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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING -- B. WING	10/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL DR JEFFERSONVILLE, IN 47130

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 10/31/22 Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810 At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. At the time of the survey, the census was 8. Quality Review completed on 11/03/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 10/31/22 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	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick O'Heran	QIDP Manager	11/15/2022

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.

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	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 in corridors and all living areas, plus the basement. 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 Slow with an E-Score of 3.8. Quality Review completed on 11/03/22			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	1. Based on observation and interview, the facility failed to ensure 3 of 3 portable fire extinguishers located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features	K S100	To correct the deficient practice the extinguishers and emergency lights will be inspected LSC. As well as the service provider will be contacted to inspect the emergency lights. All staff responsible for the maintenance of the home will be trained to ensure	11/30/2022

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	obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations on 10/31/22 between 10:15 a.m. and 12:00 p.m. during a tour of the facility with the Area Supervisor, the inspection tags on all three fire extinguishers showed they were not inspected monthly during September and so far in October of 2022. Based on interview at the time of observations, the Area Supervisor acknowledged the lack of a September and October monthly inspection on the three fire extinguisher attached inspection tags. This finding was reviewed with the Area Supervisor during the exit conference. 2. Based on observation and interview, the facility failed to ensure 3 of 3 interior emergency lights were tested, maintained, and the records of the testing maintained. LSC 33. 1.1.3 states the		the extinguishers and emergency lights are inspected monthly. Monitoring will be achieved by the Lead and RM completing a monthly LSC inspection form to ensure all LSC features are inspected and functional.	

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	provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. (2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the test. (5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction. This deficient practice could affect all clients and staff. Findings include: Based on observations on 10/31/22 between 10:15 a.m. and 12:00 p.m. during a tour of the facility with the Area Supervisor, the facility had three battery powered emergency light units. Based on record review between 10:15 a.m. and 12:00 p.m., there was no documentation to show the battery powered emergency lights were tested for 30 seconds monthly during the past 12 month period, furthermore, there was no documentation available for an annual 90 minute test during the past 12 months. Based on interview at the time of record review and observations, the Area Supervisor said there was no documentation to show a 30 monthly test for for the past 12 month			

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	period, plus an annual 90 minute test during the past 12 months for the three battery powered emergency lights. This finding was reviewed with the Area Supervisor during the exit conference.			
K S300 Bldg. 01	NFPA 101 Protection - Other Protection - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 6 of 6 battery operated smoke alarms in client rooms was available for review. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review on 10/31/22 between 10:15 a.m. and 12:00 p.m. with the Area Supervisor	K S300	To correct the deficient practice the battery-operated smoke detectors will be inspected. All staff responsible for the maintenance of the home will be trained to ensure the smoke detectors will be inspected monthly. Monitoring will be achieved by the Lead and RM completing a monthly LSC inspection form to ensure all LSC features are inspected and functional.	11/30/2022

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	present, there was no documentation available to show that client room battery operated smoke alarms were tested monthly, furthermore, there was no documentation to show when the batteries were last changed in the client room battery operated smoke alarms. Based on interview at the time of record review, the Area Supervisor said there was no documentation available to show a monthly test of the client room smoke alarms or when the batteries were last changed in the smoke alarms. Based on observations during a tour of the facility with the Area Supervisor, there was one battery operated smoke alarm in each of the six client sleeping rooms. This finding was reviewed with the Area Supervisor during the exit conference.			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to ensure complete documentation was provided for 1 of 1 fire alarm system in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed	K S345	To correct the deficient practice the service provider will be contacted to inspect the smoke detectors and pull station. Additionally, all staff responsible for maintenance of the home will be trained to ensure all inspections are thoroughly	11/30/2022

