PRINTED:	09/01/2021
FORM AP	PROVED
OMB NO.	0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 08/03/2021
NAME OF F	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP CODE PACHE DR	
RES CAP	RE COMMUNITY A	LTERNATIVES SE IN		RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	(X5) COMPLETION DATE
E 0000					
Bldg			E 0000		
	Facility Number: 0 Provider Number: AIM Number: 100	15G157			
	Care Community A not in compliance v Requirements for M	Preparedness survey, Res Iternatives SE IN was found with Emergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR			
	-	ertified beds. All 8 beds are aid. At the time of the survey,			
	Quality Review cor	npleted on 08/10/21			
	The requirement at NOT MET as evide	42 CFR, Subpart 483.475 is enced by:			
E 0007 Bldg	441.184(a)(3), 483 483.73(a)(3), 484 485.68(a)(3), 485 491.12(a)(3), 494 EP Program Patie §403.748(a)(3), §4 (3), §441.184(a)(3) §482.15(a)(3), §4				
		485.727(a)(3), §485.920(a)			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.\*\* \*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. \*NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] E 007 EP Program Patient Based on record review and interview, the E 0007 09/03/2021 Population CFR(s): 483.475(a)(3) facility failed to ensure the emergency preparedness plan addressed the type of services /p> the ICF/IID facility has the ability to provide in /p> 1. The administrator has an emergency in accordance with 42 CFR developed a Transfer Agreement 483.4753(a)(3). This deficient practice could that will ensure the emergency affect all occupants. plan policies and procedures addresses the special needs of its FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 2 of 55

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		15G157	B. WING		08/03/2021
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP CODE	
RES CA	RE COMMUNITY	ALTERNATIVES SE IN		PACHE DR RSONVILLE, IN 47130	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET
	Findings include:			client population, including, but	
	2			not limited to, persons at risk, th	e
	Based on review of	of the facility's Emergency		type of services the ICF/IID	
	Preparedness Plan	(EPP) documentation and		facility has the ability to provide	
	interview on 08/0	3/2021 between 10:50 a.m. to		an emergency, and continuity of	
	-	ne Program Director, the EPP		operations, including delegation	
		e type of services the ICF/IID		of authority and succession plar	IS
	1	ility to provide in an		in accordance with 42 CFR	
		ional documentation was not		483.475(a)(3).	
		w at the time of the survey.		2. The need for transfer of a	
		w at the time of record review,		person from YOUR FACILITY to	)
		ctor acknowledged that types of		RECEIVING FACILITY shall be	
	-	be provided to the community		determined and recommended I	у
	were not included	in the EPP.		the person's healthcare team,	
				possibly including the attending	
	-	as reviewed with the Program		physician in such team's own	
	-	e Exit Conference held on		judgment. When a transfer is	
	08/03/2021 betwe	en 2:30 p.m. and 3:00 p.m.		recommended as medically	
				appropriate, a person supported at YOUR FACILITY shall be	
				transferred and admitted to RECEIVING FACILITY as	
				promptly as possible under the	
				circumstances, provided that be	ds
				and other appropriate resources	
				are available.	
				3. The area supervisor and	
				program manager will train all st	aff
				on the policies and procedures	
				and the program overview will b	e
				placed in the Emergency Disast	er
				Preparedness Manual for	
				reference as needed.	
				4. The corrective action will b	e
				monitored and reviewed for	
				effectiveness at a minimum of	
				every two years	

	STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         15G157		DENTIFICATION NUMBER: A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 08/03/2021		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				3011 AF	ADDRESS, CITY, STATE, ZIP COE PACHE DR	DE			
_					RSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
					The persons responsib be the, Program Manage Supervisor, and Residen Manager	er, Area			
E 0009 Bldg	441.184(a)(4), 48 483.73(a)(4), 484 485.68(a)(4), 485 486.360(a)(4), 49 Local, State, Triba §403.748(a)(4), § (4), §441.184(a)(4 §482.15(a)(4), §4 (4), §484.102(a)(4 §485.625(a)(4), § (4), §486.360(a)(4 §494.62(a)(4) [(a) Emergency P develop and main preparedness pla and updated at le	83.73(a)(4), §483.475(a) 4), §485.68(a)(4), 485.727(a)(5), §485.920(a)							
	collaboration with and Federal emer officials' efforts to	ess for cooperation and local, tribal, regional, State, rgency preparedness maintain an integrated a disaster or emergency							
	(4) Include a proc collaboration with and Federal emer	ties only at §494.62(a)(4)]: ess for cooperation and local, tribal, regional, State, rgency preparedness maintain an integrated							

