DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & ME

483.475.

accordance with 42 CFR 483.475.

At this Emergency Preparedness 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

The facility has 8 certified beds. At the time of the

The requirement at 42 CFR, Subpart 483.475 is

403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2),

483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)

§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)

Quality Review completed on 01/02/24

Survey Date: 12/20/23

Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810

survey, the census was 8.

NOT MET as evidenced by:

EP Testing Requirements

(2), §491.12(d)(2), §494.62(d)(2).

E 0000

Bldg. --

NTERS FOR	R MEDICARE & MEDIC	AID SERVICES				ОМ	B NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	· /	JILDING	LDING		X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	-	2401 C	ADDRESS, CITY, STATE, ZIP COD ORNWELL DR RSONVILLE, IN 47130	-		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
0000 Ildg		paredness Survey was Idiana Department of Health in	E 00	000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE AED

(X6) DATE 01/15/2024

Mark Slaughter

E 0039

Bldg. --

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

X1) PROVIDER/SUPPLIER/CLIA	ì, î		ISTRUCTION	. ,	OMB NO. 0938-039 DATE SURVEY OMPLETED
15G247					2/20/2023
	•	2401 CO	RNWELL DR		
		L	SONVILLE, IN 47	130	
TATEMENT OF DEFICIENCIE		ID			(X5)
			CROSS-REFERENCED TO THE APPROPRIATE		COMPLETIO
LSC IDENTIFYING INFORMATION 6.54, CORFs at §485.68, ns" under §485.727, 20, RHCs/FQHCs at D Facilities at §494.62]: acility] must conduct ace emergency plan lity] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is nduct a facility-based every 2 years; or ity] experiences an actual de emergency that requires nergency plan, the [facility] gaging in its next required or individual, facility-based e following the onset of the ditional exercise at least osite the year the full-scale ise under paragraph (d)(2) oconducted, that may imited to the following: cale exercise that is or individual, facility-based c) or er drill; or rcise or workshop that is and includes a group narrated, emergency scenario, and a ements, directed ared questions designed		IAG			DATE
	IDENTIFICATION NUMBER 15G247 TERNATIVES SE IN TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 6.54, CORFs at §485.68, ns" under §485.727, 20, RHCs/FQHCs at D Facilities at §494.62]: acility] must conduct the emergency plan lity] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is nduct a facility-based every 2 years; or ity] experiences an actual de emergency that requires nergency plan, the [facility] gaging in its next required or individual, facility-based following the onset of the litional exercise at least osite the year the full-scale ise under paragraph (d)(2) conducted, that may imited to the following: cale exercise that is or individual, facility-based ; or er drill; or rcise or workshop that is and includes a group narrated, emergency scenario, and a ements, directed ared questions designed	X1) PROVIDER/SUPPLIER/CLIA X2) MU IDENTIFICATION NUMBER A. BU 15G247 B. WI TERNATIVES SE IN TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION 3.54, CORFs at §485.68, ns" under §485.727, 20, RHCs/FQHCs at D D Facilities at §494.62]: acility] must conduct acility] must conduct acility-based e emergency plan bity] must do all of the full-scale exercise that is every 2 years; or nunity-based exercise is nuct a facility-based every 2 years; or requires nergency plan, the [facility] jaging in its next requires nergency plan, the [facility] jaging in its next requires nergency plan, the [facility] jaging in its next required or individual, facility-based following the onset of the litional exercise at least osite the year the full-scale ise under paragraph (d)(2) conducted, that may imited to the following: cale exercise that is or individual, facility-based ; or ; or recept cale is a group nararated, group	X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CON IDENTIFICATION NUMBER A. BUILDING 15G247 B. WING STREET AI 2401 CC JEFFER TATEMENT OF DEFICIENCIE ID PREFIX TAG 5.54, CORFs at §485.68, TAG 5.54, CORFs at §485.727, Z0, RHCs/FQHCs at D Facilities at §494.62]: D acility] must conduct ee emergency plan iity] must do all of the full-scale exercise is full-scale exercise that is every 2 years; or ivy] experiences an actual de emergency plan, the [facility] jaging in its next requires nergency plan, the [facility] nergency plan, the [facility] jaging in its next requires nergency plan, the [facility] jaging in its next requires nergency plan, the facility-based following the onset of the ditional exercise at least osite the year the full-scale ise under paragraph (d)(2) conducted, that may imited to the following: cale exercise that is or individual, facility-based ; or ; or r drill; or ;	X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING	X1) PROVIDERSUPPLIERCLIA X2) MULTIPLE CONSTRUCTION X3) I DENTIFICATION NUMBER A BUILDING

