STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G184	A. BUILDING -- B. WING	07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	1818 H ST BEDFORD, IN 47421

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 07/06/21 Facility Number: 000717 Provider Number: 15G184 AIM Number: 100234700 At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey, the census was 8. Quality Review completed on 07/09/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 07/06/21 Facility Number: 000717 Provider Number: 15G184 AIM Number: 100234700 At this Life Safety Code survey, Res Care Community Alternatives SE IN was found not in	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This two-story facility with a basement was not sprinkled. This facility has a fire alarm system with smoke detection on all levels including the corridors, common living areas, basement and hard-wired smoke detectors in all client sleeping rooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.9. Quality Review completed on 07/09/21			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	Based on observation, records review, and interview, the facility failed to ensure 1 of 4 portable fire extinguisher located in the facility was inspected at least monthly and the inspections were documented including the date and initials of the person performing the	K S100	Maintence superviosr will conduct training with techs to ensure all extinguishers are inspected monthly. Area Supervisor and Residential Manager will be trained on monthly inspections of	08/05/2021

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	inspection. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation and interview during the facility tour with the Residential Manager on 07/06/21 from 11:40 a.m. to 12:05 p.m., 4 of 4 fire extinguishers in the home had affixed inspection and maintenance tags. The fire extinguisher located in the basement was missing the two most recent monthly inspections. Based on interview at the time of observation the Residential Manager stated the monthly checks of the basement fire extinguisher were evidently not conducted. This finding was acknowledged by the Residential Manager during the facility tour from 11:40 a.m. and 12:05 p.m. and again at the exit conference at 12:15 p.m. on 07/06/21.		fire extinguisher tags to ensure completion of monitoring practices Persons Responsbile: Program Manager, Area Supervisor and Residential Manager	

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K S211 Bldg. 01	NFPA 101 Means of Egress - General Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 Based on observation and interview, the facility failed to maintain 1 of 2 designated means of escape be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. This deficient practice could affect all occupants needing to use the front door means of escape from common areas and client sleeping areas. Findings include: Based on observation and interview during the facility tour with the Residential Manager on 07/06/21 from 11:40 a.m. to 12:05 p.m. the sidewalk landing immediately below the last front porch step is broken apart and eroded. This section of deteriorating concrete sidewalk is part of the path of the means of escape from the facility to the public way. Based on interview at the time of the observation, the Residential Manager acknowledged the deteriorated concrete sidewalk and that it is part of the path to the public way. This finding was acknowledged by the Residential Manager during the facility tour from 11:40 a.m. and 12:05 p.m. and again at the exit conference at 12:15 p.m. on 07/06/21.	K S211	Maintence supervisor has been contacted with assignment to complete repairs. Area Supervisor and Residentail manager will inspect weekly until complete. Residential Manager and Area Supervisor will be trained on enviromental inspections as well as reporting issues to appropriate personnel. Person Resonsible: Area Supervisor Residential Manager Program Manager	08/05/2021
K S331 Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING (Prompt)			

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	Interior wall and ceiling finish in accordance with section 10.2. In Prompt Evacuation Capability facilities, Class A, Class B, or Class C is permitted. There are no requirements for interior floor finish. 33.2.3.3, 33.2.3.3.3			
	Based on observation and interview, the facility failed to ensure the interior finish in the entryway of the stairwell was rated Class A, Class B or Class C for a Prompt rated facility. This deficient practice could affect all occupants. Findings include: Based on observation and interview during the facility tour with the Residential Manager on 07/06/21 from 11:40 a.m. to 12:05 p.m., the stairwell in the entryway was covered with wood paneling. Based on an interview at the time of observation, the Residential Manager stated she thought maintenance had previously treated the wood paneling but was unable to locate documentation to confirm the wood paneled stairwell was treated to provide a flame spread rating of a Class A, Class B or Class C interior finish. This finding was acknowledged by the Residential Manager during the facility tour from 11:40 a.m. and 12:05 p.m. and again at the exit conference at 12:15 p.m. on 07/06/21.	K S331	Maintence supervisor will spray fire retardent spray on entryway. Area Supervisor and Residental Mananger will do weekly inspections until complete. Program Manger will compete environmental inspection training with RM and AS , training will include providing supporting documentation of treatment being completed and being accessible in home for review by outside entities Person resonsible Area Supervisor, Program Manager, Residential Manager	08/05/2021
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70,			