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	in accordance with the Table 14.4.5 Testing Frequencies. This deficient practice could affect all clients and staff. Findings include: Based on record review on 10/31/22 between 10:15 a.m. and 12:00 p.m. with the Area Supervisor present, there was documentation for an annual fire alarm system test/inspection, plus smoke detector sensitivity test dated 02/17/22, and a semi-annual fire alarm system visual inspection dated 08/17/22 by the facility's fire alarm system vendor, however, the documentation for both reports was incomplete. The inspection reports provided did not include an test/inspection/sensitivity test of the three hard wired smoke detectors and the one pull station located in the basement. Based on interview at the time of record review, the Area Supervisor acknowledged the lack of information about the three basement smoke detectors and one pull station being tested/inspected/sensitivity tested during the annual and semi-annual fire alarm system inspections dated 02/17/22 and 08/17/22. This finding was reviewed with the Area Supervisor during the exit conference.		reviewed for accuracy. Monitoring will be achieved by the Lead and RM completing a monthly LSC inspection form to ensure all LSC features are inspected and functional. As well the QA department will review all inspection reports upon completion to ensure they are accurate and thorough.	
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or			

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	automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7			
	Based on observation and interview, the facility failed to ensure 1 of 6 client sleeping room doors would close completely and latch into its door frame in this non-sprinklered home. This deficient practice could affect all clients. Findings include: Based on observations on 10/31/22 between 10:15 a.m. and 12:00 p.m. during a tour of the facility with the Area Supervisor, the middle north hall bedroom (JF/JM) door would not close completely and latch into its frame when tested several times. Based on interview at the time of observation, the Area Supervisor agreed bedroom (JF/JM) door did not close completely and latch when tested. This finding was reviewed with the Area Supervisor during the exit conference.	K S363	To correct the deficient practice the door will be repaired to latch completely. All staff responsible for the maintenance of the home will be trained to ensure all LSC features are functional. Monitoring will be achieved by the Lead and RM completing a monthly LSC inspection form to ensure all LSC features are inspected and functional.	11/30/2022
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2			
	Based on observation and interview, the facility failed to ensure an electrical receptacle in 1 of 6 client sleeping rooms was protected in according	K S511	To correct the deficient practice the cover plate to the receptacle will be replaced. All staff	11/30/2022

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	with 33.2.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect at least two clients. Findings include: Based on observations on 10/31/22 between 10:15 a.m. and 12:00 p.m., one electrical receptacle on the wall in far south bedroom (CM/SS) had a broken faceplate over the receptacle. The top third of the faceplate was missing. Based on interview at the time of observation, the Area Supervisor agreed the faceplate was broken and a portion missing from the electrical receptacle in CM/SS bedroom. This finding was reviewed with the Area Supervisor during the exit conference.		responsible for the maintenance of the home will be trained to ensure all LSC features are functional. Monitoring will be achieved by the Lead and RM completing a monthly LSC inspection form to ensure all LSC features are inspected and functional.	
K S712 Bldg. 01	NFPA 101 Fire Drills 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;			

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	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)			
	Based on record review and interview, the facility failed to ensure a fire drill was conducted quarterly on 3 of 3 shifts during 3 of 4 quarters during the past 12 months. This deficient practice could affect all clients. Findings include: Based on record review on 10/31/22 between 10:15 a.m. and 12:00 p.m. with the Area Supervisor present, there were no fire drill reports available for review for the following shifts and quarters: a. First Shift (day) of the forth quarter (October, November, and December) of 2021 and so far in 2022, and the first quarter (January, February, and March) of 2022 b. Second shift (evening) of the first quarter (January, February, and March) of 2022, and the third quarter (July, August, and September) of 2022 c. Third shift (night) of the forth quarter (October, November, and December) of 2021 and so far in 2022, and the third quarter (July, August, and September) of 2022 Based on interview at the time of record review, the Area Supervisor said there were no other fire drill reports available to review.	K S712	To correct the deficient practice all three shifts will be completed in the last quarter of 2022. All staff will be trained completing evacuation drills per the established drill calendar. Additional monitoring will be achieved by the AS review the completed drills compared to the drill calendar twice monthly. Ongoing monitoring will be achieved by the Lead and RM completing a monthly LSC inspection form to ensure all LSC requirements are met.	11/30/2022

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	This finding was reviewed with the Area Supervisor during the exit conference.			