	STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G193		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/21/2024	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	13711 E	ADDRESS, CITY, STATE, ZIP COD BENNETTSVILLE RD HIS, IN 47143		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg	conducted by the I accordance with 42		E 0000			
	Survey Date: 02/2 Facility Number: 02/2 Provider Number: 100	000723 15G193				
	Community Altern compliance with E Requirements for I	Preparedness survey, Res Care atives SE In was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR				
	The facility has 7 c survey, the census	pertified beds. At the time of the was 7.				
	Quality Review co	mpleted on 02/23/24				
E 0018 Bldg	and (v), 441.184(483.475(b)(2), 48 485.920(b)(1), 48 Procedures for Ti §403.748(b)(2), § (ii) and (v), §441. §482.15(b)(2), § (1), §494.62(b)(1) [(b) Policies and preparedness poon the emergence	procedures. The [facilities] d implement emergency licies and procedures, based y plan set forth in paragraph	CNATURE	THE	(VA) DATE	
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	GNATURE	TITLE	(X6) DATE	
Mark Slau	ghter		AED		03/04/2024	

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

PRINTED: 03/05/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G193	r í	UILDING	NSTRUCTION	(X3) DATE COMPI 02/21	LETED	
	PROVIDER OR SUPPLIER	R LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 13711 BENNETTSVILLE RD MEMPHIS, IN 47143					
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E RIATE	(X5) COMPLETION DATE	
TAG	(a) of this section, paragraph (a)(1) of communication placetion. The policine reviewed and upder [annually for LTC the policies and part the following:] [(2) or (1)] A system on-duty staff and a relocated during the must document the location of the recolocation. *[For PRTFs at §4§483.73(b), ICF/II §460.84(b):] Policine system to track the and sheltered resulter ICF/IID or PACE] emergency. If one residents are relocated emergency, the [FPACE] must document docation. *[For Inpatient HoPolicies and proceed includes considerineeds of evacueed includes considerineeds of evacueed includes considerineeds of evacueed in the paragraph (a)(1) or paragraph (a)(1) or (a)(1) or (b)(1)	risk assessment at of this section, and the an at paragraph (c) of this ies and procedures must be lated at least every 2 years facilities]. At a minimum, rocedures must address on the track the location of sheltered patients in the ring an emergency. If sheltered patients are the emergency, the [facility] the specific name and seiving facility or other of the location of on-duty staff idents in the [PRTF's, LTC, care during and after anduty staff and sheltered cated during the PRTF's, LTC, ICF/IID or ament the specific name are receiving facility or other aspice at §418.113(b)(6):]		TAG	DEFICIENCY)		DATE	
	` '	imary and alternate means with external sources of						

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Event ID:

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Facility ID: 000723

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PRINTED: 03/05/2024

CENTERS FO	OMB NO. 0938-039					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G193	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/21/2024	
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	13711	ADDRESS, CITY, STATE, ZIP COD BENNETTSVILLE RD HIS, IN 47143		
(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 APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	employees' on-du the hospice's care the on-duty emplo are relocated duri hospice must doo and location of the location.	ack the location of hospice ity and sheltered patients in e during an emergency. If byees or sheltered patients ing the emergency, the ument the specific name e receiving facility or other				
	procedures. (2) S CMHC, which inc and treatment ne- responsibilities; tr of evacuation loca	afe evacuation from the ludes consideration of care eds of evacuees; staff ansportation; identification ation(s); and primary and of communication with				
	procedures. (2) A documentation th actual donor infor confidentiality of p	potential and actual donor secures and maintains the				
	procedures. (2) S dialysis facility, w responsibilities, a Based on record refailed to ensure em and procedures inclocation of on-duty the ICF/IID facility emergency. If on-dare relocated during	194.62(b):] Policies and afe evacuation from the hich includes staff and needs of the patients. View and interview, the facility ergency preparedness policies lude a system to track the staff and sheltered clients in vis care during and after an uty staff and sheltered clients in the type of the emergency, the ICF/IID ment the specific name and	E 0018	1.and clients, whether they evacuate or shelter in place. Including the consideration of and treatment needs of evacua staff responsibilities; transportation; identification of evacuation locations; and prim and means of communication.	ees, ary	03/05/2024

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location of the receiving facility or other location

in accordance with 42 CFR 483.475(b)(2). This

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external assistance.