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIR			(X3) DATE SURVEY COMPLETED 12/20/2023		
	PROVIDER OR SUPPLI	R ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 2401 CORNWELL DR JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY)		OULD BE	(X5) COMPLETIC DATE		
		mergency events, and revise ergency plan, as needed.						
	the patient's hon conduct exercise plan at least ann the following: (i) Participate in community base (A) When a com accessible, cond based functional (B) If the hospice man-made emer of the emergenc exempt from eng scale community facility-based fur onset of the emergenc (ii) Conduct an a years, opposite t functional exerci of this section is include, but is no (A) A second ful community-base functional exerci (B) A mock disa (C) A tabletop e led by a facilitato discussion using	ospices that provide care in the. The hospice must as to test the emergency ually. The hospice must do a full-scale exercise that is d every 2 years; or munity based exercise is not uct an individual facility exercise every 2 years; or e experiences a natural or gency that requires activation y plan, the hospital is paging in its next required full based exercise or individual actional exercise following the argency event. additional exercise every 2 he year the full-scale or se under paragraph (d)(2)(i) conducted, that may at limited to the following: I-scale exercise that is d or a facility based se; or ster drill; or xercise or workshop that is or and includes a group						
		atements, directed epared questions designed emergency plan.						
		ospices that provide inpatient e hospice must conduct						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP			(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	24	REET ADDRESS, C 01 CORNWEL FFERSONVILI	LDR		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)		EFERENCED TO THE APPROF	BE	(X5) COMPLETIC DATE
	per year. The ho (i) Participate in that is communit (A) When a com accessible, cond facility-based fur (B) If the hospice man-made emer of the emergency exempt from eng full-scale commu- functional exerci- emergency even (ii) Conduct an a that may include following: (A) A second ful community-base functional exerci- (B) A mock disa (C) A tabletop e facilitator that ind using a narrated emergency scen statements, dired questions design emergency plan. (iii) Analyze the maintain docume exercises, and e the hospice's em *[For PRFTs at § §482.15(d), CAH (2) Testing. The conduct exercise	munity-based exercise is not uct an annual individual actional exercise; or e experiences a natural or gency that requires activation y plan, the hospice is aging in its next required unity based or facility-based se following the onset of the t. additional annual exercise , but is not limited to the I-scale exercise that is d or a facility based se; or ster drill; or xercise or workshop led by a cludes a group discussion , clinically-relevant ario, and a set of problem cted messages, or prepared ued to challenge an hospice's response to and entation of all drills, tabletop mergency events and revise ergency plan, as needed. e441.184(d), Hospitals at s at §485.625(d):] [PRTF, Hospital, CAH] must es to test the emergency ear. The [PRTF, Hospital,					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247		A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLI	R ALTERNATIVES SE IN	2401 CORNWELL DR JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
	that is communit (A) When a com accessible, cond facility-based fur (B) If the [PRTF, an actual natura that requires act plan, the [facility its next required or individual, fac following the ons (ii) Conduc exercise or and limited to the foll (A) A second fu community-based facility-based fur (B) A m (C) A tableto is led by a facilit: discussion, using clinically-relevan set of problem s messages, or pr to challenge an (iii) Analyze and maintain do tabletop exercise and revise the [f needed. *[For PACE at § (2) Testing. The conduct exercise plan at least ann organization mu (i) Participate in that is communit	munity-based exercise is not luct an annual individual, actional exercise; or Hospital, CAH] experiences or man-made emergency vation of the emergency is exempt from engaging in full-scale community based lity-based functional exercise set of the emergency event. an [additional] annual that may include, but is not owing: I-scale exercise that is d or individual, a actional exercise; or lock disaster drill; or op exercise or workshop that ator and includes a group g a narrated, t emergency scenario, and a tatements, directed epared questions designed emergency plan. the [facility's] response to cumentation of all drills, es, and emergency events acility's] emergency plan, as 460.84(d):] PACE organization must es to test the emergency ually. The PACE st do the following: an annual full-scale exercise						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	ISTRUCTION	(X3) I	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		C	OMPLETED	
		15G247	B. WI	NG		1	2/20/2023	
NAME OF I	PROVIDER OR SUPPLIEF	2		STREET AI	DDRESS, CITY, STA	TE, ZIP COD		
					RNWELL DR			
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	SONVILLE, IN 4	7130		
X4) ID		STATEMENT OF DEFICIENCIE		ID		AN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCE	ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	COMPLETIC	
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFIC	LIENCT	DATE	
		ct an annual individual,						
	-	tional exercise; or						
	• •	xperiences an actual natural						
		ergency that requires						
		mergency plan, the PACE						
		gaging in its next required						
		nity based or individual,						
	facility-based fund	tional exercise following the						
	onset of the emer	gency event.						
	(ii) Conduct a	n additional exercise every						
	2 years opposite t	he year the full-scale or						
	functional exercise	e under paragraph (d)(2)(i)						
	of this section is o	onducted that may include,						
	but is not limited t	o the following:						
	(A) A second full-	scale exercise that is						
	• •	or individual, a facility						
	based functional e	-						
	(B) A mock disas							
		ercise or workshop that is						
		and includes a group						
	discussion, using							
	-	emergency scenario, and a						
	set of problem sta							
	-	pared questions designed						
	to challenge an er							
	-	PACE's response to and						
	•	ntation of all drills, tabletop						
		nergency events and revise						
		gency plan, as needed.						
		+ \$400.70(-1)-1						
	*[For LTC Facilitie							
	• •	ty] must conduct exercises						
	-	ency plan at least twice per						
		announced staff drills using						
		ocedures. The [LTC facility,						
	ICF/IID] must do t	-						
	• •	an annual full-scale exercise						
	that is community							
		nunity-based exercise is not						
	Laccessible condu	ct an annual individual,	1					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER 15G247	A. BUILDING B. WING	<u></u>	_	COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	2401	T ADDRESS, CITY, STATE, ZIP CORNWELL DR ERSONVILLE, IN 47130	COD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
	actual natural or n requires activation LTC facility is exer- required a full-sca- individual, facility- following the onse- (ii) Conduct an a- that may include, following: (A) A second full- community-based based functional a- (B) A mock disas (C) A tabletop ex- led by a facilitator discussion, using clinically-relevant set of problem sta- messages, or pre- to challenge an e- (iii) Analyze the [response to and r all drills, tabletop events, and revise emergency plan, *[For ICF/IIDs at 8 (2) Testing. The I exercises to test fi twice per year. Th following: (i) Participate in a that is community (A) When a comm accessible, condu- facility-based func- (B) If the ICF/IID	cility] facility experiences an man-made emergency that in of the emergency plan, the empt from engaging its next ale community-based or based functional exercise et of the emergency event. dditional annual exercise but is not limited to the -scale exercise that is d or an individual, facility exercise; or ster drill; or tercise or workshop that is includes a group a narrated, emergency scenario, and a atements, 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)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the an annual full-scale exercise					

