facilitator, using emergency scenar statements, directed	DPO's response to and entation of all tabletop mergency events, and revise d OPO's] emergency plan, as D3.748]: the RNHCI must conduct the emergency plan. The the following: ber-based, tabletop exercise . A tabletop exercise is a the led by a facilitator, using a ly-relevant emergency set of problem statements, es, or prepared questions lenge an emergency plan. RNHCI's response to and entation of all tabletop mergency events, and revise ergency plan, as needed. eview and interview, the facility an additional test of the the least once per year. The sust do the following: ditional exercise that may limited to the following: cale exercise that is or an individual, facility-based e.	E 0039	<ol> <li>The administrator will ensitive participation in a full-scale community based exercise and table top exercise is present in EPP manual.</li> <li>The area supervisor and program manager will ensure documentation of the table top exercise and the community based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed. The associate executive director wireview the training documentation</li> </ol>	d a the the

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2021 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER 402	CROSS-REFERENCED TO THE APPROPRIATE	(X5)
PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION         TAG	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
<ul> <li>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.</li> <li>Findings include:</li> <li>Based on record review of RES CARE Emergency/Disaster Preparation Manual documentation with the Associate Executive Director (AED) on 08/03/2021 between 3:15 p.m. and 4:00 p.m., documentation of an additional or activation of the Emergency Preparedness Plan was not available for review. Based on interview during record review, it was determined that the EPP did not include scheduled testing or an actual activation documentation. The AED stated that a tabletop exercise of the Emergency Preparedness plan has been scheduled on 10/21/2021.</li> <li>The deficiency was reviewed with the AED during the Exit Conference.</li> <li>This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence.</li> </ul>		COMPLETI DATE

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	xi) provider/supplier/clia identification number 15G442	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIEF	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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	.D BE	(X5) COMPLETIO DATE	
< 0000 Bldg. 01	Code Recertificatio 05/20/21 was condu Department of Heat 483.470(j). Survey Date: 08/03 Facility Number: 0 Provider Number: 0 Provider Number: 100 At this Life Safety Community Alterna compliance with Re Medicaid, 42 CFR a from Fire and the 2 Protection Associat	00956 15G442	К 0	000	Persons Responsible: A Program Manager, Area Supervisor, and Resider Manager, DSP. Quality Assurance Manager, Are Supervisor, Associate Executive Director.	itial		

PRINTED: 08/27/2021

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	402 E	f address, city, state, zip cod WING LN ERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE	
	Board and Care O	ccupancies. lding was determined to be fully				
	sprinklered. The a detection connecte panel. The facility smoke detection in	ttic is protected by heat ed to the fire alarm control has a fire alarm system with a corridors and all living areas. capacity of 8 and had a census				
	(E-Score) using N Approaches to Lif facility Prompt wi	Evacuation Difficulty Score FPA 101A, Alternative & Safety, Chapter 6, rated the th an E-Score of 0.6.				
< S345	Quality Review co	ompleted on 08/05/21				
Bldg. 01	in accordance wi complying with the National Electric National Fire Ala Records of system and testing are re 9.7.5, 9.7.7, 9.7.6 1. Based on recor- interview; the faci- system initiating da accordance with the frequency in NFP2 states a manual fire provided in accord the provisions of 3	m - Testing and (Prompt) em is tested and maintained ith an approved program ne requirements of NFPA 70, Code, and NFPA 72, rm and Signaling Code. em acceptance, maintenance eadily available.	K S345	1. The administrator will ens annual functional testing for initiating devices such as smok detectors, heat detectors, relea devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm syste	le Ise S	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/03/2021 15G442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE required for life safety shall be installed, tested, and that reports of the and maintained in accordance with the applicable tests/inspections are available in requirements of NFPA 70, National Electric Code the facility for review. and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 2. The administrator will ensure states testing shall be performed in accordance sensitivity testing of the fire alarm with the schedules in Table 14.4.5. Table 14.4.5 at system is completed by Koorsen 15(e) states the requirements of 14.4.5.5 shall Fire and Security every alternate apply to heat detectors. Section 14.4.5.5 states year after install and that reports restorable fixed-temperature, spot-type heat of the tests/inspections are detectors shall be tested in accordance with available in the facility for review. 14.4.5.5.1 through 14.4.5.5.4. Two or more Koorsen Fire and Security will detectors shall be tested on each initiating circuit also forward inspection reports to annually. Different detectors shall be tested each the QA Manager for monitoring of year. Records shall be kept by the building owner completion. specifying which detectors have been tested. Within 5 years, each detector shall have been The Program Manager will 3. tested. This deficient practice could affect all meet with a representative from clients, staff, and visitors. Koorsen Fire and Security, a tentative date has been set for Findings include: June 16, 2021 The Facility will require schedule required testing Based on record review on 08/03/2021 between and request copies of inspections 10:30 a.m. and 1:00 p.m. with the Associate and testing mailed to the program Executive Director, documentation of heat manager upon completion to the detector testing for two devices located in the Program Manager at 4341 attic was not available for review. The most recent Security PKWY Suite 101 New Inspection and Testing Report dated August 4, Albany IN 47150. 2020 indicated that the two heat detectors in the attic were not included in the report. Survey of the 4 The Program Manager attic was not possible because no ladder was spoke with the Kris Carney from available. Based on interview at the time of record Koorsen Fire and Security review, the AED stated the fire alarm system effective immediately all sites will inspection should now include the inspection and have an annual functional fire testing of heat detectors or the wiring connecting alarm inspection in the Month of the devices to the faire alarm control panel. The February and a semiannual fire AED stated that testing would be accomplished in alarm visual inspection completed August at the next regularly scheduled inspection in August on August 6, 2021 to and service appointment. include a sensitivity test. Repair of the devices that failed the 9FM522 Facility ID: 000956

