Lindsay Johnson

PRINTED: 10/23/2023 FORM APPROVED OMB NO. 0938-039

10/18/2023

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G749		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/28/2023	
	PROVIDER OR SUPPLIE RE SOUTHEAST IN			16613 S	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD VILLE, IN 47126		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg	conducted by the In Health in accordant Survey Date: 09/2 Facility Number: 09/2 Facility Number: 10/2 Provider Number: 200 At this Emergency Southeast Indianal with Emergency Provider and Medicare and Medicare and Medicare and Suppliers, 42 0 The facility has 4 coertified for Medicare the census was 4. Quality Review co	D11595 15G749 1905630 Preparedness survey, Res Care was found not in compliance reparedness Requirements for icaid Participating Providers CFR 483.475. Pertified beds. All 4 beds are aid. At the time of the survey, Impleted on 10/02/23 142 CFR, Subpart 483.475 is	E 000	00			
E 0039 Bldg	441.184(d)(2), 484 483.73(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 §483.475(d)(2), §	.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)					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	I	TITLE		(X6) DATE

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

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QA Manager

PRINTED: 10/23/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPI	LETED
		15G749	B. W	ING		09/28	/2023
				CTREET	ADDRESS OF A STATE TIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2		1	ADDRESS, CITY, STATE, ZIP COD		
DEC CAE		IDIANIA			SIMA GRAY RD		
KES CAR	RE SOUTHEAST IN	IDIANA		HEINKY	VILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For ASCs at §41	6.54, CORFs at §485.68,					
	OPO, "Organization	ons" under §485.727,					
		20, RHCs/FQHCs at					
	§491.12, and ESF	RD Facilities at §494.62]:					
	(2) Testing. The [f	acility] must conduct					
	exercises to test the	he emergency plan					
	annually. The [fac	ility] must do all of the					
	following:	•					
	_						
	(i) Participate in a	full-scale exercise that is					
	community-based	every 2 years; or					
	(A) When a comn	nunity-based exercise is					
	, ,	nduct a facility-based					
		e every 2 years; or					
		ility] experiences an actual					
	, , _	ade emergency that requires					
		mergency plan, the [facility]					
		gaging in its next required					
		or individual, facility-based					
	•	e following the onset of the					
	actual event.	· ·					
	(ii) Conduct an ad	ditional exercise at least					
	every 2 years, opp	posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
	` '	limited to the following:					
		scale exercise that is					
	, ,	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	` '	ercise or workshop that is					
	, ,	and includes a group					
	discussion using a	- .					
	_	emergency scenario, and a					
	set of problem sta						

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messages, or prepared questions designed