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 09/01/2021 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	(X2) MULTIPLE C A. BUILDING B. WING		COME	e survey pleted 3/2021
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	3011 A	ADDRESS, CITY, STATE, ZIP CODI PACHE DR RSONVILLE, IN 47130	2	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	ION D BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all occupants.			/p> 1. The emergency p policies and procedures h updated to include a conti operations plan which add notification of the Indiana Department of Health duri disaster or emergency. To a process for cooperation collaboration with local, tri regional, State, and Feder emergency preparedness officials' efforts to maintair integrated response durin disaster or emergency situ	olan as been nuity of Iresses State ng a o include and bal, al an	
	08/03/2021 betwee with the Program I preparedness plan cooperation and co regional, State, or I preparedness offici response during a d situation, including facility's efforts to when applicable, o collaborative and c Based on interview the Program Direct process and makin accomplished at th organization. The I	als to maintain an integrated disaster or emergency g documentation of the ICF/IID contact such officials and, f its participation in ooperative planning efforts. v at the time of record review, for stated that developing a g contact with officials was e corporate level of the		<ol> <li>The area supervisor program manager will trai on the updated policies ar procedures and the progra overview will be placed in Emergency Disaster Preparedness Manual for reference as needed.</li> <li>The corrective action monitored and reviewed for effectiveness at a minimu every two years</li> <li>The persons responsible be the, Program Manage Supervisor, and Resident Manager</li> </ol>	n all staff nd am the n will be or m of e will r, Area	

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE process and contacts. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m. E 0015 403.748(b)(1), 418.113(b)(6)(iii), 441.184(b) (1), 482.15(b)(1), 483.475(b)(1), 483.73(b) Bldg. --(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b) (1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 6 of 55

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AND PLAN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G157		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		3011 A	ADDRESS, CITY, STATE, ZIP CODE PACHE DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E	(X5) COMPLETIO DATE
	<ul> <li>systems.</li> <li>(D) Sewage and</li> <li>*[For Inpatient He (iii):] Policies and (6) The following for hospice-opera only. The policie address the follow (iii) The provision hospice employe they evacuate or but are not limite (A) Food, water, pharmaceutical s (B) Alternate sout the following:</li> <li>(1) Temperatures and safety and for storage of provisi (2) Emergency lig (3) Fire detection systems.</li> <li>(C) Sewage and Based on record reinterview, the facil preparedness police a minimum, the pr with 42 CFR 483.4 practice could affer Findings include:</li> <li>Based on record record</li></ul>	ospice at §418.113(b)(6) procedures. are additional requirements ated inpatient care facilities s and procedures must wing: of subsistence needs for es and patients, whether shelter in place, include, d to the following: medical, and upplies. rces of energy to maintain a to protect patient health or the safe and sanitary ions. ghting. , extinguishing, and alarm waste disposal. wiew, observation, and ity failed to ensure emergency ies and procedures include at ovision of water in accordance 475(b)(1). This deficient	E 00	15	1. The administrator will et the emergency plan policies procedures addresses the provision of subsistence nee staff and clients, whether the evacuate or shelter in place, including but not limited to th following: (i) Food, water, me and pharmaceutical supplies Alternate sources of energy maintain – (A) Temperatures protect resident health and s and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire	and eds for ey ne edical, s. (ii) to s to safety /	08/23/20