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Event ID:

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES				ОМ	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G442	B. WI	NG		08/03/	2021
NAME OF	PROVIDER OR SUPPLIE			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	EK			/ING LN		
RES CA	RE COMMUNITY	ALTERNATIVES SE IN		JEFFEI	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG			DATE
	-	as reviewed with the AED during			sensitivity test has been		
	the Exit Conferen	ce.			scheduled to be completed no		
					later than September 16, 2021	Ι.	
	This deficiency w	as cited on 05/20/21. The facility			Access to the heat detectors	will	
	failed to implement	nt a systemic plan of correction			be made available and that de	evice	
	to prevent recurrence.				will be tested no later than		
					September 16, 2021. Koorser		
		d review and interview, the			Fire and Security was notified	of	
	facility failed to en	nsure all facility smoke detectors			ResCare's "In Scope Services		
	were within their	listed and marked sensitivity			Agreement" that automatically		
	range. LSC Section	on 33.2.3.4.1 states a manual fire			authorizes repair/service of fire	e	
	alarm system shal	l be provided in accordance with			systems. Koorsen will notify th	he	
	Section 9.6. Secti	on 9.6.1.3 states a fire alarm			Program Manger upon comple	etion	
	system shall be in	stalled, tested and maintained in			of all inspections to ensure an	у	
	accordance with th	he applicable requirements of			deficiencies are properly track	ed	
	NFPA 72, Nationa	al Fire Alarm Code. NFPA 72,			and repaired. Koorsen will ser	nd	
	2010 Edition, Sec	tion 14.4.5.3.1 states detector			documentation of all inspection	ns,	
	sensitivity shall be	e checked within 1 year of			services and repair to ResCar	е	
	installation, and 14	4.4.5.3.2 states every alternate			main office at 4341 Security		
	year thereafter. A	fter the second required			Parkway STE. 101 New Alban	iy IN	
	calibration test, if	sensitivity tests indicate that			47150 within 30 days of comp	leted	
	the detector has re	emained within its listed and			service. The Program Manage	er will	
	marked sensitivity	range, the length of time			follow up to ensure work is		
	between calibratic	on tests shall be permitted to be			completed and documented as	s	
	extended to a max	timum of 5 years. If the			required.		
		ided, records of detector caused					
	nuisance alarms a	nd subsequent trends of these			5. The Associate Executive	;	
		aintained. In zones or areas			Director Contacted Eric Gray	with	
	where nuisance al	arms show an increase over the			Koorsen Fire and Security on		
	previous year, cali	ibration tests shall be performed.			August 17, 2021 to schedule t	he	
		ch smoke detector is within its			inspection of the Heat Detector		
	listed and marked	sensitivity range, it shall be			the devices will be tested no la		
	tested using any o				than September 16, 2021. The		
	(1) Calibrated test				Associate Executive Director		
		s calibrated sensitivity test			scheduled a meeting with Dav	rid	
	instrument.	,			Danzo on with Aramark, ResC		
		equipment arranged for the			maintenance provider to on Au		
	purpose.				30, 2021 to cover inspection a	•	
		or/fire alarm control unit			testing requirements of fire		
		by the detector causes a signal			systems.		