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop

to challenge an emergency plan.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G749		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/28/2023	
	PROVIDER OR SUPPLIEI RE SOUTHEAST IN		16613	SIMA GRAY RD YVILLE, IN 47126	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	GOMPLETION
		nergency events, and revise ergency plan, as needed.			
	the patient's home conduct exercises plan at least annuathe following: (i) Participate in a community based (A) When a commaccessible, condubased functional editional exercis of the emerging of the emergency exempt from engascale community-facility-based functional exercis of this section is conficulted, but is not (A) A second full-community-based functional exercis (B) A mock disass (C) A tabletop exited by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an editional for hose conductions of the editional exercis (B) A mock disass (C) A tabletop exited by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an editional exercis (B) Testing for hose conductions and the editional exercis (B) A tabletop exited by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an editional exercis (B) Testing for hose conductions and the editional exercis (B) A tabletop exited by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an editional exercis (B) Testing for hose conductions and the editional exercis (B) and the	aspices that provide care in the care that provide care in the care the hospice must as to test the emergency shally. The hospice must do a full-scale exercise that is a every 2 years; or munity based exercise is not not act an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual actional exercise following the gency event. Indicate the full-scale or the ender paragraph (d)(2)(i) conducted, that may be limited to the following: I a facility based the care is a group an arrated, the emergency scenario, and a stements, directed pared questions designed mergency plan.			
		hospice must conduct			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING		COMPL	
		15G749	B. W	ING		09/28	/2023
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					SIMA GRAY RD		
RES CAF	RE SOUTHEAST IN	IDIANA		HENRY	VILLE, IN 47126		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		he emergency plan twice					
		spice must do the following: an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	' '	ict an annual individual					
		ctional exercise; or					
		experiences a natural or					
		ency that requires activation					
		plan, the hospice is					
	exempt from enga	aging in its next required					
	full-scale community based or facility-based						
	functional exercise following the onset of the						
	emergency event.						
	, ,	dditional annual exercise					
	I -	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					
		rio, and a set of problem red messages, or prepared					
	questions designe	•					
	emergency plan.	a to originary arr					
		ospice's response to and					
	. ,	ntation of all drills, tabletop					
		nergency events and revise					
		ergency plan, as needed.					
		•					
	*IFor DDETs at \$4	1/1 18/(d) Hospitals at					
	§482.15(d), CAHs	141.184(d), Hospitals at					
	` '	PRTF, Hospital, CAH] must					
		s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAHI must do the	- · · · · · · · · · · · · · · · · · · ·					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DAT	TE SURVEY PLETED 28/2023
	PROVIDER OR SUPPLIEI		16613 \$	ADDRESS, CITY, STATE, ZIP COI SIMA GRAY RD 'VILLE, IN 47126)	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREGEACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APF DEFICIENCY)		(X5) COMPLETION
TAG	(i) Participate in a that is community (A) When a commaccessible, conducted facility-based function (B) If the [PRTF, I an actual natural that requires active plan, the [facility] its next required for individual, facility following the onsequence of the conducted exercise or and the limited to the follous (A) A second full-community-based facility-based function (B) A moderate (C) A tabletop is led by a facilitate discussion, using clinically-relevant set of problem stamessages, or preto challenge an endicate of the conducted exercises and revise the [faneeded. *[For PACE at §4] (2) Testing. The Foreign at least annuorganization mustive conducted exercises plan at least annuorganization exercises plan at least annuorganization mustive conducted exercises plan at least annuorganization exercises plan at least annuorganization mustive conducted exercises plan at least annuorganization exercises plan at least annuorganiz	nunity-based exercise is not act an annual individual, etional exercise; or Hospital, CAH] experiences or man-made emergency ration of the emergency is exempt from engaging in ull-scale community based ity-based functional exercise of the emergency event. In an [additional] annual first may include, but is not wing: -scale exercise that is a or individual, a ctional exercise; or lock disaster drill; or lock exercise or workshop that for and includes a group an anarrated, emergency scenario, and a latements, directed pared questions designed mergency plan. The [facility's] response to the interpretation of all drills, is, and emergency events collity's] emergency plan, as 60.84(d):] PACE organization must is to test the emergency exercise exercise in annual full-scale exercise.	TAG			DATE

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(A) When a community-based exercise is not

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		15G749	B. WING	_	09/28/2023
NAME OF T	DROWIDED OF CURPLUS		STREET	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	PROVIDER OR SUPPLIEF	(SIMA GRAY RD	
RES CAF	RE SOUTHEAST IN	IDIANA	HENR	YVILLE, IN 47126	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ict an annual individual,			
		ctional exercise; or			
	' '	xperiences an actual natural			
		ergency that requires			
	activation of the emergency plan, the PACE is exempt from engaging in its next required				
	-				
	full-scale community based or individual, facility-based functional exercise following the				
	onset of the emer	_			
		in additional exercise every			
	, ,	the year the full-scale or			
		-			
	functional exercise under paragraph (d)(2)(i) of this section is conducted that may include,				
	but is not limited to				
		scale exercise that is			
	' '	or individual, a facility			
	based functional e	-			
	(B) A mock disas				
	' '	ercise or workshop that is			
		and includes a group			
	discussion, using				
	_	emergency scenario, and a			
	set of problem sta				
	-	pared questions designed			
	to challenge an er	· · · · · · · · · · · · · · · · · · ·			
	(iii) Analyze the F	PACE's response to and			
	maintain documer	ntation of all drills, tabletop			
	exercises, and em	nergency events and revise			
	the PACE's emerg	gency plan, as needed.			
	*[For LTC Facilitie	es at §483.73(d):1			
	_	ity] must conduct exercises			
		ency plan at least twice per			
	_	announced staff drills using			
		ocedures. The [LTC facility,			
	ICF/IID] must do t				
	-	an annual full-scale exercise			
	that is community				
		nunity-based exercise is not			
	' '	ict an annual individual,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G749		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/28/2023		
		ROVIDER OR SUPPLIER			16613 S	DDRESS, CITY, STATE, ZIP COD SIMA GRAY RD VILLE, IN 47126		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
		actual natural or natu	ility] facility experiences an man-made emergency plan, the mpt from engaging its next le community-based or based functional exercise 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 pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed. [483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the mannual full-scale exercise.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	.ETED
		15G749	B. W	NG		09/28	/2023
		<u> </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			SIMA GRAY RD		
RES CAF	RE SOUTHEAST IN	IDIANA			VILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY		DATE
		mergency plan, the ICF/IID					
		gaging in its next required					
		nity-based or individual,					
	facility-based functional exercise following the onset of the emergency event.						
	(ii) Conduct an additional annual exercise						
	1 ' '						
	that may include, but is not limited to the following:						
	_	scale exercise that is					
	, ,						
	community-based or an individual, facility-based functional exercise; or						
	(B) A mock disaster drill; or						
	(C) A tabletop exercise or workshop that is						
	led by a facilitator and includes a group						
	discussion, using	- -					
	_	emergency scenario, and a					
	set of problem sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	nergency plan.					
	(iii) Analyze the IC	CF/IID's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	34.102]					
	(d)(2) Testing. The	e HHA must conduct					
	exercises to test t	he emergency plan at					
	least annually. Th	e HHA must do the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based	; or					
	(A) When a c	ommunity-based exercise					
	is not accessible,	conduct an annual					
	individual, facility-	based functional exercise					
	every 2 years; or.						
	, ,	A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
	full coala commun	nity-based or individual	1				I