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) 08/03/2021 between 12:30 p.m. and 2:00 p.m. detection, extinguishing, and with the Program Director, the storage container alarm systems; and (D) Sewage and waste disposal in accordance in the basement for water had 13 gallons of with 42 CFR 483.475(b)(1). bottled water. Based on interview at the time of observation, the Program Director we calculated 2. The area supervisor and the the total amount of of water that should be in program manager will train all staff on the policies and procedures storage is 30 gallons (8 consumers and 2 staff x 1 gallon per day x 3 days = 30 gallons). The and the program overview will be Program Director agreed that the policy placed in the Emergency Disaster Preparedness Manual for indicated that water was to be stored for an emergency and that only 13 gallons of water reference as needed. were found in emergency supply storage. 3 The program manger will purchase and will deliver 30 This deficiency was reviewed with the Program gallons of drinking water to be Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m. stored for emergency supply before 8/18/2021. The program manager will 4. train the residential manager and area supervisor on the storage is 30 gallons (8 consumers and 2 staff x1 gallon per day x 3 days = 30 gallons) If less than 30 gallons of 5. water is stored for emergency supply staff are to replenish supply, if unable staff will contact **Residential Manager or Area** Supervisor in order to obtain water. 6. ResCare Management Team will conduct random monthly site visits to ensure an adequate emergency supplies are available FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 8 of 55

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 15G157 B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/03/2021			
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	-	3011 A	ADDRESS, CITY, STATE, ZIP COD PACHE DR RSONVILLE, IN 47130	E	
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	The persons responsib be the, Program Manage Supervisor, and Resider Manager	er, Area	DATE
E 0018 Bldg	<ul> <li>(ii) and (v), 441.18</li> <li>483.475(b)(2), 48</li> <li>485.920(b)(1), 48</li> <li>Procedures for Tr Patients</li> <li>§403.748(b)(2), §-</li> <li>(6)(ii) and (v), §44</li> <li>(2), §482.15(b)(2)</li> <li>§483.475(b)(2), §-</li> <li>(1), §486.360(b)(1)</li> <li>[(b) Policies and p</li> <li>must develop and</li> <li>preparedness pol</li> <li>based on the emergination of the emerging of</li></ul>	485.625(b)(2), §485.920(b) ), §494.62(b)(1). procedures. The [facilities] implement emergency icies and procedures, ergency plan set forth in					

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	(X2) MULT A. BUILI B. WING	DING	ISTRUCTION	(X3) DATE COMPL <b>08/03</b> /	ETED
NAME OF	PROVIDER OR SUPPLIE	R	3	011 AP	DDRESS, CITY, STATE, ZIP CODE ACHE DR		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN	J	EFFER	SONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE			
	<ul> <li>§483.73(b), ICF/II at §460.84(b):] Po A system to track and sheltered res ICF/IID or PACE] emergency. If on residents are relo emergency, the [F PACE] must docu and location of the location.</li> <li>*[For Inpatient Ho Policies and proce (ii) Safe evacuation includes consider needs of evacues transportation; ide location(s) and pr of communication assistance.</li> <li>(v) A system to tra- employees' on-du the hospice's care the on-duty emplo are relocated duri hospice must doc and location of the location.</li> <li>*[For CMHCs at § procedures. (2) S CMHC, which inc and treatment near responsibilities; tr of evacuation location</li> </ul>	PRTF's, LTC, ICF/IID or iment the specific name e receiving facility or other ospice at §418.113(b)(6):]					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 08/03/2021 15G157 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) external sources of assistance. \*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. \*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. 1. The administrator will ensure Based on record review and interview, the E 0018 09/02/2021 facility failed to ensure emergency preparedness the emergency plan policies and policies and procedures include a system to track procedures addresses the the location of on-duty staff during and after an tracking of staff and clients, whether they evacuate or shelter emergency. If on-duty staff during the emergency, the ICF/IID facility must document in place. Including the the specific name and location of the receiving consideration of care and facility or other location in accordance with 42 treatment needs of evacuees. staff responsibilities; transportation; CFR 483.475(b)(2). This deficient practice could affect all staff. identification of evacuation locations; and primary and means Findings include: of communication with external assistance. Based on record review and interview on 2. The area supervisor and 08/03/2021 between 10:50 a.m. to 12:30 p.m. program manager will train all staff with the Program Director, there was nothing in on the policies and procedures the Emergency Preparedness policy which and the program overview will be placed in the Emergency Disaster addressed a system to track the whereabouts of Preparedness Manual for staff during an emergency. Based on interview at reference as needed. the time of record review, the Program Director 3. The Facility created a staff indicated that staff keep their timesheets on-line. The Program Director acknowledged that the tracking form to work in system did not account for the location of the conjunction with staff contact list to provided a means of tracking staff. The Program Director acknowledged that there was no written policy and procedure which staff through an emergency addressed the tracking of staff using the online event. The program Manager will