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Event ID:

9FM522

Facility ID: 000956

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/03/2021 15G442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be Persons Responsible: AED, cleaned and recalibrated, or replaced. Program Manager, Area The detector sensitivity cannot be tested or Supervisor, and Residential measured using any spray device that administers Manager, DSP Koorsen Fire an unmeasured concentration of aerosol into the and Security Representative. detector. This deficient practice could affect all Aramark clients, staff, and visitors. Findings include: Based on record review with the Associate Executive Director (AED) on 08/03/2021 between 3:15 p.m. and 4:00 p.m., documentation of smoke detector sensitivity testing within the most recent two year period was not available for review. Based on interview at the time of record review, the Area Director acknowledged documentation of smoke detector sensitivity testing within the most recent two year period was not available for review and that no other documentation that could indicate that sensitivity testing and results were available. The AED stated that testing would be accomplished in August at the next regularly scheduled inspection and service appointment. The deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence. K S351 **NFPA 101** Sprinkler System - Installation Bldg. 01 Sprinkler System - Installation Event ID: 9FM522 Facility ID: 000956 Page 16 of 26 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	A. BUILDING <u>01</u> COMPI B. WING 08/03		te survey 1pleted 03/2021		
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		402 EW	ADDRESS, CITY, STATE, ZIP CO /ING LN RSONVILLE, IN 47130	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
	installed, for eithe building coverage accordance with shall initiate the f accordance with modified below. supply shall be d In Prompt Evacu sprinkler system with NFPA 13D, of Sprinkler Syste and two Family D Homes, shall be Automatic sprink closets not excee feet and in bathro square feet, prov spaces are finish materials providin thermal barrier. In Prompt Evacu where an automa system is in acco Standard for the Sprinkler System not be required in exceeding 24 squ not exceeding 55 provided that suc lath and plaster of providing a 15-m In Prompt Evacu buildings four or above grade plan with NFPA 13R, Installation of Sp Residential Occu	a, the system shall be in Section 9.7 and ire alarm system in Section 9.6, as The adequacy of the water ocumented. ation facilities, an automatic in accordance Standard for the Installation ems in One wellings and Manufactured oermitted. ers shall not be required in eding 24 square ooms not exceeding 55 ided that such ed with lath and plaster or ng a 15-minute ation Capability facilities tric sprinkler rdance with NFPA 13, Installation of s, automatic sprinklers shall o closets not uare feet and in bathrooms square feet, h spaces are finished with r material nute thermal barrier. ation Capability facilities in fewer stories ne, systems in accordance					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	A. BUILDING		
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	402	EET ADDRESS, CITY, STATE, ZIP COD EWING LN FERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETI DATE
	required for exist installations in ac Where an autom attics used for liv storage, or fuel-fi protected by July living purposes, s equipment meet 1. Protected by h activate the fire a according to 9.6. 2. Protected by a according to 9.7. 3. Constructed of according to 9.7. 3. Constructed of according to NFF 33.2.3.5.3, 33.2.3 33.2.3.5.3.4, 33.2 1. Based on obser facility failed to pl adequate for the la sprinklered group could affect all res the facility. Findings include: Based on observat Executive Director the facility betwee constructed the spra sprinkler in Bedrow within and in front interview with the the AED stated tha construction. The	cordance with 33.2.3.5.6. atic sprinkler is installed, ing purposes, red equipment are sprinkler 5, 2019. Attics not used for storage, or fuel-fired one of the following: eat detection system to larm system utomatic sprinkler system	K \$351	<ol> <li>The Facility will ensure the installation an additional automosprinkle head to adequately protect the bedroom #5.</li> <li>The Facility will ensure the installation an additional automosprinkle head to adequately protect the bedroom #4.</li> <li>The Facility will ensure the installation an additional automosprinkle head to adequately protect the bedroom #4.</li> <li>The Facility will ensure the installation an additional automosprinkle head to adequately protect the Pantry.</li> <li>The Facility will ensure the installation an additional automosprinkle head to adequately protect the Pantry.</li> <li>The Facility will ensure the pantry.</li> </ol>	he he hatic