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2.The area supervisor and

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	NSTRUCTION 	(X3) DATE COMPL	
		15G193	B. W	ING		02/21/	2024
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		13711 E	ADDRESS, CITY, STATE, ZIP COD BENNETTSVILLE RD HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	deficient practice co	ould affect all occupants.		program manager will train all sta on the policies and procedures and the program overview will be			
	AM to 1:40 PM, no located ensuring the preparedness policie system to track the sheltered clients in during and after an and sheltered clients emergency, the ICF specific name and loor other location. But of record review, the House Supervisor a policy and was unal evidence or addition deficient finding.	w on 02/21/2024 from 10:00 documentation could be a facility's emergency and procedures include a docation of on-duty staff and the ICF/IID facility's care emergency. If on-duty staff is are relocated during the AIID facility must document the ocation of the receiving facility hased on interview at the time and eknowledged the lack of the provide any further than information contrary to this experience is supervisor during the exit			placed in the Emergency Disa Preparedness Manual for reference as needed. 3 A member of the Administrative team will condumonthly site reviews for all clie in facility and the administrator hold a weekly ICF meeting to discuss issues that arise in the facility. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP, DSL, Quality Assurance.	ster uct a ents r will	
E 0039 Bldg	0039 403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2),						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G193	ì	UILDING	NSTRUCTION	(X3) DATE COMP. 02/21	
	PROVIDER OR SUPPLIE			13711 B	DDRESS, CITY, STATE, ZIP COD SENNETTSVILLE RD		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	IIS, IN 47143		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	CION ID BE OPRIATE	(X5) COMPLETION DATE
	§491.12, and ESF	RD Facilities at §494.62]:					
	exercises to test t	facility] must conduct he emergency plan cility] must do all of the					
	(i) Participate in a community-based (A) When a common accessible, confunctional exercis (B) If the [faction natural or man-materization of the exempt from exempt from exempt from exempt from exempt from exempt from the community-based functional exercis actual event. (ii) Conduct an additional exercis functional exercis (i) of this section is include, but is not (A) A second full-community-based functional exercis (B) A mock disast						
	discussion using a clinically-relevant set of problem sta messages, or pre to challenge an ei (iii) Analyze the [f maintain documei exercises, and en	emergency scenario, and a stements, directed pared questions designed					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		15G193	B. W	ING		02/21/	/2024
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	· ·		13711 E	BENNETTSVILLE RD		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For Hospices at	· · -					
	, , ,	spices that provide care in					
		e. The hospice must					
		s to test the emergency					
	-	ally. The hospice must do					
	the following:						
		a full-scale exercise that is					
	community based						
	, ,	nunity based exercise is not					
		exercise every 2 years; or					
		• •					
	(B) If the hospice experiences a natural or						
	man-made emergency that requires activation of the emergency plan, the hospital is						
		aging in its next required full					
		based exercise or individual					
		ctional exercise following the					
	onset of the emer	_					
		dditional exercise every 2					
	' '	e year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
		scale exercise that is					
	, ,	or a facility based					
	functional exercise	e; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta						
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
	(3) Testing for hos	spices that provide inpatient					
	care directly. The	hospice must conduct					
	exercises to test t	he emergency plan twice					
	per year. The hos	spice must do the following:					
	(i) Participate in a	an annual full-scale exercise					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G193		A. BUILDING B. WING		COMPLETED 02/21/2024	
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	13711	ADDRESS, CITY, STATE, ZIP COD BENNETTSVILLE RD HIS, IN 47143		
(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)	(X5) COMPLETION DATE	
	accessible, condufacility-based functional exercise functional exercise emergency event. (ii) Conduct an activate may include, following: (A) A second full-community-based functional exercise functional exercise functional exercise functional exercise functional exercise (B) A mock disassing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the himaintain documer exercises, and emithe hospice's emergency sementics.	nunity-based exercise is not ct an annual individual ctional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required aity based or facility-based at following the onset of the dditional annual exercise but is not limited to the scale exercise that is or a facility based a; or ter drill; or ercise or workshop led by a audes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared at to challenge an ospice's response to and intation of all drills, tabletop nergency events and revise argency plan, as needed.				
	§482.15(d), CAHs (2) Testing. The [Foundard exercises plan twice per year CAH] must do the (i) Participate in a that is community.	PRTF, Hospital, CAH] must to test the emergency ar. The [PRTF, Hospital, following:				

