STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G167	A. BUILDING 01 B. WING	08/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	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: 08/31/16 Facility Number: 000701 Provider Number: 15G167 AIM Number: 100248800 At this Life Safety Code 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 2000 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 not sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and common living areas. The facility has a capacity of seven and had a census of six at the time of this survey. Calculation of the Evacuation Difficulty	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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	Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.24. Quality Review completed on 09/02/16 - DA			
K 0130 Bldg. 01	1. Based on observation and interview, the facility failed to ensure monthly fire extinguisher inspections were documented, including the date and initials of the person performing the inspections for 1 of 1 portable fire extinguisher. LSC 101, 4.5.7 states any device, equipment or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 10, Standard for Portable Fire Extinguishers, 4-3.1 requires extinguishers shall be inspected monthly. NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. NFPA 10, 4-3.4.2 requires at least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. This deficient practice could affect all clients, staff and visitors in the facility.	K 0130	**K130:** Corrective Action: (Specific): All fire extinguishers in the home will be inspected and those inspections will be documented on the service tag. All staff at the home will be re-trained on service and inspection of all fire extinguishers in the home at least monthly and documentation on the service tags. All fire extinguishers in the home will be inspected and documentation on the service tags will be evident. How others will be identified: (Systemic): The Maintenance Coordinator will visit the home at least monthly to ensure that all fire extinguishers in the home are inspected and documentation of those inspections are completed at least every month. The Program Manager will visit the home at least twice monthly to	09/30/2016

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	Findings include: Based on observation of the fire extinguisher inspection/maintenance tag on 08/31/16 at 2:25 p.m. during a tour of facility with the Residential Manager, there was no documentation on the inspection tag to show the portable fire extinguisher in the kitchen was inspected since February of 2016. This was acknowledged by the Residential Manager at the time of observation. 2. Based on observation, record review and interview; the facility failed to ensure documentation for the testing of 2 of 2 battery powered emergency lights was maintained. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires a functional test be conducted at 30 day intervals and an annual test be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants if the facility were		ensure that inspections of all fire extinguishers are completed and those inspections are documented on the service tag at least monthly. Measures to be put in place: All fire extinguishers in the home will be inspected and those inspections will be documented on the service tag. All staff at the home will be re-trained on service and inspection of all fire extinguishers in the home at least monthly and documentation on the service tags. All fire extinguishers in the home will be inspected and documentation on the service tags will be evident. Monitoring of Corrective Action: The Maintenance Coordinator will visit the home at least monthly to ensure that all fire extinguishers in the home are inspected and documentation of those inspections are completed at least every month. The Program Manager will visit the home at least twice monthly to ensure that inspections of all fire extinguishers are completed and those inspections are documented on the service tag at least monthly.	

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	required to evacuate in an emergency during a loss of normal power. Findings include: Based on observations on 08/31/16 between 2:25 p.m. and 2:45 p.m. during a tour of the facility with the Residential Manager, the facility had two battery powered emergency light units. Based on review of the Emergency Book at 2:15 p.m., there was a Simplex/Grinnell report dated 02/16 which indicated both battery powered emergency light sets were tested for 90 minutes, however, there was no documentation available to show the battery powered emergency lights were tested monthly for at least 30 seconds. This was acknowledged by the Home Manager at the time of record review and observation.		**Completion date: 9/30/2016**	
K S018 Bldg. 01	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4 Doors are self-closing or automatic closing in accordance with 7.2.1.8 Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2.			

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	Based on observation and interview, the facility failed to ensure 2 of 5 client sleeping room doors in this unsprinklered home were not restricted from closing manually or automatically. This deficient practice could affect all clients in the facility. Findings include: Based on observations on 08/31/16 between 2:25 p.m. and 2:45 p.m. during a tour of the facility with the Residential Manager, the following was noted: 1. Client sleeping room #4 (located on the right side of the hall, last door) the door was held wide open with a water jug. 2. Client sleeping room #5 (located on the right side of the hall, first door) the door was held wide open with a dresser. This was acknowledged by the Residential Manager at the time of observations.	K S018	**K0018:** Corrective Action: (Specific): All staff will be re-trained on ensuring that client sleeping rooms are not restricted from closing manually or automatically and that all client sleeping room doors are not blocked open with any object. The dresser and jug of water will be removed from client #4 and #5's sleeping room doors. How others will be identified: (Systemic): The Residential Manager will be at the home at least three times weekly to ensure that all client sleeping room doors are not restricted from closing automatically or manually. The QIDP will be at the home at least weekly to ensure that all client sleeping room doors are not restricted from closing automatically or manually. Measures to be put in place: All staff will be re-trained on ensuring that client sleeping rooms are not restricted from closing manually or automatically and that all client sleeping room doors are not blocked open with any object. The dresser and jug of water will be removed from client #4 and #5's sleeping room doors.	09/30/2016

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			Monitoring of Corrective Action: The Residential Manager will be at the home at least three times weekly to ensure that all client sleeping room doors are not restricted from closing automatically or manually. The QIDP will be at the home at least weekly to ensure that all client sleeping room doors are not restricted from closing automatically or manually. **Completion date: 09/30/2016**	