OMB NO. 0938-039

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		со	(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIEI RE COMMUNITY A	LTERNATIVES SE IN	-	2401 CC	DDRESS, CITY, STATE, ZI DRNWELL DR SONVILLE, IN 47130		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO	N SHOULD BE	(X5) COMPLETIO
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO TH DEFICIENCY		DATE
	is exempt from en full-scale commun facility-based fund onset of the emer (ii) Conduct an ad that may include, following: (A) A second full- community-based facility-based fund (B) A mock disast (C) A tabletop exe led by a facilitator discussion, using clinically-relevant set of problem sta messages, or pre to challenge an en (iii) Analyze the IC maintain documen exercises, and en the ICF/IID's eme *[For HHAs at §48 (d)(2) Testing. Th exercises to test t least annually. Th following: (i) Participate in a community-based (A) When a c is not accessible, individual, facility- every 2 years; or. (B) If the HH natural or man-ma activation of the en exempt from enga	ditional annual exercise but is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed bared questions designed mergency plan. CF/IID's response to and ntation of all drills, tabletop mergency events, and revise rgency plan, as needed. CF4.102] e HHA must conduct he emergency plan at e HHA must do the full-scale exercise that is					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	15G247 B. WING			(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHU (CROSS-REFERENCED TO THE AF TAG DEFICIENCY)		HOULD BE	(X5) COMPLETIO DATE	
	onset of the eme (ii) Conduct an a years, opposite functional exerci- of this section is include, but is no (A) A secon community-based facility-based fun (B) A mock (C) A tablet is led by a facilit discussion, usin- clinically-relevar set of problem s messages, or pr to challenge an (iii) Analyze the maintain docum exercises, and et the HHA's emer *[For OPOs at § (d)(2) Testing. T exercises to test OPO must do th (i) Conduct a pa or workshop at le exercise is led b group discussion relevant emerge problem stateme prepared questic emergency plan actual natural or requires activatic OPO is exempt	dditional exercise every 2 the year the full-scale or se under paragraph (d)(2)(i) conducted, that may ot limited to the following: d full-scale exercise that is d or an individual, nctional exercise; or disaster drill; or op exercise or workshop that ator and includes a group g a narrated, t emergency scenario, and a tatements, directed epared questions designed emergency plan. HHA's response to and entation of all drills, tabletop mergency events, and revise gency plan, as needed. 486.360] he OPO must conduct the emergency plan. The e following: per-based, tabletop exercise east annually. A tabletop y a facilitator and includes a n, using a narrated, clinically ncy scenario, and a set of ents, directed messages, or ons designed to challenge an . If the OPO experiences an man-made emergency plan, the from engaging in its next exercise following the onset					