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Event ID:

I1RX21

Facility ID: 000723

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		15G193	B. WING		02/21/2024	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
				BENNETTSVILLE RD		
RES CAF	≺E COMMUNITY A 	LTERNATIVES SE IN	MEMF	PHIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	RIATE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ct an annual individual,				
	1	tional exercise; or				
	. , -	Hospital, CAH] experiences				
		or man-made emergency				
	-	ation of the emergency				
		s exempt from engaging in				
	1	ull-scale community based				
		ty-based functional exercise				
	_	et of the emergency event.				
	· '	an [additional] annual				
		at may include, but is not				
	limited to the following:					
	(A) A second full-scale exercise that is					
	community-based or individual, a facility-based functional exercise; or					
	1					
	, ,	ck disaster drill; or				
		exercise or workshop that				
	1	or and includes a group				
	discussion, using					
	I -	emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er					
	. , , .	ne [facility's] response to umentation of all drills,				
	•	s, and emergency events				
	needed.	cility's] emergency plan, as				
	niceucu.					
	*[For PACE at §46	60.84(d):]				
		ACE organization must				
	1 ' '	to test the emergency				
	plan at least annu	5				
	organization must	-				
	1 -	n annual full-scale exercise				
	that is community					
		nunity-based exercise is not				
	` '	ct an annual individual,				
	facility-based fund					
	1	periences an actual natural				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G193		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/21/2024	
NAME OF	PROVIDER OR SUPPLIE	8			DDRESS, CITY, STATE, ZIP COD BENNETTSVILLE RD		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	IIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	i e	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		ergency that requires emergency plan, the PACE					
		ngaging in its next required					
		nity based or individual,					
		ctional exercise following the					
	onset of the emer	_					
		an additional exercise every					
	2 years opposite	the year the full-scale or					
	functional exercis	e under paragraph (d)(2)(i)					
	of this section is of	conducted that may include,					
	but is not limited to the following:						
	(A) A second full-scale exercise that is						
	community-based or individual, a facility						
	based functional exercise; or						
	(B) A mock disaster drill; or (C) A tabletop exercise or workshop that is						
		and includes a group					
	discussion, using						
		emergency scenario, and a					
	1	atements, directed					
		pared questions designed					
	to challenge an e						
	_	PACE's response to and					
	maintain docume	ntation of all drills, tabletop					
	exercises, and en	nergency events and revise					
	the PACE's emer	gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):]					
		ity] must conduct exercises					
	_	ency plan at least twice per					
		announced staff drills using					
	1 .	ocedures. The [LTC facility,					
	ICF/IID] must do t	_					
		an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
		uct an annual individual,					
	facility-based fund						
		cility] facility experiences an					
	actual natural of f	man-made emergency that					1

