STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G442	A. BUILDING -- B. WING	01/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130

(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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 12/20/18 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/22/19 Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760 At this PSR survey, Res Care Community Alternatives SE IN was found not 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 01/28/19 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0004 Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.475(a). This deficient practice could affect all occupants. Findings include:	E 0004	1.The emergency preparedness program will be reviewed annually by the safety committee and a committee member will sign off on the review form located in the emergency preparedness manual. 2.The Safety Committee, program manager, area supervisor and associate executive director	02/21/2019

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

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	Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., the emergency preparedness documentation indicated the last time the plan was reviewed on 07/21/17. Based on interview at the time of record review, the Direct Support Professional confirmed the plan was updated over a year ago. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		will ensure the documentation of annual review of the program is in place in the manual.	
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. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., the emergency preparedness plan failed to address 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. Based on interview at the time of record review then again during the exit conference, the Direct Support Professional confirmed the lack of documentation.	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 reference as needed. 3.This information is located in section 21 of the Emergency Disaster Preparedness Manual 4.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 5.The persons responsible will be the Executive Director, Associate Executive Director, Program Manager, Area Supervisor, and Residential Manager.	02/21/2019

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	This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.			
E 0009 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., no documentation was available to show the group home included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Based on interview at the time of record review, the Direct Support Professional confirmed no contact has been made and no more documentation was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0009	1.The emergency plan policies and procedures will be updated to include continuity of operations, this section will include email and phone numbers for notification of the Indiana State Department of Health. 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 reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the Executive Director, Associate Executive Director, Program Manager, Area Supervisor, and Residential Manager.	02/21/2019

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E 0013 Bldg. --	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., the policies and procedures of the facility's emergency preparedness plan indicated the plan was last updated on 07/21/17. Based on interview at the time of record review then again at the exit conference, the Direct Support Professional confirmed the plan has not been updated in over a year. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0013	1.The emergency plan policies and procedures will be updated and reviewed annually by the Executive Director . 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. 3.The persons responsible will be the, Executive Director, Program Manager, Area Supervisor, and Residential Manager	02/21/2019
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	E 0015	1.The administrator will ensure the emergency plan policies and procedures addresses the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, including but not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to	02/21/2019

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	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 observation with the Direct Support Professional on 01/22/19 at 1:23 p.m., the facility was unable to provide documentation for the policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place for sewage and waste disposal. Based on interview at the time of record review, the Direct Support Professional confirmed no documentation was available to review for the provision of the aforementioned subsistence needs. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		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). 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0018 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants.	E 0018	1.The administrator will ensure the emergency plan policies and procedures addresses the tracking of staff and clients, whether they evacuate or shelter in place. Including the consideration of care and treatment needs of evacuees, staff responsibilities; transportation; identification of evacuation locations; and primary and means of communication with external assistance.	02/21/2019

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	Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., no policies and procedures which include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency was available to review. Based on interview at the time of record review, the Direct Support Professional confirmed no such documentation was available to review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0020 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the ICF/IID facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.475(b)(3). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., no policies and procedures which include information for safe evacuation from the ICF/IID facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities;	E 0020	1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses safe evacuation of from the ICF/IID facility and includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. 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.	02/21/2019

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	transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance was available for review. Based on interview at the time of record review then again during the exit conference, the Direct Support Professional confirmed no evacuation policy was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0022 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 01/22/19 at 1:23 p.m., the Direct Support Professional confirmed no policies and procedures which include information about a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0022	1.The administrator will ensure the emergency plan policies and procedures addresses a means to shelter in place for staff, volunteers and clients who remain in the facility. Including but 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). 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for	02/21/2019

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			reference as needed.	
E 0023 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., no policies and procedures which include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records was available to review. Based on interview at the time of record review, the Direct Support Professional confirmed no such documentation was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0023	1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses a system of medical documentation of from the ICF/IID facility and includes consideration of maintaining protection of confidentiality of patient information and secures and maintains availability of records. 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. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	02/21/2019
E 0024 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing	E 0024	1.The emergency plan policies and procedures will be updated to include volunteers in an emergency or other emergency	02/24/2019

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	strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., no policies and procedures which include the use of volunteers in an emergency or other emergency staffing strategies was available for review. Based on interview at the time of record review, the Direct Support Professional confirmed no such documentation was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		staffing strategies including the integration of State and Federal designated healthcare professionals to address surge needs during an emergency. 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. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
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 record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., no policies and procedures which include the development of	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	02/21/2019