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMI	(X3) DATE SURVEY COMPLETED 08/03/2021	
NAME OF 1	PROVIDER OR SUPPLIE	ËR		3011 A	ADDRESS, CITY, STATE, ZIP CODE PACHE DR			
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN BE PRIATE	(X5) COMPLETION DATE	
	Director during the	vise. as reviewed with the Program e Exit Conference held on en 2:30 p.m. and 3:00 p.m.			train the area supervisor an residential manager on the this form. 4.The corrective action w monitored and reviewed fo effectiveness at a minimun bi-annual	us of rill be r		
					The persons responsible the, Program Manager, Are Supervisor, and Residentia Manager	ea		
E 0020 Bldg	(ii), 441.184(b)(3 (3), 483.73(b)(3) (1), 485.727(b)(1 (1), 494.62(b)(2) Policies for Evac §403.748(b)(3), § (6)(ii), §441.184( §482.15(b)(3), §4 (3), §485.68(b)(1	16.54(b)(2), 418.113(b)(6) ), 482.15(b)(3), 483.475(b) , 485.625(b)(3), 485.68(b) ), 485.920(b)(2), 491.12(b) . and Primary/Alt. Comm. §416.54(b)(2), §418.113(b) b)(3), §460.84(b)(3), 483.73(b)(3), §483.475(b) ), §485.625(b)(3), §485.920(b)(2), §491.12(b) 2)						
	must develop an preparedness por based on the em paragraph (a) of assessment at paragraph (c) of and procedures a updated at least LTC facilities]. A	procedures. The [facilities] d implement emergency dicies and procedures, ergency plan set forth in this section, risk aragraph (a)(1) of this communication plan at this section. The policies must be reviewed and every 2 years [annually for t a minimum, the policies must address the following:]						

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. \*[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. \* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. \* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. The emergency plan policies 09/02/2021 Based on record review and interview, the E 0020 1. facility failed to ensure emergency preparedness and procedures will be updated to policies and procedures include information for include a continuity of operations FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 13 of 55

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 08/03/2021 15G157 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) safe evacuation from the ICF/IID facility in plan which addresses safe accordance with 42 CFR 483.475(b)(3). This evacuation of from the ICF/IID deficient practice could affect all occupants. facility and includes consideration of care and treatment needs of evacuees; staff responsibilities; Findings include: transportation; identification of Based on record review and interview on evacuation location(s); and 08/03/2021 between 10:50 a.m. to 12:30 p.m. primary and alternate means of with the Program Director, the portion of the communication with external Emergency Preparedness Plan for Evacuation sources of assistance. was a template and provided no site specific 2 In the event of an emergency event If possible, it is policies or procedures. The Program Director acknowledged that the information contained in ideal for the consumers to remain the plan was a template or outline to be in their own homes. If this is not completed specifically for the facility site. possible, hotel accommodations need to be arranged or relocation This deficiency was reviewed with the Program to group homes Longest St, Director during the Exit Conference held on Apache Drive, or New Albany 08/03/2021 between 2:30 p.m. and 3:00 p.m. and/or Jasper offices. The area supervisor and 3. program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. The corrective action will be 4 monitored and reviewed for effectiveness at a minimum every two years. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NFV121 Facility ID: 000693 If continuation sheet Page 14 of 55

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) E 0023 403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), Bldg. --483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4) Policies/Procedures for Medical Documentation §403.748(b)(5), §416.54(b)(4), §418.113(b) (3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b) (5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b) (4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. \*[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NFV121 Facility ID: 000693 If continuation sheet Page 15 of 55