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AND PLAN (T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/20/2023		
	ROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	maintain docume exercises, and e the [RNHCI's and needed. *[RNCHIs at §40 (d)(2) Testing. Th exercises to test RNHCI must do (i) Conduct a par at least annually group discussion narrated, clinical scenario, and a s directed messag designed to chal (ii) Analyze the F maintain docume exercises, and e the RNHCI's eme Based on record ra failed to conduct a emergency plan of emergency proced do all of the follow full-scale exercise a. When a commu accessible, conduc facility-based fund b. If the ICF/IID f natural or man-ma activation of the e facility is exempt full-scale commur facility-based full- year following the (ii) Conduct an ad include, but is not	he RNHCI must conduct the emergency plan. The the following: ber-based, tabletop exercise . A tabletop exercise is a held by a facilitator, using a ly-relevant emergency set of problem statements, es, or prepared questions lenge an emergency plan. RNHCI's response to and entation of all tabletop mergency events, and revise ergency plan, as needed. eview and interview, the facility at least two exercises to test the n an annual basis using the lures. The ICF/IID facility must wing: (i) Participate in an annual that is community-based; or nity-based exercise is not et an annual individual,	E 0039	 E 039 EP Training Requirements: 1 The administrator will ensite participation in a full-scale community based exercise and table top exercise is present in EPP manual. 2 A full scale community based drill The Great Shake out on Thursday the 19th of Octobe 2023 a second tabletop exercise will be completed on January 2024. 3 The area supervisor and program manager will ensure documentation of the table top exercise and the community based exercise are present in the table top exercise and the community based exercise are present in the table top exercise and the community based exercise are present in the table top exercise are present in the table top exercise and the community based exercise are present in the table top exercise are present in the table tabl	l a the it er se 30,		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X: 	b) date survey completed 12/20/2023
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
RES CA	RE COMMUNITY	ALTERNATIVES SE IN		RSONVILLE, IN 47130	
(X4) ID PREFIX		Y 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 APPROPRIATE	(X5) COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		or an individual, facility-based		Emergency Disaster	
	functional exercise			Preparedness Manual for	
	b. A mock disaste	·		reference as needed. The	
	-	cise or workshop that is led by a		associate executive director will	
		ludes a group discussion led by		review the training documentatio	n
	-	a narrated, clinically-relevant		to ensure it has been completed	
		io, and a set of problem		and is present. The safety	
		ed messages, or prepared		committee will review and update	e
		d to challenge an emergency		annually as needed.	
	plan.			4 This information is located	in
	•	CF/IID facility's response to and		section 22 of the Emergency	
		tation of all drills, tabletop		Disaster Preparedness Manual	
		ergency events, and revise the		5 Dated Documentation will b	
		emergency plan, as needed in 2 CFR 483.475(d)(2).		provided showing the completion	
		ctice could affect all occupants.		of a tabletop exercise 6 The AED will in service the	
	This deficient pray	ence could affect all occupants.		6 The AED will in service the Program Manager, Area	
	Findings include:			Supervisor and Residential	
	i manigs merude.			Manager on the requirement of	
	Based on review of	of "Emergency/Disaster		conducting an annual community	,
		ual-Cornwell Drive"		based exercise and maintaining	
	-	ted 03/22/22 with the Program		documentation.	
		Iome Manager during record		7 All supervisory staff	
		5 a.m. to 12:30 p.m. on 12/20/23,		responsible for maintaining drills	
		at least two exercises		will be retrained to ensure each	
	conducted within	the most recent twelve month		group home is completing the	
	period to test the e	emergency plan using the		drills per LSC. Ongoing monitorin	ng
	emergency proceed	lures was not available for		will be achieved by the Quality	0
	review. Based on	interview at the time of record		Assurance Department	
	review, the Progra	m Director stated the facility		maintaining a tracking	
	just completed an	emergency preparedness		spreadsheet to ensure all drills a	re
	-	d the facility has not		completed per the calendar.	
	documented a con	nmunity based disaster drill,			
		hop or conducted a tabletop		Persons Responsible: AED,	
		e most recent twelve month		Program Manager, Area	
		testing documentation was not		Supervisor, and Residential	
	available for revie	w at the time of the survey.		Manager, DSP Quality Assurance.	
	These findings we Director during th	re reviewed with the Program e exit conference.			