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G193		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/21/2024		
		ROVIDER OR SUPPLIER	LTERNATIVES SE IN		13711 E	NDDRESS, CITY, STATE, ZIP COD BENNETTSVILLE RD HIS, IN 47143		
	(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
		LTC facility is exercived a full-scalindividual, facility-following the onset (ii) Conduct an act that may include, following: (A) A second full-community-based based functional of (B) A mock disast (C) A tabletop excled by a facilitator discussion, using clinically-relevant set of problem staling messages, or prepto challenge an er (iii) Analyze the [Li response to and nall drills, tabletop of events, and revise emergency plan, at (2) Testing. The IC exercises to test the twice per year. The following: (i) Participate in an that is community. (A) When a community. (A) When a community accessible, conduted facility-based function of the exercise is exempt from entire that is exempt f	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 e the [LTC facility] facility's as needed. [483.475(d)]: DF/IID must conduct the emergency plan at least e ICF/IID must do the					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G193		· ′	LDING	NSTRUCTION	(X3) DATE COMPI 02/21		
	DF PROVIDER OR SUPPLIE			13711 B	DDRESS, CITY, STATE, ZIP COD		
RES (CARE COMMUNITY A	ALTERNATIVES SE IN		MEMPH	IIS, IN 47143		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX CROSS-REFERENCED TO THE APPROPI TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		ON D BE DPRIATE	(X5) COMPLETION
TAG	facility-based fundonset of the emer (ii) Conduct an act that may include, following: (A) A second full-community-based facility-based fund (B) A mock disast (C) A tabletop excled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an etii) Analyze the IC maintain docume exercises, and enthe ICF/IID's emer *[For HHAs at §44 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the Henatural or man-mactivation of the exempt from engatull-scale community-scale communi	dditional annual exercise but is not limited to the scale exercise that is d or an individual, ctional exercise; or ter drill; or ercise or workshop that is r and includes a group a narrated, emergency scenario, and a atements, directed epared questions designed mergency plan. CF/IID's response to and ntation of all drills, tabletop mergency events, and revise ergency plan, as needed. 84.102] the HHA must conduct the emergency plan at the HHA must do the a full-scale exercise that is d; or community-based exercise conduct an annual -based functional exercise that experiences an actual adde emergency that requires emergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the		TAG	DEFICIENCY		DATE

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Facility ID: 000723

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

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G193		A. BUILDING B. WING	COMPLETED 02/21/2024	
NAME OF 1	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COD	
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		BENNETTSVILLE RD HIS, IN 47143	
(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)	
TAG	 	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCT!	DATE
		e year the full-scale or e under paragraph (d)(2)(i)			
	of this section is c				
		limited to the following:			
		full-scale exercise that is			
	community-based				
		ctional exercise; or			
		isaster drill; or			
	(C) A tabletor	exercise or workshop that			
	is led by a facilitat	or and includes a group			
	discussion, using				
clinically-relevant emergency scenario, and a					
	set of problem statements, directed				
	messages, or prepared questions designed				
	to challenge an er				
		HA's response to and nation of all drills, tabletop			
		nergency events, and revise			
		ency plan, as needed.			
	*[For OPOs at §48	86 3601			
	-	e OPO must conduct			
		he emergency plan. The			
	OPO must do the				
		er-based, tabletop exercise			
		ast annually. A tabletop			
	exercise is led by	a facilitator and includes a			
	group discussion,	using a narrated, clinically			
	_	cy scenario, and a set of			
	l '	nts, directed messages, or			
	l ' ' '	ns designed to challenge an			
		If the OPO experiences an			
		nan-made emergency that			
		n of the emergency plan, the om engaging in its next			
	· ·	xercise following the onset			
	of the emergency	_			
		PO's response to and			
		ntation of all tabletop			
		nergency events, and revise			
	1		1		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED			ETED	
		15G193	B. WI	NG		02/21/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			BENNETTSVILLE RD		
RES CARE COMMUNITY ALTERNATIVES SE IN				HIS, IN 47143			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	OPO's] emergency plan, as					
	needed.						
	*[RNCHIs at §403						
		e RNHCI must conduct					
		he emergency plan. The					
	RNHCI must do th						
	l ','	er-based, tabletop exercise A tabletop exercise is a					
		led by a facilitator, using a					
		r-relevant emergency					
		et of problem statements,					
		s, or prepared questions					
	_	enge an emergency plan.					
	_	NHCI's response to and					
		ntation of all tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
	Based on record rev	view and interview, the facility	E 00)39	1 The administrator will en	sure	03/05/2024
	failed to conduct ex	ercises to test the emergency			the participation in a full-scale		
		er year. The ICF/IID facility			community based exercise and	d a	
	must do the followi				table top exercise is present ir	the	
		annual full-scale exercise that			EPP manual.		
	is community-based				2 A full scale community		
		ity-based exercise is not			based drill The Great Shake o		
		an annual individual,			on Thursday the 19th of Octob		
	facility-based funct				2023 a second tabletop exerci	se	
		cility experiences an actual			was complete on January 30,		
		e emergency that requires			2024.		
		nergency plan, the ICF/IID			3 The area supervisor and		
		om engaging its next required ty-based or individual,			program manager will ensure documentation of the table top		
		cale functional exercise for 1			exercise and the community	,	
	1	onset of the actual event.			based exercise are present in	the	
		itional exercise that may			Emergency Disaster	u IC	
	` '	imited to the following:			Preparedness Manual for		
	a. A second full-sca	C			reference as needed. The		
		or an individual, facility-based			associate executive director w	ill	
	functional exercise.				review the training documenta		
	h A mock disaster		1		to ensure it has been complete		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I1RX21

