STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 10/04/18 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 11/30/18 Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230 At this PSR survey, Residential Care Community Alternatives SE IN Inc was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. At the time of the survey, the census was 4. Quality Review completed on 12/05/18 - DA	E 0000		
E 0007 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice could affect all occupants.	E 0007	1.The emergency plan policies and procedures will be updated to include a) continuity of operations and b) Delegations of authority and succession plans. 2.The area supervisor and program manager will train all staff on the policies and procedures updates and the updates will be placed in the Emergency Disaster Preparedness Manual for	12/30/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on record review on 11/30/18 at 11:30 a.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not address: a) Continuity of operations. b) Delegations of authority and succession plans. Based on interview concurrent with record review it was acknowledged by the RM the EPP did not address items a and b above. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.		reference as needed.	
E 0015 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 11/30/18 at 11:35 a.m. with the Residential Manager (RM) the emergency preparedness plan did not address 1) alternative sources of energy.	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.	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2) emergency lighting, 3) fire detection, extinguishing and alarms. 4) proper disposal of sewage and waste. Based on interview concurrent with record review with the RM it was stated this policy did not contain information concerning items 1,2,3 and 4. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			
E 0025 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Plan with the Residential Manager (RM) on 11/30/18 at 11:40 a.m., there was no documentation of policy and procedures for the arrangement with other facilities to receive residents in the event of operations in the facility. This was confirmed by the RM at the time of record review. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0025	1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses arrangements with other ICF/IID facilities and/or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	12/30/2018
E 0026				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all clients. Findings include: Based on record review on 11/30/18 at 11:53 a.m. with the Residential Manager (RM) there was nothing in the emergency preparedness manual which addressed compliance with the 1135 waiver declared by the Secretary. Based on interview concurrent with record review with the RM it was stated she was not aware this waiver needed to be addressed and stated the policy would be updated to include the 1135 waiver. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0026	1.The administrator will ensure the table of contents for the emergency disaster preparedness manual is updated to include the location of the policy on the Roles of the facility Under a Waiver declared by Secretary is in the emergency preparedness manual. 2.The area supervisor and program manager will train all staff on the table of contents, the policy and procedure, where to locate the policy, and the policy will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	12/30/2018
E 0030 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants.	E 0030	1.The administrator will ensure the emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses a) contact information for other ICF's and b) client physicians. 2.The area supervisor and program manager will train all staff	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on record review on 11/30/18 at 11 38 p.m. with the Residential Manager (RM) the Emergency Preparedness Plan (EPP) did not document a. contact information for other ICF's, or b. client physicians. Based on interview concurrent with record review with the RM it was confirmed the communication portion of the EPP did not include items a , or b. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.		on the policies and procedures updates and the updates will be placed in the Emergency Disaster Preparedness Manual for reference as needed.	
E 0031 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) Other sources of assistance (iii) The State Licensing and Certification Agency (iv) The State Protection and Advocacy Agency in accordance with 42 CFR 483.475(c)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 11/30/18 at 11:55 a.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not include how to communicate with Indiana Protection and Advocacy Services (IPAS). Based on interview concurrent with record review with the AM it was acknowledged the EPP did not include the means to communicate with IPAS in the communication	E 0031	1.The administrator will ensure the emergency plan policies and procedures will be updated to include a continuity of operations plan which includes how to communicate with Indiana Protection and Advocacy Services (IPAS). 2.The area supervisor and program manager will train all staff on the continuity of operations plan and the plan will be present in the Emergency Disaster Preparedness Manual for reference as needed.	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	portion of the EPP. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			
E 0036 Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants. Findings include: Based on record review on 11/30/18 at 11:59 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include a training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.475(d). Based on interview concurrent with record review with the RM it was acknowledged the EPP did not include a training and testing program. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0036	1.The administrator will ensure the emergency plan policies and procedures annual emergency training and testing program is implemented in all locations and evidence of the annual training and testing is present in the EPP manual. 2.The area supervisor and program manager will train all staff on the annual training and testing and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review and update annually as needed.	12/30/2018
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency	E 0037	1.The administrator will ensure the emergency plan policies and procedures initial training in emergency preparedness policies and procedures to all new and	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 11/30/18 at 12:09 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include a. Initial training in emergency preparedness policies and procedures to all new and existing staff. b. Provide EPP training at least annually. c. Maintain documentation of the training. d. Demonstrate staff knowledge of emergency procedures. Based on interview concurrent with record review with the RM it was stated the EPP did not contain items a, b, c, and d described above. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.		existing staff, annual emergency training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed and present in the EPP manual. The ResCare "On The Job" training checklist will be updated to include initial training in emergency preparedness of all new employees. The annual training requirements list will also be updated to include the training of all existing employees. 2.The residential manager, area supervisor and program manager will provide initial training to all new staff and the ResCare trainer will provide annual training to existing staff. Testing results will be available to demonstrate staff knowledge of emergency procedures. The training and testing documentation will be present in the Emergency Disaster Preparedness Manual/HR personnel files for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review and update annually as needed.	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced	E 0039	1.The administrator will ensure the participation in a full-scale community based exercise and a	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff drills using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 11/30/18 at 12:00 p.m. with the Residential Manager (RM) the facility lacked documenrtation of participation in any exercises for the past year. Based on interview concurrent with record review with the RM it was stated the facility had not participated in any exercises for the past year. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction		table top exercise is present in the 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 the Emergency Disaster Preparedness Manual for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review and update annually as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to prevent recurrence.			