PRINTED: 01/18/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 12/20/2023 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0000 Bldg. 01 A Life Safety Code Recertification Survey was K 0000 conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 12/20/23 Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810 At this Life Safety Code survey, Res Care Community Alternatives SE IN was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 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 building with a basement was non sprinklered. The facility has a fire alarm system with smoke detection on all levels in corridors and all in all living areas. The facility has battery operated smoke detectors installed 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 1.3. Quality Review completed on 01/02/24 K S100 **NFPA 101** General Requirements - Other Bldg. 01 General Requirements - Other Facility ID: 000769 Event ID: KMB621 Page 12 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULT A. BUILE B. WING	IPLE CONSTRUCTION DING <u>01</u>	СОМ	(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	2	TREET ADDRESS, CITY, STATE, ZIP C 401 CORNWELL DR EFFERSONVILLE, IN 47130	OD		
(X4) ID		STATEMENT OF DEFICIENCIE		D PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX		VCY MUST BE PRECEDED BY FULL		EFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	1	AG DEFICIENCY)		DATE	
	2012 EXISTING	2KS agation any LSC					
		RKS section any LSC 3.2 General Requirements					
		essed by the provided					
		eficient. This information,					
	-	plicable Life Safety Code or					
		itation, should be included					
	on Form CMS-25						
		ation and interview, the facility	K S10	0 K0100 General Requir	ements -	01/31/2024	
		f 2 smoke barrier doors which		Other:		01/01/202	
	were arranged to se	elf close or automatic close with			g will be tested		
	-	ctivation would resist the		1.The facility will ens			
	passage of smoke.	LSC Section 33.1.1.3 states the		emergency lighting will			
	provisions of Chap	ter 4, General, shall apply. LSC		monthly for a minimum			
	Section 4.6.12.4 re	quires any device, equipment,		seconds and an annua	l test of 90		
	system, condition,	arrangement, level of		minutes for all units in			
	protection, fire-resi	stive construction, or any		2.The Program Mana	ager will		
		ring periodic testing,		in-service the Maintena	ance		
		ation to ensure its maintenance		Manager on the inspec	tion and		
	-	bected, or operated as specified		documentation of mon	thly 30		
		A standards. This deficient		second duration test.			
	practice could affee	ct all clients, staff and visitors.		3.The Area Supervis in-service the facility st			
	Findings include:			ensuring smoke barrier remain free of and obs	r doors		
	Based on observati	ons with the Program Director		will prevent the smoke	barrier door		
		e facility from 12:30 p.m. to 1:00		from closing.			
	-	he smoke barrier door in the		4.Random monthly s			
	-	ld in the fully open position		will be conducted by a			
		d magnetic hold open device		ResCare's Administrat			
		fire alarm system activation but		ensure smoke barrier o			
		ed from swinging to self close		remain free from obsta			
		oor frame because a wheeled		would prevent them fro	om closing		
		stored up against the door to		properly.			
	-	closing. The door self closed					
		e door frame when the shelving		Persons Responsible			
		he door was tested to close.		Manager, Area Superv			
	Based on interview	rogram Director agreed the		Residential Manager, [
		would fail to self close and		Koorsen Fire and Secu	inty.		

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KMB621 Facility ID: 000769

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		A. BUILDING B. WING		Cor 12/	te survey Mpleted 20/2023
	PROVIDER OR SUPPLI RE COMMUNITY	ER ALTERNATIVES SE IN	240	EET ADDRESS, CITY, STAT 1 CORNWELL DR FERSONVILLE, IN 4		
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE O TO THE APPROPRIATE TENCY)	(X5) COMPLETIC DATE
		r frame with the tiered shelf				
	-	ere reviewed with the Program ae exit conference.				
	interview; the fac battery operated e was maintained in 7.9.3, Periodic Te Equipment, requi conducted for 30 an annual test to b battery powered e not less than a 1 ½ shall be fully oper test. Written reco tests shall be kept the authority havi practice could aff	d review, observation and ility failed to ensure 3 of 3 emergency lights in the facility accordance with LSC 7.9. LSC esting of Emergency Lighting res a functional test to be seconds at 30 day intervals and be conducted on every required emergency lighting system for 4 hour duration. Equipment rational for the duration of the ords of visual inspections and by the owner for inspection by ng jurisdiction. This deficient fect all clients, staff and visitors.				
	and the House Ma p.m. on 12/20/23, emergency light of recent twelve more review. Based or review, the Progra- battery operated ef for the most recent available for reviet the Program Direct from 12:30 p.m. to three battery oper noted in the facility	eview with the Program Director anager from 10:35 a.m. to 12:30 monthly battery operated locumentation for the most at period was not available for a interview at the time of record am Director agreed monthly emergency light documentation at twelve month period was not ew. Based on observations with ctor during a tour of the facility o 1:00 p.m. on 12/20/23, a total of ated emergency lights were ty and each battery operated when its respective test button				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247			A. BUILDING	01	COMPLETED
		B. WING		12/20/2023	
			STREE	T ADDRESS, CITY, STATE, ZIP C	OD
NAME OF I	PROVIDER OR SUPPLIE	R	2401	CORNWELL DR	
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN	JEFF	ERSONVILLE, IN 47130	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		xed a sticker to each light			
	-	nnual 90 minute testing was			
		3/23 but the contractor did not			
	document monthly	30 second duration testing.			
	These findings we	re reviewed with the Program			
	Director during the	e exit conference.			
K S253	NFPA 101				
	Number of Exits	- Patient Sleeping and			
Bldg. 01	Non-SI				
	Number of Exits	- Patient Sleeping and			
	Non-Sleeping Ro	oms			
	2012 EXISTING	(Prompt)			
	Every sleeping ro	oom and living area shall			
		primary means of escape			
		e a safe path of travel to the			
	outside.				
	Where sleeping r	ooms or living areas are			
		ne level of exit discharge, the			
	primary means o	f escape shall be an interior			
		ce with 33.2.2.4, an exterior			
	stair, a horizontal	exit, or a fire escape stair.			
	In addition to the	primary route, each			
		all have a second means of			
		ists of one of the following:			
		door, stairway, passage, or			
		ay of unobstructed travel to			
		dwelling at street or ground			
		pendent of and remotely			
		primary means of escape.			
		passage through an			
		able space, independent of			
	-	ated from the primary means			
	-	proved means of escape.			
		outside window or door			
		e inside without the use of			
		ecial effort that provides a			
		not less than 5.7 square			
		nall be not less than 20			
	LIGEL THE WILLING	1011 DC 1101 ICSS 111011 ZU			