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AND PLAN	AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 15G157 B. WING		<u></u>	COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	3011 A	ADDRESS, CITY, STATE, ZIP CODE APACHE DR ERSONVILLE, IN 47130	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E DATE
	records. *[For OPOs at §4 procedures. (2) A documentation th actual donor infor confidentiality of p information, and s availability of reco Based on record re facility failed to en policies and proced medical documenta information, protec information, and se availability of reco CFR 483.475(b)(4) could affect all occ Findings include: Based on record re 08/03/2021 betwee with the Program I procedures which if documentation that protects confidentia and secures and ma records was availal interview at the tim Program Director s Books" could be re has an electronic com maintained off site acknowledged that Plan did not address information, protect	botential and actual donor secures and maintains the ords. view and interview, the sure emergency preparedness hures include a system of ation that preserves client exts confidentiality of client ecures and maintains the rds in accordance with 42 b. This deficient practice upants. view and interview on in 10:50 a.m. to 12:30 p.m. Director, no policies and nclude a system of medical t preserves client information, ality of client information, aintains the availability of bele to review. Based on ne of record review, the stated that the consumer "Red produced because the nurse opy of the document . The Program Director the Emergency Preparedness as the preservation of client	E 0023	<ol> <li>The emergency plan polic and procedures will be updated include a continuity of operatio plan which addresses a system medical documentation of from the ICF/IID facility and includes consideration of maintaining protection of confidentiality of patient information and secures and maintains availability of records.</li> <li>The area supervisor and program manager will train all s on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.</li> <li>The corrective action will monitored and reviewed for effectiveness at a minimum bi-annual</li> <li>The persons responsible will be the, Program Manager, Area</li> </ol>	d to ns n of s s s staff be

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIEF		3011	TADDRESS, CITY, STATE, ZIP CODE APACHE DR		
		LTERNATIVES SE IN		ERSONVILLE, IN 47130	1	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	Ϋ́,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE	
	Director during the	s reviewed with the Program Exit Conference held on n 2:30 p.m. and 3:00 p.m.		Supervisor, and Residentia Manager	ai	
0032 403.748(c)(3), 416.54(c)(3), 418.113(c)(3) 441.184(c)(3), 482.15(c)(3), 483.475(c)(3)						
Bldg	483.73(c)(3), 484. 485.68(c)(3), 485. 486.360(c)(3), 49 Primary/Alternate §403.748(c)(3), §4 (3), §441.184(c)(3) §482.15(c)(3), §4 (3), §484.102(c)(3) §485.625(c)(3), §4 (3), §486.360(c)(3) §494.62(c)(3). [(c) The [facility] n an emergency press	102(c)(3), 485.625(c)(3), 727(c)(3), 485.920(c)(3), 1.12(c)(3), 494.62(c)(3) Means for Communication 416.54(c)(3), §418.113(c) 3), §460.84(c)(3), 33.73(c)(3), §483.475(c) 3), §485.68(c)(3), 485.727(c)(3), §485.920(c)				
	local laws and mu at least every 2 ye facilities]. The co	st be reviewed and updated ears [annually for LTC mmunication plan must				
<ul> <li>include all of the following:</li> <li>(3) Primary and alternate means for communicating with the following:</li> <li>(i) [Facility] staff.</li> <li>(ii) Federal, State, tribal, regional, and local emergency management agencies.</li> </ul>	Iternate means for th the following: tribal, regional, and local					
	and alternate mea the ICF/IID's staff regional, and loca	483.475(c):] (3) Primary ans for communicating with Federal, State, tribal, I emergency management				
	agencies. Based on record rev facility failed to ens	view and interview, the	E 0032	1. The method of communicating using both a	09/02/202	

### 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 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) preparedness communication plan includes (3) primary and alternate means of Primary and alternate means for communicating communicating with ICF/IID staff, Federal, State, regional, and local with the following: (i) ICF/IID facility's staff (ii) emergency managements Federal, State, tribal, regional, or local emergency management agencies in accordance agencies will be place in the EPP with 42 CFR 483.475(c)(3). This deficient by the Program Manager. practice could affect all occupants. 2. All staff will be trained on Findings Includes:

Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, the Emergency Preparedness Plan has as a alternate means of communication radios that would be brought to the facility. Based on interview at the time of record review, the Program Director there has been no training or exercise to ensure that this method of communication can be useful in an

This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.

emergency.

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**NFV121** 

Facility ID: 000693

the method of communicating

means of communicating with

regional, and local emergency

ICF/IID staff, Federal, State,

the EPP includes a copy the method of communicating using

both a primary and alternate

ICF/IID staff, Federal, State, regional, and local emergency managements agencies.

ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will

review the Emergency Preparedness Manual and document the visit on the Home

means of communicating with

The Area Supervisor will

managements agencies.

3.