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/28/2023	
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COI SIMA GRAY RD	D	
RES CAF	RE SOUTHEAST IN	IDIANA		/VILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	SHOULD BE COMPLETION	
	onset of the emer (ii) Conduct an ad years, opposite th	tional exercise following the gency event. ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i)				
	of this section is c include, but is not	onducted, that may limited to the following: full-scale exercise that is				
	(B) A mock d (C) A tabletor	ctional exercise; or isaster drill; or o exercise or workshop that or and includes a group				
	set of problem sta	emergency scenario, and a				
	to challenge an er (iii) Analyze the H maintain documer					
		ency plan, as needed.				
	exercises to test t OPO must do the	e OPO must conduct he emergency plan. The following:				
	or workshop at lea exercise is led by group discussion,	er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of				
	problem statemen prepared question emergency plan. I	ots, directed messages, or us designed to challenge an fithe OPO experiences an man-made emergency that				
	requires activation OPO is exempt from	n of the emergency plan, the om engaging in its next xercise following the onset				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G749		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/28/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 16613 SIMA GRAY RD HENRYVILLE, IN 47126				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	maintain documer exercises, and em the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the the test to the te	e RNHCI must conduct he emergency plan. The	E 00)39	To correct deficient practice, a least two exercises will be completed annually to test emergency procedures on an annual basis. The emergency calendar will be updated to incompleted annually. All staff responsible maintaining drills will be trained the calendar. In addition to the multi-state earthquake drill conducted on 10/20/2022, a second exercise is scheduled be completed on 10/19/2023. supervisory staff responsible for maintaining drills will be retrained to ensure each group home is completing the drills per LSC. Ongoing monitoring will be	drill clude d for ed on e to All for	11/07/2023

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/23/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G749		A. BUILDING B. WING		COMPLETED 09/28/2023	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD	
RES CAF	RE SOUTHEAST IN	DIANA		YVILLE, IN 47126	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0000	facilitator, using a nemergency scenario statements, directed questions designed to plan; (iii) analyze the and maintain docume exercises, and emergic ICF/IID facility's enaccordance with 42 deficient practice construction. Findings include: Based on review of Preparedness Manual O4/22/22 with the Proparedness Manual (QIDP) during reconstruction of 11:50 a.m. on 09/28 two exercises to test annual basis using the other provided of multi-state earthqual emergency prepared agreed documentativest emergency processor of available for survey. These findings were	arrated, clinically-relevant, and a set of problem messages, or prepared to challenge an emergency are ICF/IID facility's response to mentation of all drills, tabletop gency events, and revise the mergency plan, as needed in CFR 483.475(d)(2). This build affect all occupants. "Emergency/Disaster all documentation dated rogram Manager and the all Developmental Professional and review from 10:05 a.m. to 8/23, documentation of at least the emergency procedures was riew. Based on interview at the w, the Program Manager and	IAU	achieved by the Quality Assurance Department maintaining a tracking spreadsheet to ensure all drills completed per the calendar.	
Bldg. 01		Certification and ey was conducted by the of Health in accordance with	K 0000		