OMB NO. 0938-039

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		2401 C	ADDRESS, CITY, STATE, ZII ORNWELL DR RSONVILLE, IN 47130		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETIO
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ht shall be not less than 24 om of the opening shall be					
	not more than 44	inches above the floor.					
	Such means of e	escape shall be acceptable					
		following criteria are met:					
		ow shall be within 20 feet of					
	finished ground I						
	-	ow shall be directly					
		e department rescue					
		proved by the authority					
	having jurisdictio						
		ow or door shall open onto					
	an exterior balco	-					
		ving a sill height below the					
		I ground level are that					
	-	-					
		vindow well meet the					
	following criteria:						
		ow well allows the window to					
	be fully openable						
		ow is not less than 9 square					
	-	and width of not less than					
	36 inches.						
		vell deeper than 43 inches					
		l, permanently affixed ladder					
		ng with the following:					
		dder or steps do not extend					
	more than 6 inch						
		dder or steps are not					
	obstructed by the						
		ng room has a door leading					
		tside of the building with					
		d ground level or to a					
		ets the requirements of					
		33.2.2.2.2, that means of					
		considered as meeting all					
		rements for the sleeping					
	room.	.					
		means of escape from each					
		nall not be required where the					
	facility is protected	ed throughout by approved					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA

CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-039	
(X3) DATE SURVEY	
COMPLETED	
10/00/0000	

	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		2401 C	address, city, state, zip cod ORNWELL DR RSONVILLE, IN 47130		
X4) ID	SUMMARY	Y 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 APPROPRIATE	COMPLET	l'ION
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		ler system in accordance					
	with 33.2.3.5.						
	-	pproved means of escape					
	-	d to continue to be used.					
		2.2, 33.2.2.3.1 through					
	33.2.2.3.4	ion and interview, the facility	K S	757	K0253: Number of Exits -Patier	ot 05/21/2	
		-	K S.	255		nt 05/31/2	.024
	failed to ensure 3 of 5 client sleeping rooms were provided with a secondary means of escape in accordance with 33.2.2.3. LSC Section 33.2.2.3 requires a secondary egress from each sleeping room with multiple provisions. This deficient practice could affect at least 3 clients.				Sleeping and Non-Sleeping Rooms.		
					1.The administrator will ensure		
					client sleeping rooms maintain a		
					secondary escape with multiple	1	
					provisions including windows		
					providing a clear with of eleven		
	Findings include:				inches when open and an		
	6				unobstructed secondary means	of	
	Based on observat	ions with the Program Director			escape in accordance with		
		e facility from 12:30 p.m. to 1:00			33.2.2.3.		
	-	the one window in the Bedroom			2.The Program Director will		
	-	ght of 24 inches and a width of			schedule repair/replacement of t	the	
	-	nimum clear width of 5.1 square			window with the ResCare		
		dow in Bedroom #2 opened to a			maintenance coordinator. The		
		ches and a width of 31 inches for			ResCare maintenance coordinat	tor	
	-	width of 5.1 square feet. The one			will inspect all windows to ensure	e	
	window in Bedroc	om #3 opened to a height of			they meet all criteria for means of		
	22.25 inches and a	a width of 34 inches for a			escape. The facility manager wil		
	minimum clear wi	dth of 5.2 square feet. Each			ensure secondary means of		
	window served as	the secondary means of egress			escape are not blocked with		
	for the room. All	measurements were made with a			furniture.		
	measuring tape. E	Based on interview at the time of			3.Bedroom window 1,2, and 3		
		he Program Director agreed the			will be replaced to ensure an		
		condary means of egress did			approved means of escape.		
	·	r opening of not less than 5.7			Competitive bids will be accepte	d	
	-	e windows in the fully open			until February 15, 2024 and		
	position.				contractor selected by February		
					29, 2024. The replacement		
	-	re reviewed with the Program			windows will be installed before		
	Director during the	e exit conference.			May 31, 2024.		
					4.The facility will perform		

