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	02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWALL 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	. A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 12/21/17 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/14/18 Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810 At this PSR survey, Res Care Community Alternatives Se In was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey, the census was 6. Quality Review completed on 02/19/18 - DA The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IDD facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent	E 0037	The agency has developed an Emergency Disaster Preparedness Plan that meets all Federal, State, and local emergency preparedness requirements and the plan will be reviewed	03/16/2018

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

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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	with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all clients in the facility. Findings include: Based on review of the Res Care Emergency Disaster Preparedness Manual dated 07/21/17 with the home manager on 02/14/18 at 10:15 a.m., there was no documentation of initial training or annual training for staff over the past year. This was confirmed by the home manager at the time of record review. This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.		and updated annually by the Safety Committee. All staff will be trained on the plan policies and procedures and participate in a community based disaster drill. The Program Manager will train the area supervisor on the policies and procedures and the area supervisor will train all facility employees. The Safety Committee will monitor to ensure all training has been completed as required under 42 CFR, Subpart 483.475	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IDD facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IDD facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IDD facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional	E 0039	The agency has developed an Emergency Disaster Preparedness Plan that meets all Federal, State, and local emergency preparedness requirements and the plan will be reviewed and updated annually by the Safety Committee. The administrator will ensure all staff participate in two annual training exercises each year. The Program Manager will train the area supervisor on the policies and procedures and the area supervisor will train all facility	03/16/2018

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	exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IDD facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IDD facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all clients in the facility. Findings include: Based on review of the Res Care Emergency Disaster Preparedness Manual dated 07/21/17 with the home manager on 02/14/18 at 10:15 a.m., there was no documentation of two annual training exercises conducted over the past year. This was confirmed by the home manager at the time of record review. This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.		employees. The Safety committee will monitor to ensure all employees have completed two annual training exercises as required under CFR(s): 483.475(d)(2).	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 12/21/17 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 02/14/18	K 0000		

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	Facility Number: 000769 Certification Number: 15G247 AIM Number: 100248810 At this PSR survey, Res Care Community Alternatives Se In was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility with a basement was not sprinkled. The facility has a fire alarm system with smoke detection on all levels including the corridors, common living areas and basement. The facility has a capacity of 8 and had a census of 6 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 2.40. Quality Review completed on 02/19/18 - DA			
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. Based on observation and interview, the facility	K S100	The administrator will ensure	03/16/2018

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	failed to ensure 2 of 2 battery operated emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all clients in the facility. Findings include: Based on observation on 02/14/18 with the home manager during a tour of the facility from 10:12 a.m. to 10:55 a.m., the facility had a battery operated emergency light fixture located on the wall in the West client sleeping room corridor and the East client sleeping room corridor with a sticker on each light from Koorsen Fire & Security indicating an annual ninety minute test was conducted on February 2017. Furthermore, when asked if the facility had documentation of monthly testing conducted over the past year, the home manager stated the facility does not have documentation of monthly testing over the past year for the two battery backup lights. This was confirmed by the home manager at the time of observations. This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.		a functional test of emergency lighting equipment will be conducted for 30 seconds at 30 day intervals and an annual test will be conducted on every required battery-operated emergency lighting system for not less than a 1 ½ hour duration. Koorsen Fire and Security will conduct the 1 ½ hour annual testing and the maintenance coordinator will conduct the monthly 30 seconds testing. Both parties conducting the testing will then provide proper documentation to the Quality Assurance Manager upon completion. The QA Manager will monitor to ensure the facility remains in compliance with regulatory requirements. The administrator and Quality Assurance Manager will meet with Koorsen Fire and Security on March 14, 2018 to ensure they are meeting all requirements in accordance with LSC 7.9. LSC 7.9.3. The Program Director will	

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			train the maintenance coordinators on conducting the testing and maintaining documentation.	
K S253 Bldg. 01	NFPA 101 Number of Exits - Patient Sleeping and Non-Sl Number of Exits – Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Prompt) Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, each sleeping room shall have a second means of escape that consists of one of the following: 1. It shall be a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape. 2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape. 3. It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 square feet. The width shall be not less than 20 inches. The height shall be not less than 24			