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	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 was available for review. Based on interview at the time of record review, the Direct Support Professional confirmed no such documentation was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0026 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 occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., no policies and procedures which include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was available for review. Based on interview at the time of record review, the Direct Support Professional confirmed no such documentation was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction	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. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	02/21/2019

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	to prevent recurrence.			
E 0029 Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.475(c). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., the emergency preparedness communication plan was updated on 07/21/17. Based on interview at time of record review, the Direct Support Professional confirmed the communication plan was updated over a year ago. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0029	1.The emergency plan policies and procedures will develop and maintain an emergency preparedness plan that complies with Federal, State and local laws that must be reviewed annually. 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. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	02/21/2019
E 0033 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)	E 0033	1.The emergency plan policies and procedures will develop and maintain an emergency preparedness plan that complies with Federal, State and local laws that must be reviewed annually to include a method for sharing information and medical documentation for patients under	02/21/2019

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	(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., no documentation was available for a communication plan which includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care. Based on interview at the time of record review, the Direct Support Professional confirmed no documentation was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		the facility's care; a means of releasing patient information as permitted under 45 CFR 164.510(b)(1)(ii); a means of providing information general information and location of patients as permitted under 45 CFR 164.510(b)(1)(ii). 2.The area supervisor and program manager will train all staff on the communication plan and the plan will be present in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0034 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in	E 0034	1.The administrator will ensure the emergency plan policies and procedures will be updated to include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction.	02/21/2019

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	accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., the facility was unable to provide documentation for a communication plan including a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee. Based on interview at the time of record review, the Direct Support Professional confirmed no documentation was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		2.The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0035 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., the facility was unable to provide documentation for a communication plan which includes a method for sharing information from the emergency plan that	E 0035	1.The administrator will develop and maintain an emergency preparedness plan that complies with Federal, State and local laws that must be reviewed annually to include a method for sharing information the facility has determined appropriate, with clients and their family or representatives. 2.The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority	02/21/2019

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	the facility has determined is appropriate with clients and their families or representatives. Based on interview at the time of record review, the Direct Support Professional confirmed no documentation was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed.	
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 with the Direct Support Professional on 01/22/19 at 1:23 p.m., no emergency preparedness training and testing plan was available for review. Based on interview at the time of record review, the Direct Support Professional confirmed no such documentation was available for review. This deficiency was cited on 12/20/18. 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 in accordance with CFR 483.475(d) 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. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	02/21/2019

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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 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 with the Direct Support Professional on 01/22/19 at 1:23 p.m., no emergency preparedness training and testing program was available for review. Based on interview at the time of record review, the Direct Support Professional confirmed no documentation was available for the emergency preparedness training and testing program. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.	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 existing staff, annual emergency training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed in accordance with CFR 483.475(d)(1) and present in the EPP manual. 2.The area supervisor and program manager will provide initial training to all existing staff and new staff and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	02/21/2019
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 emergency plan policies and procedures includes the	02/21/2019

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	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 with the Direct Support Professional on 01/22/19 at 1:23 p.m., no documentation was available for a second community-based or tabletop exercise drill. Based on interview at the time of record review, the Direct Support Professional confirmed that only one exercise was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction		participation in a full-scale community based exercise and a table top exercise in accordance with CFR 483.475(d)(2) and present in the EPP manual. 2.The area supervisor and program manager will conduct the table top exercise and ensure documentation of the table top exercise and the community based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed. 1.The Program Manager will schedule a training event with community based services the Area Supervisor, and Residential Manager ensure the facility takes part in the training. 2.The Program Manager will contact local community based services to schedule a community based table top exercise before February 23, 2019. 3.Persons Responsible: Program Manager, Area Supervisor, and Residential Manager.	

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	to prevent recurrence.			
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 12/20/18 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 01/22/19 Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760 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 with the exception of the staff office, the storage room, the air handler room, the east bathroom and the hot water heater room. 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 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 0.6.	K 0000		

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	Quality Review completed on 01/28/19			
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, 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 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, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NPFA 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 with the Direct Support Professional on 01/22/19 at 1:23 p.m., no documentation for a smoke detector sensitivity test was available for review. Based on interview at the time of record review, the Direct Support	K S345	1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. **3.The Program Manager met with Eric Gray with Koorsen Fire and Security, on Feburary**	02/21/2019

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	Professional acknowledged the aforementioned condition and confirmed no other documentation was available for review. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		**4, 2019 to schedule required testing and request copies of inspections and testing are emailed to the program manager upon completion.**	
K S346 Bldg. 01	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 complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the insurance company and contacting the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Direct Support Professional acknowledged the	K S346	1.The administrator will ensure the Fire Watch Policy for the fire alarm system includes the web link for contacting the Incident Reporting system located on the Indiana State Department of Health Gateway. The QA Manager will update the Fire Watch policy to include: 1.notification of the insurance carrier 2.the web link for contacting the Incident Reporting System located on the Indiana Department of Health Gateway.	02/21/2019