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
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	Г OF HEALTH AND HU R MEDICARE & MEDIC						ORM APPROVED 1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	A. B	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING STREET ADDRESS, CITY, STATE, ZIR COD		(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIEI	R LTERNATIVES SE IN		402 EV	ADDRESS, CITY, STATE, ZIP COD VING 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
	does not appear to a The AED stated that one of the tasks to b that must be compet- having a difficult ti This deficiency wa during the Exit Con This deficiency wa failed to implement to prevent recurren 2. Based on observe facility failed to pla adequate for the fue sprinklered group b could affect all clie the facility.	s cited on 05/20/21. The facility t a systemic plan of correction			<ul> <li>5) The Facility will ensure installation an additional autor sprinkle head to adequately protect the bathroom #2.</li> <li>6) Koorsen Fire and Secur was notified by the Program Manager on May 20, 2021 to schedule the installation of an additional automatic sprinkler the bathroom and are added t inspection and testing of the Sprinkler System.</li> <li>7) The Program Manager contacted Aramark on May 20, 2021 and submitted a work or to have ResCare Maintenance verify install the installation required by LSC and add the inspection and testing to the stallation of the stallatio</li></ul>	natic rity in o the ), der	
	Findings include:				inspection and testing to Koorsen's scope of work.		

Based on observation with the Associate Executive Director on 08/03/2021 during a tour of the facility between 1:00 p.m. and 2:00 p.m., the quantity of combustibles in Bedroom #4 exceeds that for a typical bedroom. Stuffed animals filled the entire floor, bed, and flat surfaces of dressers in the room. Based on an interview with the AED at the time of observation, the AED acknowledged that the quantity was higher than normal and that an assessment by the sprinkler system designer had not been completed to verify that the existing sprinkler design was adequate for the combustible load in the room. The AED stated that modifying the sprinklers was one of the tasks to be performed on a work order that must be competitively bid and they are having a difficult time finding contractors.

The Associate Executive 8) Director contacted Joe Moore with Aramark Services on June 11. 2021 the Facilities maintenance vendor to ensure the scope of work for Koorsen Fire and Security for the installation of additional sprinkler heads are included. Upon completion no later than December 31, 2021 documentation will be made available for review.

9) The Associate Executive Director scheduled a meeting with David Danzo on with Aramark,

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	r of health and hu R medicare & medic					FC	08/27/2021 ORM APPROVED AB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MUL A. BUII B. WIN	LDING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	during the Exit Con This deficiency wa failed to implement to prevent recurrent 3. Based on obser- facility failed to pla a fully sprinklered practice could affect the facility. Findings include: Based on observati Executive Director tour of the facility there was no sprint Pantry enclosure ap from space former the room was creat modified to protect combustibles and p to be greater than r The lack of sprinkl acknowledged by to observations. The a	is cited on 05/20/21. The facility t a systemic plan of correction			ResCare maintenance provid on August 30, 2021 to cover installation and maintenance requirements of fire systems. Updated bids will be collected later than September 30, 202 contract work will be complet later than December 31, 202 build in time based on the reemergence of COVID. Wo may be completed sooner ba on contractor material and lat availability. 10) The Associate Executive Director scheduled a meeting the Regional Director of Facil Maintenance Joe Moore to streamline the bid process to ensure required work outside the agreed upon scope of wo maintenance and repair for Auguest 19, 2021. Persons Responsible: Koo Fire and Security, Aramark Maintenance Manager, Program Manager, Area Supervisor, and Residential Manager, DSP , Aramark	d no 21 and ed no 1 to rk ised bor e g with lity e of ork for <b>rsen</b>	

This deficiency was reviewed with the AED during the Exit Conference.

This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence.