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	inches. The bottom of the opening shall be not more than 44 inches above the floor. Such means of escape shall be acceptable where one of the following criteria are met: a. The window shall be within 20 feet of finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an exterior balcony. 4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following: 1. The ladder or steps do not extend more than 6 inches into the well. 2. The ladder or steps are not obstructed by the window. 5. If the sleeping room has a door leading directly to the outside of the building with access to finished ground level or to a stairway that meets the requirements of exterior stairs in 33.2.2.2.2, that means of escape shall be considered as meeting all the escape requirements for the sleeping room. a. A second means of escape from each sleeping room shall not be required where the facility is protected throughout by approved automatic sprinkler system in accordance			

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	with 33.2.3.5. b. Existing approved means of escape shall be permitted to continue to be used. 33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through 33.2.2.3.4 Based on observation and interview, the facility failed to ensure 1 of 8 client sleeping room secondary means of escape window would open from the inside of the facility. LSC 33.2.2.3.1 requires in addition to the primary route, each sleeping room shall have a secondary means of escape consisting of one of the following, unless the provisions of 33.2.2.2.3.2, 33.2.2.3.3, or 33.2.2.3.4 are met: (3) Outside window or door operable from the inside, without the use of tools, keys, or special effort, that provides a clear opening of not less than 5.7 ft2 (0.53 m2), with the width not less than 20 in. (510 mm), the height not less than 24 in. (610 mm), and the bottom of the opening not more than 44 in. (1120 mm) above the floor, with such means of escape acceptable, provided that one of the following criteria are met: (a) The window is within 20 ft. (6100 mm) of the finished ground level. (b) The window is directly accessible to fire department rescue apparatus, as approved by the authority having jurisdiction. (c) The window or door opens onto an exterior balcony. This deficient practice could affect 1 client in the facility who resides in client sleeping room #1 on the East Hall. Findings include: Based on observation on 02/14/18 at 10:42 a.m. with the home manager, client sleeping room #1 on the East Hall failed to open on three separate attempts. Based on an interview at the time of observation, the home manager stated client sleeping room windows were used as a secondary means of escape during an evacuation and the	K S253	The administrator will ensure the window in client sleeping room #1 on the East Hall will open without the use of tools, keys, or special effort, provides a clear opening of not less than 24 in. and the bottom of the opening not more than 44 in. above the floor, with such means of escape acceptable provided that one of the following criteria are met: (a) The window is within 20 ft. of the finished ground level. (b) The window is directly accessible to fire department rescue apparatus, as approved by the authority having jurisdiction. (c) The window or door opens onto an exterior balcony. The Program Director will ensure repair/replacement of the window is completed. The ResCare maintenance coordinator will inspect all windows to ensure they meet all criteria for means of	03/16/2018

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	maintenance supervisor ordered parts for all windows in the home but they are still waiting on parts. This was confirmed by the home manager at the time of observation. This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.		escape.	
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 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system including the components was inspected annually to protect 4 of 4 clients. LSC 9.6.1.3 requires fire alarm systems to be installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, Table 14.4.5 requires functional testing to be conducted annually for initiating devices such as smoke detectors, release devices, and fire alarm boxes. This deficient practice affects all clients in the facility. Findings include: Based on record review on 02/14/18 at 10:20 a.m. with the home manager, there was no record available for review to indicate an annual	K S345	**1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review.** **2.The administrator will**	03/16/2018

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	functional test was conducted on fire alarm system components. This was confirmed by the home manager at the time of record review. This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence. 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all clients in the facility. Findings include: Based on record review with the home manager on 02/14/18 at 10:20 a.m., there was no records available for review to indicate a two year sensitivity test was conducted on ten photoelectric smoke detectors located in the facility. This was confirmed by the home manager at the time of record review. This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.		**ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion.** 3. The executive director and the QA manager will meet with Koorsen Fire and Security on March 14, 2018 to ensure they are completing all system testing as required by LSC 9.6.1.3 and NFPA 14.4.5.3.2.	

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