(X2) MULTIPLE CONSTRUCTION

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		x1) provider/supplier/clia identification number 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		COM	(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2	TREET ADDRESS, CITY, STATE, ZII 401 CORNWELL DR EFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH AG DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
				monthly drills to ensu are operating proper any defect through th maintenance reques discovered. Persons Responsible Manager, Area Supe Residential Manager Manager	ly and report ne t form when e: Program ervisor,		
K S345 Bldg. 01	in accordance wi complying with the National Electric National Fire Ala Records of system and testing are re 9.7.5, 9.7.7, 9.7.8 Based on record re failed to maintain accordance with N Section 9.6. NFP4 unless otherwise pp inspections shall be the schedules in Ta- required by the autor Table 14.3.1 states visually inspected a. Control unit troop b. Remote annunce c. Initiating deviced	m - Testing and (Prompt) em is tested and maintained th an approved program the requirements of NFPA 70, Code, and NFPA 72, rm and Signaling Code. m acceptance, maintenance eadily available. 8, and NFPA 25 view and interview, the facility 1 of 1 fire alarm systems in FPA 72, as required by LSC 101 A 72, Section 14.3.1 states that ermitted by 14.3.2, visual the performed in accordance with able 14.3.1, or more often if hority having jurisdiction. that the following must be semi-annually: able signals	K S34:	5 K0345: Fire Alarm S Testing and Mainter 1.The administrato annual functional tes initiating devices suc detectors, release de fire alarm boxes is pe Koorsen Fire and Se fire alarm system and of the tests/inspectio available in the faciliti 2.The administrato visual semi-annual fi system inspection is	r will ensure ting for h as smoke evices, and erformed by curity on the d that reports ns are ty for review. r will ensure re alarm	01/31/2024	