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 11/30/18 Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230 At this PSR survey, Res Care Community Alternatives SE IN was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 6 and had a census of 4 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 0.08. Quality Review completed on 12/05/18 - DA	K 0000		
K S100	NFPA 101 General Requirements - Other			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 02	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 and interview, the facility failed to ensure 2 of 3 fire extinguishers were protected. NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4 requires that portable fire extinguishers types shall be (1) secured on a hanger (2) in the bracket supplied by the manufacturer (3) in a listed bracket approved for such purpose (4) in cabinets or wall recesses. This deficient practice could affect all occupants. Findings include: Based on observation on 11/30/18 during tour between 1:15 p.m. to 2:05 p.m. with the Residential Manager (RM),1 of 3 fire extinguishers in the home were on the floor unsupported. Based on interview at the time of observation, the RM indicated maintenance was scheduled to correct this condition. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S100	1.The maintenance coordinators will be trained by the program managers to ensure the Portable Fire Extinguishers are secured on hangers. 2.The maintenance coordinators will ensure all fire extinguishers in the facility are secured on hangers. The program manager and associate executive director will follow up to ensure the fire extinguishers are secured on hangers. The area supervisor will check the fire extinguishers monthly and the residential manager will check the fire extinguishers weekly to ensure the fire extinguishers remain on secured hangers at all times.	12/30/2018
K S222 Bldg. 02	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation and interview, the facility failed to ensure 1 of 2 bathroom doors with locks on the inside were arranged such that staff can rescue clients in an emergency if the bathroom door becomes locked from the inside. This deficient practice could affect all occupants. Findings include: Based on observation on 11/30/18 between the hours of 12:45 p.m. and 1:15 p.m. with the Residential Manager (RM), the client bathroom door could be locked from the inside and when the RM was asked to provide a key to unlock the bathroom door a key to do so could not be located. Based on interview at the time of	K S222	1.The area supervisor and program manager will ensure all bathroom doors allow opening from the outside during an emergency when locked and keys to unlock the doors are available to all staff of the facility. 2.The program manager will ensure the locks on the bathroom doors are keyed locks and will train all staff on the location of the keys. The program manager will conduct periodic checks to ensure the keys are present in the facility and that all staff know the location of the keys. The area supervisor	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observation, the RM lacked the knowledge to unlock the client bathroom door. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.		will conduct monthly checks and the residential manager will conduct weekly checks to ensure the keys are present in the facility and all staff know the location of the keys.	
