# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION <u>01</u>	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 12/08/2022	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP COD ORNWELL DR RSONVILLE, IN 47130	-	
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)		LD BE COMPLETION	
K 0000			mo		DITL	
Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 10/31/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).		K 0000			
	Survey Date: 12/0 Facility Number: Provider Number: AIM Number: 100	000769 15G247				
	Alternatives SE IN with Requirements 42 CFR Subpart 43 and the 2012 Editi Protection Associa	y, Res Care Community was found not in compliance for Participation in Medicaid, 33.470(j), Life Safety from Fire on of the National Fire tion (NFPA) 101, Life Safety ter 33, Existing Residential ecupancies.				
	sprinklered. The f with smoke detect areas, plus the base	ding with a basement was non acility has a fire alarm system on in corridors and all living ement. The facility has a had a census of 8 at the time of				
	(E-Score) using N	Evacuation Difficulty Score FPA 101A, Alternative e Safety, Chapter 6, rated the an E-Score of 3.8.				
	Quality Review co	mpleted on 12/12/22				
K S100	NFPA 101 General Require	ments - Other				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE	
Patrick O'l	Heran		QIDP Ma	nager	01/06/2023	

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.

OMB NO. 0938-039

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/08/2022 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 01 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. K S100 Based on observation and interview, the facility To correct the deficient practice, 01/08/2023 failed to ensure 3 of 3 interior emergency lights the service provider inspected and were tested, maintained, and the records of the repaired the emergency lights on testing maintained. LSC 33. 1.1.3 states the 12-12-22. All staff responsible for provisions of Chapter 4, General, shall apply. LSC LSC features have been re-trained 4.6.12.3 states existing life safety features obvious ensuring LSC features are to the public, if not required by the Code, shall functional and inspected timely. either be maintained or removed. LSC 7.9.3.1.1 Supervisory staff have been trained testing of required emergency lighting systems ensuring all POC items are shall be permitted to be conducted as follows: addressed by the due date set (1) Functional testing shall be conducted monthly, within the POC. Ongoing with a minimum of 3 weeks and a maximum of 5 monitoring will be achieved by the weeks between tests, for not less than 30 lead and AS completing a LSC seconds. inspection monthly. As well as (2) The test interval shall be permitted to be that, the QIDP Lead will be extended beyond 30 days with approval of the monitoring the progress of all authority having jurisdiction. submitted POCs. (3) Functional testing shall be conducted annually for a minimum of  $1\frac{1}{2}$  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 12/08/22 between 12:00

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Event ID: LD9H22

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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 B. WING 12/08/2022 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE p.m. and 12:30 p.m. during a tour of the facility with the QIDP, the facility had three battery powered emergency light units. Based on record review between 12:00 p.m. and 12:30 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 QIDP said there was no documentation to show a 30 monthly test for for the past 12 month 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 QIDP during the exit conference. This deficiency was cited on 10/31/22. The facility failed to implement a systemic plan of correction to prevent recurrence. K S300 **NFPA 101** Protection - Other Bldg. 01 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 K S300 To correct the deficient practice 01/08/2023 observation, the facility failed to ensure the batteries will be replaced. The documentation for the preventative maintenance battery replacement will be of 6 of 6 battery operated smoke alarms in client documented on monitoring sheet. rooms was available for review. NFPA 101 in All staff responsible for LSC 4.6.12.3 states existing life safety features obvious features have been re-trained LD9H22 Event ID: Facility ID: 000769 Page 3 of 7 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

01/13/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULTIPLE C A. BUILDING B. WING	COMP	(X3) DATE SURVEY COMPLETED 12/08/2022	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP C ORNWELL DR RSONVILLE, IN 47130	OD	
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	<ul> <li>maintained. NFPA</li> <li>Tests. Fire-warning maintained and test manufacturer's pull requirements of CL Inspection, testing shall satisfy the reconform to the equ published instructing could affect all click</li> <li>Findings include:</li> <li>Based on record rep.m. and 12:30 p.r. was no documentation to the equipation of the client room battery tested monthly, fur documentation to the smoke alarms. Ba record review, the documentation ava of the client room batteries were last Based on observat with the QIDP, the smoke alarm in earooms.</li> <li>This finding was rethered the tested monthing was rethered to the client room the tested monthered for the client room batteries were last based on observat with the QIDP, the smoke alarm in earooms.</li> </ul>	as cited on 10/31/22. The facility a systemic plan of correction		ensuring LSC features functional and inspecte Supervisory staff have ensuring all POC items addressed by the due of within the POC. Ongoin monitoring will be achie lead and AS completing inspection monthly. As that, the QIDP Lead wi monitoring the progress submitted POCs.	ed timely. been trained s are date set ng eved by the g a LSC well as II be	
( S345	NFPA 101 Fire Alarm Syste	m - Testing and				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 12/08/2022	
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Bldg. 01	in accordance wi complying with the National Electric National Fire Ala Records of syste and testing are re 9.7.5, 9.7.7, 9.7.8 Based on record re failed to ensure co provided for 1 of 1 with 9.6.1.3. LSC system to be instal accordance with N Code and NFPA 7 NFPA 72, 7-3.2 re in accordance with Frequencies. This all clients and staff Findings include: Based on record re p.m. and 12:30 p.m was documentation system test/inspect sensitivity test data fire alarm system v by the facility's fire however, the docu incomplete. The in not include an test the three hard wire pull station located interview at the tire	(Prompt) em is tested and maintained th an approved program ne requirements of NFPA 70, Code, and NFPA 72, rm and Signaling Code. m acceptance, maintenance eadily available. 3, and NFPA 25 eview and interview, the facility mplete documentation was fire alarm system in accordance 9.6.1.3 requires a fire alarm led, tested, and maintained in FPA 70, National Electrical 2, National Fire Alarm Code. quires testing shall be performed in the Table 14.4.5 Testing deficient practice could affect	KS	345	To correct the deficient practice the smoke detectors and pull station were inspected on 12-19-22. All staff responsible f LSC features have been re-trai ensuring LSC features are functional and inspected timely Supervisory staff have been tra- ensuring all POC items are addressed by the due date set within the POC. Ongoing monitoring will be achieved by the lead and AS completing a LSC inspection monthly. As well as that, the QIDP Lead will be monitoring the progress of all submitted POCs. Addendum: The service provider will be contacted to complete sensitivit testing on the three basement smoke detectors and inspect the pull station in the basement. A written report will be available for review upon completion of the	for ned iined the ty	01/08/202