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE (CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01			PLETED
15G247		В.	WING		12/2	0/2023	
NAMEOF		D		STREE	T ADDRESS, CITY, STATE, ZIP COI)	
	PROVIDER OR SUPPLIE				CORNWELL DR		
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		JEFF	ERSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	ROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	d. Notification app				Koorsen Fire and Securi	ty and	
	e. Magnetic hold-o	-			that reports of the		
	-	tice could affect all clients, staff			tests/inspections are ava		
	and visitors.				the facility for review. Ko		
	E' 1' ' 1 1				Fire and Security will als		
	Findings include:				inspection reports to the		
					Manager for monitoring of	of	
	Based on review of the fire alarm system				completion.		
	inspection contractor's "Alarm System Inspection" documentation dated 01/25/23 with				Demons Deenensikler D		
	·	the Program Director and the House Manager			Persons Responsible: P	•	
	from 10:35 a.m. to 12:30 p.m. on 12/20/23,				Manager, Area Supervis		
		a visual semi-annual fire alarm			Residential Manager, Ma	amenance	
		six months after 01/25/23 was			Manager		
		eview. Based on interview at the					
		ew, the Program Director stated					
		m system inspection					
		s not available for review and					
		tion for a semi-annual visual fire					
	-	ection six months after $01/25/23$					
	was not available f						
	These findings we	re reviewed with the Program					
	Director during the	e exit conference.					
S347	NFPA 101						
	Smoke Detection						
3ldg. 01	Smoke Alarms						
	2012 EXISTING	(Prompt)					
	Approved smoke	alarms shall be provided in					
	accordance with	9.6.2.10, unless either of the					
	following exist:						
	• •	tected throughout by an					
		atic sprinkler system, in					
		33.2.3.5, that uses quick					
		lential sprinklers, and					
		proved smoke alarms					
	installed in each						
		9.6.2.10, that are powered					
	I by the building el	ectrical system, or					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN	2401	T ADDRESS, CITY, STATE, ZIP COD CORNWELL DR ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E (X5) COMPLETIO DATE
	approved autom accordance with quick-response of existing battery- each sleeping ro opinion of the au facility has demo maintenance, ar program ensure smoke alarms. Smoke alarms si including basem spaces and unfit smoke alarms si rooms, dens, da These alarms sh building electrica activated, shall it audible in all slea 33.2.3.4.3. Based on observar sleeping rooms wa approved smoke a 9.6.2.10. This def clients, staff and w Findings include: Based on observar during a tour of th p.m. on 12/20/23, rooms in the facilit smoke alarm insta sleeping room had operated smoke al the room. Each si the building electric	tion and interview, 5 of 5 client ere not provided with an larm in accordance with LSC ficient practice could affect all	K S347	K0347 Smoke Detectors: 1.The administrator will ensur the installation of smoke alarms are powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas. 2.The Maintenance Manager request bids and select a vende for installation of approved smo detectors NLT February 15, 202 Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP	will or oke 24.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	240	ET ADDRESS, CITY, STATE, ZIP COD 1 CORNWELL DR FERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY 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	
K S363 Bldg. 01	smoke alarms. Ba the observations, t each of the client s provided with a sn by the building ele These findings we Director during the NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet requirements: 1. Doors shall other mechanism door closed. 2. No doors sh the occupant fror 3. Doors shall automatic-closing in buildings other throughout by an sprinkler system Door assemblies swing in the direct	sed on interview at the time of he Program Director agreed leeping rooms was not hoke alarm which was powered ctrical system. The reviewed with the Program e exit conference. all of the following be provided with latches or is suitable for keeping the all be arranged to prevent in closing the door. be self-closing or g in accordance with 7.2.1.8 than those protected approved automatic in accordance with 33.2.3.5. with leaves required to ction of egress travel are sted annually per 7.2.1.15.				
	Based on observat failed to ensure the bedrooms had no i latched into the do practice could affe Findings include: Based on observat during a tour of the p.m. on 12/20/23,	ion and interview, the facility e corridor door to 2 of 5 client mpediment to closing and or frame. This deficient ct all clients, staff and visitors. ions with the Program Director e facility from 12:30 p.m. to 1:00 the corridor door to Bedroom #1 yere equipped with a self closing	K S363	1. The Area Supervisor will in-service the facility staff on ensuring smoke barrier doors bedroom doors remain free of obstacle that will prevent the smoke barrier door from closin 2. Random monthly site revie will be conducted by a member ResCare's Administrative Tea ensure smoke barrier and bedroom doors remain free fro obstacles that would prevent t	and g. ws r of m to m	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 15G247 B. WING 12/20/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE device but each door was propped in the fully from closing properly. open position with a wedge placed under the door. Based on interview at the time of the observations, the Program Director agreed each of the two bedroom doors had an impediment to Persons Responsible: Program closing and latching into the door frame. Manager, Area Supervisor, Residential Manager, DSP These findings were reviewed with the Program Director during the exit conference. K S712 **NFPA 101** Fire Drills Bldg. 01 Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities: c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)

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

Event ID:

KMB621 Facility ID: 000769

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If continuation sheet Page 22 of 23

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		2401 C	ADDRESS, CITY, STATE, ZIP COI CORNWELL DR RSONVILLE, IN 47130	D	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	CTION	(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	COMPLETIO DATE
	failed to provide de conducted on the f the second shift for third shift for 2 of a practice affects all Findings include: Based on review o and "Emergency E documentation wit Home Manager du a.m. to 12:30 p.m. fire drill conducted quarter (April, May quarter (July, Aug available for review of a fire drill conducted first quarter (Janua on the third shift in 2023 was also not interview at the tim Manager stated the per day, additional not available for review documentation of a first, second and the aforementioned ca available for review These findings were	h the Program Director and the ring record review from 10:35 on 12/20/23, documentation of a l on the first shift in the second y, June) 2023 and in the third ast, September) 2023 was not w. In addition, documentation acted on the second shift in the ry, February, March) 2023 and a the first and third quarters in available for review. Based on ne of record review, the Home e facility operates three shifts fire drill documentation was wiew and agreed a fire drill conducted on the ind shifts in the lendar quarters in 2023 was not	KS	712	 K0712 Fire Drills: 1.All staff at the Facility re-trained on conducting quarterly on all shifts. TH Residential Manager will drills to ensure all require area conducted. The Pr Manager will train the Ar Supervisor and the Area Supervisor and the Area Supervisor will train all fa staff. 1.The Area Supervisor the home at least month ensure the drills are in th and up to date. 1.The Residential Man submit monthly drills to t Department upon comple QA Department will notif Manager and Program n the facility has not performonthly drills are completed as required. 1.The Area supervisor 	fire drills he review all ed drills ogram ea acility will visit ly to he home hager will he QA etion. The ty the Area hanager if rmed d. will ted as er will / lls are	01/31/202
					Persons Responsible: F Manager, Area Supervis Residential Manager, DS	or,	