K S341 Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm panels were installed and maintained with a primary and secondary source of reliable power. LSC Section 9.6.2.10 requires compliance with NFPA 72, National Fire Alarm Code, 2010 Edition. NFPA 72 at 10.5.3.2 requires fire alarm systems shall be provided with at least two independent and reliable power supplies, one primary and one secondary (Standby), each of which shall be of adequate capacity for the application. This deficient practice could affect all clients, as well as staff and visitors in the facility. Findings include: Based on observation on 11/30/18 during tour between 1:15 p.m. to 2:05 p.m. with the Residential Manager (RM) it was observed the fire alarm control panel (FACP) did not have a secondary power supply to ensure the facility would be	K S341	1.The program manager will ensure proof that the fire alarm system is provided with at least two independent and reliable power supplies, one primary and one secondary (Standby) is present in the facility. 2.The program manager will contact Koorsen Fire and Security to provide proof that a secondary power supply is present in the facility and the facility is protected in the event of a primary power outage. The written documentation will be present in the facility for reference as needed.	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	protected in the event of a primary power outage. Based on interview concurrent with the observation, the RM was asked why the FACP did not have a secondary power supply such as DC batteries and the answer was the FACP never had them to her knowledge. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K S346 Bldg. 02	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 Based on record review and interview, the facility failed to provide a written policy when the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. NFPA 25, 15.5.2 (4) requires where a required fire protection system is out of service for more than 10 hours in a 24-hour period, the impairment coordinator shall arrange for all of the following: (5) the fire department has been notified and (6) the insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. This deficient practice could affect all clients in the facility. Findings include:	K S346	1.The area supervisor and program manager will ensure the Fire Watch Policy is in the emergency preparedness manual in the home for review as needed. 2.The area supervisor will train all staff on the Fire Watch Policy and ensure all staff know the location of the policy for reference when needed.	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review on 11/30/18 at 12:10 p.m. with the Residential Manager (RM) the written Fire Watch Policy for the automatic sprinkler system was not available for review. This was acknowledged by the RM at the time of record review. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K S353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing 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 with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, and interview, the facility failed to document monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states an inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. This deficient practice could affect all clients in the facility. Findings include: Based on record review on 11/30/18 at 12:07 p.m. with the Residential Manager, there was no documentation the sprinkler gauge and valves had been inspected on a monthly basis for the past year. Based on interview concurrent with record review it was acknowledged by the RM the wet sprinkler gauge and valves were not inspected and documented on a monthly basis and were unaware of this requirement. This deficiency was cited on 10/04/14. The facility	K S353	1.The administrator will ensure monthly sprinkler gauge inspections and monthly control valve inspections are conducted by the ResCare maintenance coordinator and is clearly documented on the control valve and gauge inspection tags. Proof of the inspections will be available in the facility for review. 2.The program manager will ensure all inspections reports from Koorsen Fire and Safety are conducted and present in the facility. The maintenance coordinator will ensure tags are placed on the system control valve and gauge and will initial the tags at each inspection for the review of the authority having jurisdiction upon request. The program manager will complete periodic checks to ensure the inspections are being completed as required.	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to implement a systemic plan of correction to prevent recurrence.			
K S354 Bldg. 02	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written policy when the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. NFPA 25, 15.5.2 (4) requires where a required fire protection system is out of service for more than 10 hours in a 24-hour period, the impairment coordinator shall arrange for all of the following: (5) the fire department has been notified and (6) the insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. This deficient practice could affect all clients in the facility. Findings include: Based on record review on 11/30/18 at 12:10 p.m. with the Residential Manager (RM) the written Fire Watch Policy for the automatic sprinkler system was not available for review. This was acknowledged by the RM at the time of record review.	K S354	1.The area supervisor and program manager will ensure the Fire Watch Policy is in the emergency preparedness manual in the home for review as needed. 2.The area supervisor will train all staff on the Fire Watch Policy and ensure all staff know the location of the policy for reference when needed.	12/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K S711 Bldg. 02	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan The administration of every resident board and care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility. All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	additional personal risk. 32.7.1, 32.7.2, 33.7.1, 33.7.2 Based on record review, observation and interview, the facility failed to ensure there was a complete fire safety plan in place which addressed the use of the pull stations to ensure the safety of 4 of 4 clients. This deficient practice could affect all clients, as well as staff and visitors. Findings include: Based on record review on 11/30/18 at 12:30 p.m. with the Residential Manager (RM), the facility's Fire Emergency plan did not address the use of pull stations to activate the alarm to notify all occupants in the event of a fire. Based on observation and interview during the tour between 1:00 p.m. to 1:30 p.m. the RM was asked how to operate the fire alarm system and she replied the pull station required a key. She was asked to produce the key and after approximately five minutes a key could not be produced. This deficiency was cited on 10/04/14. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S711	1.The area supervisor will ensure the Fire Safety Plan which includes use of the pull stations is in the home for review as needed. 2.The area supervisor will train all staff on the Fire Safety Plan, the use of pull stations, and the location of pull station keys. The area supervisor will ensure all staff know the location of the plan and pull station keys for reference when needed. The residential manager will ensure the pull station keys are available for use at all times.	12/30/2018