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	lack of documentation. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		The area supervisor will be trained on the updated Fire Watch policy by the QA Manager. The area supervisor will train all facility staff on the updated Fire Watch policy. 2. The Program Manager will ensure the correct Fire Watch Policy is in the home. Persons Responsible: QA Manager, Program Manager, Area Supervisor, Residential Manager.	
K S351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with Section 9.6, as modified below. The adequacy of the water supply shall be documented. In Prompt Evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55			

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	square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood			

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	according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.1, 33.2.3.5.3.3, 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7 Based on observation and interview, the facility failed to provide sprinkler protection for 1 of 1 office. This deficient practice could affect staff only. Findings include: Based on observation with the Direct Support Professional on 1/22/19 at 1:23 p.m., the office lacks a sprinkler head or sprinkler coverage. Based on interview at the time of observation, the Direct Support Professional confirmed no sprinkler protection was provided for the office. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S351	1.The administrator will ensure sprinkler head or sprinkler coverage is provided for the office. 2.The program manager will ensure installation of sprinkler head installation for the office by Koorsen Fire and Safety. 3.Bids will be collected by February 15, 2019 for installation of additional sprinkler head in office, contractor will be selected by February 28, 2019 and installation will be complete by March 31, 2019.	02/21/2019
K S353 Bldg. 01	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			

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	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 (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,			

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	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. _____ (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 1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 33.2.3.5.8. LSC 33.2.3.5.8.1-15 indicates inspection and testing frequencies as referenced in NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., there was no quarterly testing documentation for the second quarter of 2018 and the fourth quarter of 2017. Additionally, no documentation was available for the monthly gauges and control valve inspections. Based on interview at the time of observation, the Direct Support Professional acknowledged the lack of documentation. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 13R, Standard for the Installation of	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.	02/21/2019

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	15G442	A. BUILDING 01 B. WING	01/22/2019

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	Sprinkler Systems in Low Rise Residential Occupancies, 2010 Edition, Section 11.1 states at least three spare sprinklers of each type, temperature rating, and orifice size used in the system shall be installed on the premises. NFPA Section 11.3 states sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all occupants. Findings include: Based on observation with the Direct Support Professional on 01/22/19 at 1:23 p.m., only four sprinkler head spares were in the sprinkler cabinet. Additionally, no sprinkler wrench was available in the sprinkler cabinet. Based on interview at the time of the observation, the Direct Support Professional acknowledged the number of spare sprinklers heads and the lack of a sprinkler wrench. This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		3. The Program Manager met with Koorsen Fire and security and scheduled service call to ensure 6 spare sprinkler heads and sprinkler head wrench will be provided to the facility by February 28, 2019.	

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K S354 Bldg. 01	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 1 of 1 written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional on 01/22/19 at 1:23 p.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the insurance company and contacting the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Direct Support Professional acknowledged the lack of documentation.	K S354	The QA Manager will update the Fire Watch policy to include: 1.notification of the insurance carrier 2.the web link for contacting the Incident Reporting System located on the Indiana Department of Health Gateway. The area supervisor will be trained on the updated Fire Watch policy by the QA Manager. The area supervisor will train all facility staff on the updated Fire Watch policy. Persons Responsible: QA Manager, Program Manager, Area Supervisor, Residential Manager.	02/21/2019

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	This deficiency was cited on 12/20/18. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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 1 of 6 client rooms doors had no impediment to closing and positively latched into the frame. This deficient practice could affect at least 1 client. Findings include: Based on observation with the Direct Support Professional on 01/22/19 between 12:52 p.m. and 1:28 p.m., bedroom #1 door was being propped open by the closet door handle. Based on interview at the time of observation, the Direct Support Professional confirmed the bedroom door was held open by the closet door.	K S363	1.The administrator will ensure clients bedroom doors have self-closing or automatic-closing devices installed. 2.The maintenance coordinator will ensure all clients bedroom doors have self-closing or automatic-closing devices installed. 3.All corridor doors will have self closing latches installed by ResCare Maintenance and doors positively latch to frame installation and repair shall be completed before February 21, 2019.	02/21/2019

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			4.Staff will be retrained on not propping bedroom doors. 5.The Residential Manager will inspect house weekly to ensure bedroom doors are not propped open and provide on the spot corrective training if a defeciancy is found. Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections.	