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		COI	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLII	ER ALTERNATIVES SE IN	402 E	r address, city, state, zip WING LN ERSONVILLE, IN 47130	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
	facility failed to p bathrooms with fl- feet in a fully spri-	evation and interview, the lace sprinklers in 1 of 2 oor areas greater than 55 square nklered group home. This could affect all residents and cility.					
	Based on observat Executive Directo tour of the facility there was no sprin The floor area of th square feet. The la and the area of the square feet was ac times of the obser modifying the spr be performed on a	tion with the Associate r (AED) on 08/03/2021 during a between 3:15 p.m. and 4:00 p.m., kler located in Bathroom #1. he bathroom is approximately 82 ack of sprinklers in Bathroom #1 bathroom being greater than 55 knowledged by the AED at the vations. The AED stated that inklers was one of the tasks to a work order that must be and they are having a difficult actors.					
	during the Exit Co This deficiency w	as cited on 05/20/21. The facility nt a systemic plan of correction					
	<ol> <li>Based on obset facility failed to p 10 spaces without</li> </ol>	vation and interview, the lace sprinklers in 1 of more than obstructions to the spray ient practice could affect all					
	Findings include:						
	Based on observat	tion with the Associate					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/03/2021 15G442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Executive Director (AED) on 08/03/2021 during a tour of the facility between 3:15 p.m. and 4:00 p.m., the sprinkler in Bathroom #2 located in the in front of the bath/shower is obstructed by the beam at the ceiling. The beam extends 2.5 inches below the deflector and prevents water from reaching the water closet and vanity area of the bathroom. Bathroom #2 has a floor area of approximately 95 square feet. The obstruction of the beam was acknowledged by the AED at the times of the observations. The AED stated that modifying the sprinklers as necessary was one of the tasks to be performed on a work order that must be competitively bid and they are having a difficult time finding contractors. This deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence. K S353 **NFPA 101** Sprinkler System - Maintenance and Testing Bldg. 01 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance 9FM522 Facility ID: 000956 Page 22 of 26 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G442	(X2) MU A. BUI B. WIN	LDING G	nstruction <u>01</u>	CO 08,	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN		402 EW	ADDRESS, CITY, STATE, ZIP ( 'ING LN RSONVILLE, IN 47130	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
	of Sprinkler Syst Dwellings and M inspected, tested accordance with NFPA 25: 1. Control valv 25, section 13.3, 2. Gauges insp section 13.2.71) 3. Alarm devic (NFPA 25, section 4. Alarm devic (NFPA 25, section 5. Valve super semiannually (N 6. Visible sprin ((NFPA 25, section 7. Visible pipe 25, section 5.2.2 8. Visible pipe (NFPA 25, section 9. Buildings insp freezing weather filled piping (NFF 10. A represent response sprinkler (NFPA 25, section 11. A represent sprinklers are te section 5.3.1.1.1 12. Antifreeze (NFPA 25, section 13. Control valt their full range a annually (NFPA 14. Operating lubricated annual 13.3.4).	bected monthly (NFPA 25, es inspected quarterly on 5.2.6). es tested semiannually on 5.3.3). visory switches tested FPA 25, section 13.3.3.5). klers inspected annually on 5.2.1). inspected annually (NFPA ). hangers inspected annually on 5.2.3). spected annually prior to for adequate heat for water PA 25, section 5.2.5). itative sample of fast ers are tested at 20 years on 5.3.1.1.1.2). itative sample of dry pendant sted at 10 years (NFPA 25, 5). solutions are tested annually						

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	A. BUILDI B. WING	<u>01</u> сом 08/0		ATE SURVEY MPLETED /03/2021	
	PROVIDER OR SUPPLII	R ALTERNATIVES SE IN	40	REET ADDRESS, CITY, STATE, ZIP C D2 EWING LN EFFERSONVILLE, IN 47130	OD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREF TA	FIX (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETIC DATE	
	inspected, tested section 13.4.4). A. Date sprinkler necessary maint B. Show who pro- C. Note the sour automatic sprink (Provide in REM coverage for any automatic sprink 33.2.3.5.3, 33.2. and NFPA 25 1. Based on obser facility failed to e heads in the facilit Standard for the In 2010 Edition, Sec escutcheons, or ot annular space arou or shall be listed f deficient practice in the facility. Findings include: Based on observat Executive Directo facility from 3:15 the sprinkler is mi ceiling in the offic of observation, the noticed the missin day. The AED acl missing an escutor	ARKS information on non-required or partial	K \$353	<ol> <li>The Facility will end installation of an escuta in the office for the aut sprinkler head in accorn NFPA 13, Standard for Installation of Sprinkler 2010 Edition, Section 6</li> <li>Sprinkler head lo the ceiling in bedroom inspected by Koorsen Security Before July 1, needed the Sprinkler H cleaned or replaced.</li> <li>The Program Ma Area Supervisor and D Support Lead have bed in-serviced on the require monthly visual inspecti Fire alarm and Sprinkle components and if a de noted the Program Ma</li> </ol>	cheon plate tomatic dance with the Systems, 5.2.7.1. boation on #8 will be Fire and 2021. If lead will be anager, birect en tirement of ons for all er eficiency is	08/27/20	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2021 FORM APPROVED