Facility ID: 000723

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f í		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G193	A. BUILDING COMPLETED B. WING 02/21/2024			
		136 193			02/21/2024	
NAME OF P	PROVIDER OR SUPPLIER	Ł		ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		BENNETTSVILLE RD HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
TAG		se or workshop that is led by a	IAG	and is present. The safety	DATE	
	_	des a group discussion led by		committee will review and upo	late	
		narrated, clinically-relevant		annually as needed.		
	_	o, and a set of problem		4 This information is locate	ed in	
	statements, directed	l messages, or prepared		section 22 of the Emergency		
	questions designed	to challenge an emergency		Disaster Preparedness Manua	al	
	plan.			5 Dated Documentation w	ill be	
		F/IID facility's response to and		provided showing the complet	tion	
		ation of all drills, tabletop		of a tabletop exercise		
	· ·	gency events, and revise the		6 The AED will in service	the	
	_	mergency plan, as needed in		Program Manager, Area		
		CFR 483.475(d)(2). This		Supervisor and Residential		
	deficient practice co	ould affect all occupants.		Manager on the requirement		
	T' 1' ' 1 1			conducting an annual commu	•	
	Findings include:			based exercise and maintaini	ng	
	D1	·· 10.00		documentation.		
		view on 02/21/2024 from 10:00 th the Maintenance Manager		7 All supervisory staff	ille	
		sor, the facility failed to		responsible for maintaining dr will be retrained to ensure each		
	_	tion of annual exercises in the		group home is completing the		
	-	community-based exercise and		drills per LSC. Ongoing monit		
		exercise, mock disaster drill, or		will be achieved by the Quality	-	
		op. Based on interview at the		Assurance Department	'	
	-	ew, the House Supervisor		maintaining a tracking		
		nave emergency preparedness		spreadsheet to ensure all drill	s are	
	exercises.			completed per the calendar.		
	This finding was re	viewed with the Maintenance		Persons Responsible: AED,		
	Manager and House	e Supervisor during the exit		Program Manager, Area		
	conference.			Supervisor, and Residential		
				Manager, DSP Quality		
				Assurance.		
K 0000						
IV 0000						
Bldg. 02						
g. v_	A Life Safety Code	Recertification Survey was	K 0000			
	-	diana Department of Health in	12 0000			
	accordance with 42	-				
		~ /				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G193		ì í	ILDING	nstruction 02	(X3) DATE : COMPL 02/21 /	ETED	
	ROVIDER OR SUPPLIER	TERNATIVES SE IN		13711 B	DDRESS, CITY, STATE, ZIP COD BENNETTSVILLE RD IIS, IN 47143		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION /2024		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Community Alternated compliance with Remark Medicaid, 42 CFR Strom Fire and the 20 Protection Associated (LSC), Chapted Board and Care Occurred This one story facility has a fire ala alarm boxes, sprink alarms hard wired to facility has interconpowered from the binstalled in corridor areas. The facility his kitchen and attic. The and had a census of	200732 15G193 234760 Code survey, Res Care tives SE In was found not in equirements for Participation in Subpart 483.470(j), Life Safety 2012 edition of the National Fire ion (NFPA) 101, Life Safety er 33, Existing Residential					
	Approaches to Life facility Slow with a						
K S338 Bldg. 02	interior wall and co	Ceiling Finish Ceiling Finish					

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Event ID:

I1RX21

Facility ID: 000723

If continuation sheet

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ì ′		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 02 COMPLETED B. WING 02/21/2024				
		15G193	B. W	ING		02/21/	2024
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	_		ADDRESS, CITY, STATE, ZIP COD		
					BENNETTSVILLE RD		
RES CAF	≺E COMMUNITY A ·	LTERNATIVES SE IN		MEMPI	HIS, IN 47143		
(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
	permitted. There a interior floor finish	are no requirements for					
	33.2.3.3.2, 33.2.3						
		on and interview, the facility	l _K s	3338	The administrator will		03/15/2024
		interior finish in 1 of 1 living	IX	5550	ensure interior wall and ceiling	r	03/13/2024
		throoms was rated in			finish materials comply with	,	
		.2.3.3.2. LSC 33.2.3.3.2 requires			Section 10.2 providing a Class	s A	
		iling finish materials comply			or Class B materials in		
	with Section 10.2 p	roviding a Class A or Class B			accordance with 33.2.3.3.2. L	sc	
		for this slow facility. This			33.2.3.3.2		
	deficient practice co	ould affect all clients and staff.			The Maintenance Mana	_	
					will verify compliance of interior		
	Findings include:				wall and ceiling finish material		
					with manufacture for living roo	om	
		on with the Maintenance			and bathrooms to obtain		
		our of the home on 02/21/2024			verification of compliance.		
		nd 2:00 PM, wood paneling			If wall and ceiling materi		
		half of the walls in the living			compliance cannot be verified		
		neling covered the bottom half bathrooms. Based on			documented existing wall and		
		e of observation, the			ceiling material will be remove and replaced with Class A or	;u	
		ger acknowledged the			Class B materials in accordan	CE	
		ndition and confirmed there			with 33.2.3.3.2. LSC 33.2.3.3.		
		ion available to show the			no later than 15MAR2024.	۷.	
		paneling or plastic paneling			Verification of Class A o	r	
		or B flame spread rating.			Class B materials in accordan		
	_				with 33.2.3.3.2. LSC 33.2.3.3.		
	This finding was re	viewed with the Maintenance			will be verified by the Program	า	
	_	e Supervisor during the exit			Manager.		
	conference.				A member of the		
					Administrative team will condu		
					monthly site reviews for all clie		
					in facility and the administrato	r will	
					hold a weekly ICF meeting to		
					discuss issues that arise in the	е	
					facility.		
					Persons Responsible: AED,		
					Maintenance Manager, Progra	am	

03/05/2024 PRINTED: FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>02</u>	COMPLETED	
		15G193	B. WING		02/21/2024	
NAME OF I	PROVIDER OR SUPPLIER	}	STREET	ADDRESS, CITY, STATE, ZIP COD		
				BENNETTSVILLE RD		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN	MEMP	HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				Manager, Area Supervisor, and		
				Residential Manager, DSP, DS	L,	
				Quality Assurance.		
K S346	NFPA 101					
N 3340	Fire Alarm Systen	o Out of Sorvice				
Bldg. 02	Fire Alarm System					
Diag. 02	2012 EXISTING (
	,	fire alarm system is out of				
	•	han four hours in a 24-hour				
		ity having jurisdiction shall				
	•	e building shall be				
		approved fire watch shall be				
		irties left unprotected by the				
	shutdown until the fire alarm system has					
	been returned to s	-				
	33.2.3.4.1, 9.6.1.3	3, 9.6.1.5, 9.6.1.6				
		review and interview, the	K S346	The administrator will	03/05/2024	
	facility failed to pro	ovide a complete written fire		ensure when the fire alarm syst	em	
	watch policy for wh	nen the fire alarm system is out		is out of service for more than f	our	
	of service for more	than 4 hours in a 24-hour		hours in a 24-hour period, the		
	period. This deficie	ent practice affects all clients,		authority having jurisdiction sha	ıll	
	staff and visitors.			be notified, and the building sha		
				be evacuated or an approved fi	re	
	Findings include:			watch shall be provided for all		
		the state of the state of		parties left unprotected by the		
		view with the Maintenance		shutdown until the fire alarm		
	_	2024 10:00 AM and 1:40 PM, 2		system has been returned to		
	^	were reviewed. One fire watch		service		
		in an orange binder and one		The Fire Watch Policy will		
				be updated to include how ofter fire watch walk should be		
	-	tch in the information they				
	_	y in the black binder did not watch rounds should be		conducted and if it should be		
		icy in the orange binder stated		continuous. Staff will be retrained by t	he	
	-	hould be completed every 15		Area Supervisor on updated Fir		
		interview at the time of record		Watch Policy.		
		nance Manager acknowledged		A member of the		
	,			, , , , , , , , , , , , , , , , , , ,	1	

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the 2 fire watch policies did not match.