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

SUMMARY : (EACH DEFICIEN REGULATORY OR three basement smo station being tested during the annual ar system inspections of This finding was re the exit conference. This deficiency was failed to implement to prevent recurrence NFPA 101	TERNATIVES SE IN STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ke detectors and one pull 'inspected/sensitivity tested nd semi-annual fire alarm dated 02/17/22 and 08/17/22. viewed with the QIDP during cited on 10/31/22. The facility a systemic plan of correction	B.V	2401 C	ADDRESS, CITY, STATE, ZIP COD CORNWELL DR RSONVILLE, IN 47130 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPY DEFICIENCY) inspections.	TION LD BE	(X5) COMPLETIO DATE
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	<ul> <li>a. Ensure that a trained to perform</li> <li>b. Ensure that a familiar with the use emergency and district or cedures.</li> <li>2. The facility muse a. Actually evaced b. Make special evacuation of clier disabilities;</li> <li>c. File a report a d. Investigate all drills, including action; and</li> <li>e. During fire drievacuated to a sar under the Health Cor the Life Safety Corr and the Life Safety Corr and the Life Safety Corr and the Safety Corr and</li></ul>	<ul> <li>2. The facility must:</li> <li>a. Actually evacuate clients during at least one drill each year on each shift;</li> <li>b. Make special provisions for the evacuation of clients with physical disabilities;</li> <li>c. File a report and evaluation on each drill;</li> <li>d. Investigate all problems with evacuation drills, including accidents and take corrective</li> </ul>	<ul> <li>a. Ensure that all personnel on all shifts are trained to perform assigned tasks;</li> <li>b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</li> <li>2. The facility must: <ul> <li>a. Actually evacuate clients during at least one drill each year on each shift;</li> <li>b. Make special provisions for the evacuation of clients with physical disabilities;</li> <li>c. File a report and evaluation on each drill;</li> <li>d. Investigate all problems with evacuation drills, including accidents and take corrective action; and</li> <li>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.</li> </ul> </li> </ul>	<ul> <li>a. Ensure that all personnel on all shifts are trained to perform assigned tasks;</li> <li>b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</li> <li>2. The facility must: <ul> <li>a. Actually evacuate clients during at least one drill each year on each shift;</li> <li>b. Make special provisions for the evacuation of clients with physical disabilities;</li> <li>c. File a report and evaluation on each drill;</li> <li>d. Investigate all problems with evacuation drills, including accidents and take corrective faction; and</li> <li>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.</li> </ul> </li> <li>a. Facilities must meet the requirements of</li> </ul>	<ul> <li>a. Ensure that all personnel on all shifts are trained to perform assigned tasks;</li> <li>b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</li> <li>2. The facility must: <ul> <li>a. Actually evacuate clients during at least</li> <li>b. Make special provisions for the evacuation of clients with physical disabilities;</li> <li>c. File a report and evaluation on each drill;</li> <li>d. Investigate all problems with evacuation drills, including accidents and take corrective faction; and</li> <li>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.</li> <li>3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for</li> </ul> </li> </ul>	<ul> <li>a. Ensure that all personnel on all shifts are trained to perform assigned tasks;</li> <li>b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</li> <li>2. The facility must: <ul> <li>a. Actually evacuate clients during at least</li> <li>b. Make special provisions for the evacuation of clients with physical disabilities;</li> <li>c. File a report and evaluation on each drill;</li> <li>d. Investigate all problems with evacuation drills, including accidents and take corrective action; and</li> <li>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.</li> </ul> </li> </ul>

#### 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 B. WING 12/08/2022 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility K S712 To correct the deficient practice 01/08/2023 failed to ensure a fire drill was conducted drills will be conducted for each quarterly on 3 of 3 shifts during 3 of 4 quarters shift prior to 1-8-22. A drill during the past 12 months. This deficient practice calendar for 2023 has been could affect all clients. created and staff have been trained. All staff responsible for Findings include: LSC features have been re-trained ensuring LSC features are Based on record review on 12/08/22 between 12:00 functional and inspected timely. p.m. and 12:30 p.m. with the QIDP present, there Supervisory staff have been trained were no fire drill reports available for review for ensuring all POC items are the following shifts and quarters: addressed by the due date set a. First Shift (day) of the forth quarter (October, within the POC. Ongoing November, and December) of 2021 and so far in monitoring will be achieved by the 2022, and the first quarter (January, February, and lead and AS completing a LSC March) of 2022 inspection monthly. As well as b. Second shift (evening) of the first quarter that, the QIDP Lead will be (January, February, and March) of 2022, and the monitoring the progress of all third quarter (July, August, and September) of submitted POCs. 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. Furthermore, the facility was unable to provide a fire drill report since the time of the annual Life Safety Code survey conducted on 10/31/22. Based on interview at the time of record review, the QIDP said there were no other fire drill reports available to review. This finding was reviewed with the QIDP during the exit conference. This deficiency was cited on 10/31/22. The facility failed to implement a systemic plan of correction to prevent recurrence.

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