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	National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Residential Manager present on 07/06/21 between 10:00 a.m. and 11:40 a.m., no documentation was available for review to show the smoke detector sensitivity had been tested within the last two years. The annual fire alarm inspection conducted on 1/26/21 did not include the smoke detector sensitivity testing. Based on interview at the time of record review, the Residential Manager stated she had contacted the office for further documentation, but by the end of the survey no documentation of the aforementioned sensitivity testing was provided. This finding was acknowledged by the	K S345	Program Manager has contacted Johnson Controls Service Chamipon for copy of previous inspection. Program Manager will follow up weekly until copy of report is obtainied and placed in life safety book. Program Manager will provided enviromental inspection training to Area Supervisor and Residentail Manager. Person resonsible Program Manager,Area Supervisor, Residential Manager	08/05/2021

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Residential Manager during record review from 10:00 a.m. and 11:40 a.m. and again at the exit conference at 12:15 p.m. on 07/06/21.

2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:
a. Control unit trouble signals
b. Remote annunciators
c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)
d. Notification appliances
e. Magnetic hold-open devices
This deficient practice could affect all building occupants.

Findings include:

Based on record review and interview with the Residential Manager present on 07/06/21 between 10:00 a.m. and 11:40 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months before the annual fire alarm inspection conducted on 01/26/21. Based on interview at the time of record review, the Residential Manager did not know if a visual inspection of the fire alarm system was conducted 6 months prior to the 1/26/21 inspection and contacted the office but by the end of the survey no documentation was provided. This finding was

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	acknowledged by the Residential Manager during record review from 10:00 a.m. and 11:40 a.m. and again at the exit conference at 12:15 p.m. on 07/06/21.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7			
	Based on observation and interview, the facility failed to ensure 2 of 6 clients sleeping rooms were provided with a door which would self-close and latch securely in the door frame. This deficient practice could affect 3 clients. Findings include: Based on observation and interview during the facility tour with the Residential Manager on 07/06/21 from 11:40 a.m. to 12:05 p.m., the corridor doors to the upstairs North and East sleeping rooms failed to self-close and latch into their door frames. The lower hinge to the upstairs North sleeping room door was	K S363	Aramark came and repaired the door hinges on 7/7/2021. Residential Manager and Area Supvisor will conduct enviromental inspections on a weekly basis. Training on enviromental inspections will be conducted by Program Manager Person resonsible Program Manager,Area Supervisor, Residential Manager	08/06/2021

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	unattached. Based on interview at the time of observation, the Facilities Manager confirmed the aforementioned doors failed to latch into the frame and stated Maintenance would need to be notified. This finding was acknowledged by the Residential Manager during the facility tour from 11:40 a.m. and 12:05 p.m. and again at the exit conference at 12:15 p.m. on 07/06/21.			
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)			

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	Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all clients in the facility. Findings include: Based on record review of the Emergency Evacuation Drill / FIRE Reports with the Residential Manager present on 07/06/21 between 10:00 a.m. and 11:40 a.m. 3 of 4 third shift fire drills took place at 3 a.m.; 2 of 4 second shift fire drills took place around 6:30 p.m., and 3 of 4 first shift fire drills took place at or around 8 a.m. This finding was acknowledged by the Residential Manager during record review from 10:00 a.m. and 11:40 a.m. and again at the exit conference at 12:15 p.m. on 07/06/21.	K S712	Program Manager has provided a calendar with drill schedules including times the drills are to take place. Program Manger will provide inservice with Area Supervisor and Residential Manager on drill reporting and the impotrance of following the schedule of the drills, this will be included on the enviromental safety inspection that will be conducted weekly by Residential Manager and Program Manager. Persons Responsible Area Supervisor Residentail Manager Program Manager	08/05/2021