Event ID:

I1RX21

Facility ID: 000723

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Administrative team will conduct a monthly site reviews for all clients

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u> COMPLE			ETED	
		15G193	B. W	NG		02/21/	2024
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				BENNETTSVILLE RD		
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN			HIS, IN 47143		
ı					,		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		review and interview, the			in facility and the administrator	will	
	•	vide a complete written fire			hold a weekly ICF meeting to		
		en the fire alarm system is out			discuss issues that arise in the)	
		than 4 hours in a 24-hour			facility.		
	-	ent practice affects all clients,					
	staff and visitors.						
	Findings include:				Dorgona Bognangible: AED		
	rindings include.				Persons Responsible: AED, Maintenance Manager, Progra	m	
	Based on record rev	riew with the Maintenance			Manager, Area Supervisor, an		
		2024 between 10:00 AM and			Residential Manager, DSP, DS		
	_	atch policy in the black binder			Quality Assurance.	JL,	
		ten a fire watch walk should			Quality / todarance.		
		t should be continuous Based					
		time of record review, the					
		ger acknowledged the fire					
	_	black binder did not indicate					
		tch walk should occur.					
	This finding was rev	viewed with the Maintenance					
	Manager and House	Supervisor during the exit					
	conference.						
K S353	NFPA 101						
	•	- Maintenance and Testing					
Bldg. 02		- Maintenance and Testing					
	2012 EXISTING (F						
	NFPA 13 and 13R	_					
		ns installed in accordance					
		andard for the Installation of					
		, and NFPA 13R, Standard					
		of Sprinkler Systems in					
	-	pancies Up To and Including					
		ight, are inspected, tested					
		accordance with NFPA 25,					
	Standard for Inspe						
		ater Based Fire Protection					
	System.						
	NFPA 13D System						
	oprinkier systems	installed in accordance	1				

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Event ID: I1RX21

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i '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 02 COMPLETED B. WING 02/21/2024				
		15G193	B. WING		02/21/2024		
NAME OF I	DDOMINED OD GUIDDI TER)	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	·		13711 E	BENNETTSVILLE RD		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Standard for the Installation					
		ms in One- and Two-Family					
	-	nufactured Homes, are					
	inspected, tested						
	NFPA 25:	he following requirements of					
	_	s inspected monthly (NFPA					
	25, section 13.3.2	•					
	2. Gauges inspe	ected monthly (NFPA 25,					
	section 13.2.71).						
		s inspected quarterly					
	(NFPA 25, section	•					
		s tested semiannually					
	(NFPA 25, section	•					
		isory switches tested					
		PA 25, section 13.3.3.5).					
		lers inspected annually					
	((NFPA 25, sectio	•					
		nspected annually (NFPA					
	25, section 5.2.2).						
		angers inspected annually					
	(NFPA 25, section	•					
		pected annually prior to					
	_	for adequate heat for water					
		A 25, section 5.2.5). ative sample of fast					
		rs are tested at 20 years					
	(NFPA 25, section	=					
		ative sample of dry pendant					
		ed at 10 years (NFPA 25,					
	section 5.3.1.1.15	- · · · · · · · · · · · · · · · · · · ·					
		olutions are tested annually					
	(NFPA 25, section	-					
	1 '	es are operated through					
		d returned to normal					
	_	5, section 13.3.3.1).					
	- '	tems of OS&Y valves are					
		y (NFPA 25, section					
	13.3.4).	-,					
	· · · · · · · · · · · · · · · · · · ·	stems extending into					