OMR	NO	0938-039	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 08/03/2021		
NAME OF PROVIDER OR SUPPLIER       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	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	competitively bid and they are having a difficult			Supervisor or Direct Support Lea	d		
	time finding contra	ctors.		will contact (844) ResCare to			
	This deficiency we	a reviewed with the AED		create a service order.			
	This deficiency was reviewed with the AED during the Exit Conference.			4 The Associate Evenutive			
	during the Exit Conference.			4. The Associate Executive			
	This definitionary wa	s cited on 05/20/21. The facility		Director contacted Joe Moore the			
	-	t a systemic plan of correction		regional director with Aramark			
	to prevent recurren			Services on August 17, 2021 the Facilities maintenance vendor to			
	to prevent recurren			ensure the scope of work for			
	2 Based on observ	vation and interview, the		Koorsen Fire and Security cover	29		
		sure 1 of more than 10		the installation of the missing			
		s would activate properly due		escutcheon plate, sealing the			
	-	gases at the ceiling. This		unsealed pipe in the closet of			
		ould affect all clients, as well as		bedroom #8, and replacement of			
	staff and visitors in			dirty sprinkler head are included			
		-		the scope of work for maintenand			
	Findings include:			are repair. This work does not			
				required the maintenance vende	-		
	Based on observation during the facility tour on			to go through the bid process an	b		
	08/03/2021 betwee	n 3:15 p.m. and 4:00 p.m. with		is to be completed as soon a			
		utive Director, there was an		scheduling permits after the			
		tration of the ceiling in the		receipt of a work order request.			
		er location) in Bedroom #8. The		Upon completion no later than			
	-	d that the ceiling penetration		December 31, 2021			
		AED stated that the sealing of		documentation will be made			
	the pipe had been n	nissed.		available for review.			
	This deficiency wa	s reviewed with the AED					
	This deficiency was reviewed with the AED during the Exit Conference.			1.The Associate Executive			
	during the Exit Col	nerenee.		Director scheduled a meeting wit	h		
	This deficiency was cited on 05/20/21. The facility			David Danzo New Albany ResCa			
		t a systemic plan of correction		Maintenance Manager with			
	to prevent recurren			Aramark, ResCare maintenance			
	1			provider to on August 30, 2021 to			
	3. Based on observ	vation and interview, the		cover work authorized by the			
		sure 1 of more than 10		maintenance and repair scope of			
		s clean and free of foreign		work for all fire systems. An			
		affect the operation of the		emergency work order has been			
		cient practice could affect all		created and the installation of the	e		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	P) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 15G442	A. BUILDING <u>01</u> B. WING		COMPLETED 08/03/2021		
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 PREFIX TAG	(EACH DEFICIEN 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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E RIATE	(X5) COMPLETION DATE	
	clients, as well as staff and visitors in the facility. Findings include: Based on observation during the facility tour on 08/03/2021 between 3:15 p.m. and 4:00 p.m. with the Associate Executive Director (AED), the sprinkler in Bedroom #8 was covered with dust and dirt that might affect the proper activation of the sprinkler in the event of a fire. The AED acknowledged the build-up of material on the bulb of the sprinkler at the time of observation. The AED stated that cleaning the sprinkler was one of the tasks to be performed on a work order that must be competitively bid and they are having a difficult time finding contractors.		missing escutcheon plate, s the unsealed pipe in the clo bedroom #8 and replaceme dirty sprinkler head will be completed within 10 days r than August 27, 2021. 2.The Associate Executiv Director scheduled a meeti the Regional Director of Fa Maintenance Joe Moore to streamline the bid process ensure required work outsi the agreed upon scope of v maintenance and repair for Auguest 19, 2021.		oset of ent of ot later re ng with cility to de of vork for		
	during the Exit Con This deficiency wa	is cited on 05/20/21. The facility t a systemic plan of correction		Persons Responsible: AE Program Manager, Area Supervisor, and Residentia Manager, DSP Koorsen Fir and Security Representativ Aramark	al e		

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If continuation sheet

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