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
	15G184	A. BUILDING -- B. WING	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	1818 H ST BEDFORD, IN 47421

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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: 12/05/22 Facility Number: 000717 Provider Number: 15G184 AIM Number: 100234700 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 12/07/22	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: 12/05/22 Facility Number: 000717 Provider Number: 15G184 AIM Number: 100234700 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	12/14/2022

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 two-story facility with a basement was not sprinkled. This facility has a fire alarm system with smoke detection on all levels including the corridors, common living areas, basement and hard-wired smoke detectors 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 0.6. Quality Review completed on 12/07/22			
K S211 Bldg. 01	NFPA 101 Means of Egress - General Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 Based on observation and interview, the facility failed to maintain 1 of 1 designated means of egress be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. This deficient practice could affect all occupants. Findings include:	K S211	To correct the deficient practice the concrete pad that is being reconstructed will be completed by 1-5-23. As well as the construction provider will be contacted to ensure a clear path of egress is made through the front door. During construction staff will be reminded to use the	01/05/2023

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	Based on observation during a tour of the facility with Residential Manager on 12/05/22 between 10:50 a.m. and 11:20 a.m., the covered porch near the front door was under construction, concrete debris was impeding the path of egress from the front door of the facility. This finding was acknowledged at the time of discovery and again at the exit conference with the Residential Manager present.		secondary means of egress on the side of the house. The AED will be contacting the construction provider weekly to ensure the completion of the project is achieved. Ongoing monitoring will be achieved by the maintenance department and programming to formulate a plan for client safety and home usage when any construction of the home is taking place. !--[if !supportAnnotations]-->	
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			

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	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 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			

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	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 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 5 of 5 clients sleeping rooms was provided with a secondary means of escape in accordance with 33.2.2.3. LSC 33.2.2.3 requires a secondary egress from each sleeping room with multiple provisions. This deficient practice could affect all clients. Findings include: Based on observation during a tour of the facility with Residential Manager on 12/05/22 between 10:50 a.m. and 11:20 a.m., the windows in the bedrooms were obstructed. A reclining chair, a headboard, a dresser, a window air conditioner and a bed were among the items which were blocking access to the secondary means of escape in the client sleeping rooms. This finding was acknowledged at the time of discovery and again at the exit conference with the Residential Manager present.	K S253	To correct the deficient practice, all obstructions will be removed from the windows in the bedrooms. All staff will be trained to ensure no forms of egress are obstructed. Additional monitoring will be achieved by the site lead completing a weekly check of the home for any forms of egress being blocked, and address immediately. Ongoing monitoring will be achieved by ResCare administration staff completing monthly site reviews.	01/05/2023
K S346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of			

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	service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6			
	Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review and interview with the Residential Manager on 12/05/22 between 9:40 a.m. and 10:50 a.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Residential Manager acknowledged the fire watch documentation provided was incomplete. This finding was acknowledged at the time of discovery and again at the exit conference with the Residential Manager present.	K S346	To correct the deficient practice, the site will be provided with the correct copy of the fire watch policy which does include the appropriate methods of contact. All staff will be trained in the correct policy. To ensure no others were affected the QIDP will review the current Emergency disaster plan to ensure all item required policies are in the EDP manual at the site. Ongoing monitoring will be completed by the QIDP manager reviewing the EDP manual for each home annually.	01/05/2023
K S347	NFPA 101 Smoke Detection			

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Bldg. 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: 1. Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system, or 2. Buildings are protected throughout by an approved automatic sprinkler system, in accordance with 33.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms. Smoke alarms shall be installed on all levels, including basement but excluding crawl spaces and unfinished attics. Additional smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. These alarms shall be powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas. 33.2.3.4.3.			
	Based on observation and interview, the facility failed to provide access to all floors of the facility to ensure smoke detectors were installed on all floors in a non-sprinklered home. This deficient practice could affect all clients, staff, and visitors.	K S347	To correct the deficient practice, the basement will be inspected for a smoke detector. If one is found it will be inspected and/or tested depending on the type. If one is not found it will be installed	01/05/2023

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	Findings include: Based on observation during a tour of the facility with Residential Manager on 12/05/22 between 10:50 a.m. and 11:20 a.m., the basement, accessible from the outside was locked and a key was not available to access the basement floor to verify the presence of a smoke detector. The Residential Manager stated that she was not sure where the keys to the basement were located. This finding was acknowledged at the time of discovery and again at the exit conference with the Residential Manager present.		immediately. Also, the keys to the basement's exterior entrance will be available to all staff. Ongoing monitoring will be achieved by the site lead completing a monthly review of all LifeSafety features to ensure they are present, functional, and tested accordingly.	
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 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 5 clients sleeping rooms were provided with a door which would self-close and latch securely in the door frame. This deficient practice could affect 2 clients.	K S363	To correct the deficient practice, the door will be repaired to ensure it latches appropriately. All site staff will be trained to ensure all doors latch appropriately and to report any maintenance issues.	01/05/2023

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	Findings include: Based on observation during a tour of the facility with Residential Manager on 12/05/22 between 10:50 a.m. and 11:20 a.m., the upstairs sleeping room which opened into the corridor did not sef-close and latch into the frame. This finding was acknowledged at the time of discovery and again at the exit conference with the Residential Manager present.		Additional monitoring will be achieved by the site lead completing a weekly check of the home for any maintenance issues, and address immediately. Ongoing monitoring will be achieved by the site lead completing a monthly review of all LifeSafety features to ensure they are present, functional, and tested accordingly.	
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on observation and interview the facility failed to ensure smoking on the property was according to the policy by disposing cigarette butts in the provided metal or noncombustible containers with self-closing cover devices. This deficient practice could affect up to all clients and staff. Findings include: Based on observation during a tour of the facility with Residential Manager on 12/05/22 between 10:50 a.m. and 11:20 a.m., in the front porch there were over 100 cigarette butts in glass trays on the ledge around the porch. Based on interview at the time of observation, the Residential Manager stated the smoking area was around the side of the home with a metal container (not on the front	K S741	To correct the deficient practice, all staff and clients will be reminded to smoke in the designated area and use an appropriate container. Additionally, all other ashtrays will be removed from the porch. Additional monitoring will be achieved by the site lead completing a weekly check of the home for any signs of smoking occurring not in the designated area. Ongoing monitoring will be achieved by ResCare administrative staff completing monthly site reviews.	01/05/2023

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	porch). This finding was acknowledged at the time of discovery and again at the exit conference with the Residential Manager present.			