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Event ID: I1RX21

Facility ID: 000723

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u> COMPLETED B. WING 02/21/2024			LETED	
		15G193	B. W	ING		02/21	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEI	R		13711 I	BENNETTSVILLE RD		
RES CARE COMMUNITY ALTERNATIVES SE IN		LTERNATIVES SE IN		MEMPI	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	BEFEIENCT		DATE
	•	s of the building are and maintained (NFPA 25,					
	section 13.4.4).	and maintained (NFFA 25,					
		system last checked and					
	necessary mainte	-					
	1	•					
	B. Show who prov	vided the service.					
	C. Note the source	ee of the water supply for the					
	automatic sprinkle						
	l '	ARKS information on					
		non-required or partial					
	automatic sprinkle						
		5.5.8, 9.7.5, 9.7.7, 9.7.8,					
	and NFPA 25	on and interview, the facility	KS	252	1 The administrator will er	neuro	04/01/2024
		of over 10 sprinkler heads in the	KS	333	monthly sprinkler gauge	isuie	04/01/2024
		ained. NFPA 13 and 13R			inspections and monthly conti	rol	
		prinkler systems installed in			valve inspections are conduct		
	_	FPA 13, Standard for the			by the ResCare maintenance		
	Installation of Sprin	nkler Systems, and NFPA 13R,			coordinator and is clearly		
	Standard for the Ins	stallation of Sprinkler Systems			documented on the control va	lve	
		pancies Up To and Including			and gauge inspection tags. F	roof	
		ght, are inspected, tested and			of the inspections will be avai	lable	
		rdance with NFPA 25, Standard			in the facility for review.		
	_	ting and Maintenance of Water			2 The Maintenance Mana	ger	
		on System. This deficient			contacted Koorsen Fire and		
	facility.	et all clients and staff in the			Security to have the right		
	lacinty.				bathroom sprinkler and escutcheon plate replaced.		
	Findings include:				3 The sprinkler head and		
	_ mamgs morade.				escutcheon plate will be repla	ced	
	Based on observati	on with the Maintenance			no later than April 1, 2024.		
	Manager during a t	our of the facility from 1:40 PM			4 The program manager v	vill	
		21/2024, the sprinkler in the right			inspect work and report any		
	bathroom had rust				issues or delay to the Associa	ite	
	_	rinkler head. Based on			Executive Director immediate	-	
		ne of observation, the			1.A random monthly site rev		
	Maintenance Mana	ger acknowledged the			will be completed by a member	er of	1

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Event ID:

I1RX21

Facility ID: 000723

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		15G193	B. WING 02/21/2024				
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN		13711 E	ADDRESS, CITY, STATE, ZIP COD BENNETTSVILLE RD HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUDERS N. AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	_	inkler rust and corrosion and in a work order to get it			ResCare's Administrative team ensure compliance.	n to	
	_	viewed with the Maintenance e Supervisor during the exit			Persons Responsible: AED, Maintenance Manager, Progra Manager, ResCare Maintenan Area Supervisor, DSL, DSP		
K S354	NFPA 101						
Bldg. 02	Sprinkler System - Out of Service		KS	354	The Fire Watch Policy w be updated to include how ofte		
	service for more that	atic sprinkler system is out of an 10 hours in a 24-hour period. ice affects all clients, staff and			fire watch walk should be conducted and if it should be continuous. Staff will be retrained by Area Supervisor on updated F Watch Policy. A member of the		
	Manager on 02/21/2 fire watch policies v policy was located in a bla policies did not mat provided. The polic state how often fire	view with the Maintenance 2024 10:00 AM and 1:40 PM, 2 were reviewed. One fire watch in an orange binder and one ck binder. The fire watch ich in the information they y in the black binder did not watch rounds should be			Administrative team will condumonthly site reviews for all clie in facility and the administrator hold a weekly ICF meeting to discuss issues that arise in the facility Persons Responsible: AED, Maintenance Manager, Progra	ents r will	

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Event ID: 11RX21

Facility ID: 000723

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

PRINTED: 03/05/2024 FORM APPROVED OMB NO. 0938-039

r í		l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
		15G193	B. W	B. WING			/2024
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			13711 E	ADDRESS, CITY, STATE, ZIP COD BENNETTSVILLE RD HIS, IN 47143			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF fire watch rounds si minutes. Based on i review, the Mainter the 2 fire watch pol 2. Based on record facility failed to pro for when the autom service for more tha This deficient pract visitors. Findings include: Based on record rev Manager on 02/21// 1:40 PM, the fire w did not note how of should be conducte Based on interview the Maintenance M watch policy in the how often a fire wa	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION could be completed every 15 conterview at the time of record contained Manager acknowledged		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Manager, Area Supervisor, an Residential Manager, DSP, Di Quality Assurance.	nd	(X5) COMPLETION DATE

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