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	` ′	LTIPLE CO LDING	NSTRUCTION 01	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G749	B. WIN		<u>01</u>	09/28/	
NAME OF I	DDOVIDED OD GUDDI IED		 	STREET A	DDRESS, CITY, STATE, ZIP COD	<u> </u>	
	PROVIDER OR SUPPLIER RE SOUTHEAST IN				SIMA GRAY RD VILLE, IN 47126		
(X4) ID	<u> </u>	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	P	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	42 CFR 483.470(j).						
	Survey Date: 09/28	3/23					
	Facility Number: 0	11595					
	Provider Number: 15G749						
	AIM Number: 200905630						
	At this Life Safety (
		vas found not in compliance					
		for Participation in Medicaid,					
	42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire						
		ion (NFPA) 101, Life Safety					
		er 33, Existing Residential					
	Board and Care Occ	cupancies.					
	This one story facil	ity was fully sprinklered. The					
	1	arm system with smoke					
		ridors, common living areas					
	_	ng rooms. The facility has heat					
		n the attic. The facility has a					
	this survey.	ad a census of 4 at the time of					
	uns survey.						
		Evacuation Difficulty Score					
		PA 101A, Alternative					
		Safety, Chapter 6, rated the					
	facility Prompt with	an E-Score of 0.1.					
	Quality Review con	npleted on 10/02/23					
K S100	NFPA 101						
	General Requirem						
Bldg. 01	General Requirem	nents - Other					
	2012 EXISTING	N/O 1' 100					
		RKS section any LSC					
		3.2 General Requirements seed by the provided					
		ficient. This information,					

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DEPARTMEN' CENTERS FOI		FORM APPROVED OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/28/2023	
	PROVIDER OR SUPPLIEF			16613	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD VVILLE, IN 47126		
(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 APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
TAG	along with the app NFPA standard ci on Form CMS-256 Based on observation failed to ensure 1 of were installed in act 4.6.12.4 requires and condition, arrangent fire-resistive constrates requiring periodic to to ensure its mainted inspected, or operated NFPA standards. Note that the first extinguishers, states portable fire to wheeled extinguisher (2) In the bracket standards are the first extinguisher (2) In the bracket standards are the first extinguisher (3) In a listed brack (4) In cabinets or word and visitors. Findings include: Based on observation and the Qualified In Professional (QIDP from 11:50 a.m. to portable fire exting was freestanding or properly installed. of the observations,	colicable Life Safety Code or station, should be included 67. on and interview, the facility f 3 portable fire extinguishers cordance with NFPA 10. LSC my device, equipment, system, ment, level of protection, ruction, or any other feature esting, inspection, or operation enance shall be tested, and as specified in applicable NFPA 10, Standard for Portable 2010 Edition, Section 6.1.3.4 extinguishers other than ers shall be installed using any eans: anger intended for the supplied by the extinguisher exter approved for such purpose reall recesses since could affect all clients, staff ons with the Program Manager intellectual Developmental 20 during a tour of the facility 12:05 p.m. on 09/28/23, the uisher located in the office area in a file cabinet and was not Based on interview at the time in the Program Manager and the	KS		To correct deficient practice, freestanding fire extinguisher be properly installed on the with appropriate place. Maintenance tech will ensure fire extinguishers are installed the designated area following maintenance/painting is need Ongoing monitoring will be achieved through a monthly linspection completed by the Supervisor and maintenance to ensure all Life safety featurare in working order.	will wall in all all all all all all all all all al	11/07/2023
	of the observations,						

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portable fire extinguisher should have been rehung and agreed the portable fire extinguisher located in the office area was freestanding on a

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01			01	COMPLETED			
	15G749 B. WING		09/28/2023					
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 16613 SIMA GRAY RD HENRYVILLE, IN 47126				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE		
	file cabinet and was	not properly installed.						
	_	e reviewed with the Program (IDP) during the exit conference.						

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