4.

using both a primary and alternate

Area Supervisor will ensure

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(X5)

DATE

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED 08/03/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP	CODE		
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		APACHE DR ERSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID			(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	RECTION SHOULD BE APPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG			DATE	
				Visitor Sign In form lo each home.	cated in		
				<ol> <li>Monitoring of Co Action: A member of t Review Team, consist QA department, Progra Managers, QIDP-D's, Manager, AED, and A Supervisors will comp site reviews of each lo document any issues/ the site review. Site F be reviewed by each A Supervisor and Progra for that home and follow necessary to correct as</li> <li>/p&gt;</li> <li>/p&gt;</li> </ol>	the Site ting of the ram Nurse area blete monthly bocation and findings on Review will Area am Manager bw-up as all issues.		
				Program Manager, Ar Supervisor, and Resid Manager.			
E 0034 Bldg	441.184(c)(7), 48 483.73(c)(7), 484	6.54(c)(7), 418.113(c)(7), 32.15(c)(7), 483.475(c)(7), 1.102(c)(6), 485.625(c)(7), 5.727(c)(5), 485.920(c)(7),					
	491.12(c)(5), 494 Information on O §403.748(c)(7), § (7) §441.184(c)(7) §460.84(c)(7), §4 (7), §484.102(c) §485.68(c)(5), §4	4.62(c)(7) ccupancy/Needs 3416.54(c)(7), §418.113(c)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. \*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. \*[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Based on record review and interview, the E 0034 The administrator will ensure 09/02/2021 1. facility failed to ensure the emergency the emergency plan policies and preparedness communication plan includes a procedures will be updated to means of providing information about the include a method to share ICF/IID facility's occupancy, needs, and its occupancy needs and ability to provide assistance to the Authority ability to provide assistance, to the authority Having Jurisdiction. having jurisdiction or the Incident Command The area supervisor and Center, or designee in accordance with 42 CFR 2. 483.475(c)(7). This deficient practice could program manager will ensure the affect all occupants. policies and procedures update including a method to share occupancy needs and ability to Findings Include: provide assistance to the Authority FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 20 of 55

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	r í	JILDING ING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		3011 A	ADDRESS, CITY, STATE, ZIP CODE PACHE DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Based on record rev 08/03/2021 between with the Program D was available in the Plan to address a m about the facility's of ability to provide as Based on interview the Program Director information was no This deficiency was Director during the	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) riew and interview on a 10:50 a.m. to 12:30 p.m. irector, no documentation Emergency Preparedness eans of providing information occupancy, needs, and its sistance in an emergency. at the time of record review, or acknowledged that the t contained in the plan.		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) Having Jurisdiction is presen the Emergency Disaster Preparedness Manual for reference as needed. 3. The corrective action w monitored and reviewed for effectiveness at a minimum annually The persons responsible w	t in ill be <b>ill</b>	(X5) COMPLETIO DATE
: 0035 Bldg	483.475(c)(8), 483	Sharing Plan with Patients			be the, Program Manager, A Supervisor, and Residentia Manager		
	maintain an emerg communication pl Federal, State and reviewed and upd	s at §483.73(c):] ty must develop and gency preparedness an that complies with d local laws and must be ated at least annually. The an must include all of the					
	an emergency pre- plan that complies local laws and mu at least every 2 ye	483.475(c):] ust develop and maintain paredness communication with Federal, State and st be reviewed and updated ears. The communication all of the following:]					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the E 0035 1. The administrator will 09/02/2021 facility failed to ensure the emergency develop and maintain an emergency preparedness plan preparedness communication plan includes a method for sharing information from the that complies with Federal, State emergency plan that the facility has determined and local laws that must be reviewed annually to include a is appropriate with clients and their families or representatives in accordance with 42 CFR method for sharing information the facility has determined 483.475(c)(8). This deficient practice could affect all occupants. appropriate, with clients and their family or representatives. Findings include: 2. The area supervisor and program manager will ensure the Based on record review and interview on policies and procedures update 08/03/2021 between 10:50 a.m. to 12:30 p.m. including a method to share occupancy needs and ability to with the Program Director, a method for sharing information from the emergency plan with provide assistance to the Authority clients and their families was not available for Having Jurisdiction is present in review. Based on interview at the time of record the Emergency Disaster Preparedness Manual for review, the Program Director stated that an overview was provided to the families at the reference as needed. annual review. The Program Director agreed that documentation of the method for sharing Emergency Plan information with clients and their families was missing from the written The persons responsible will be the, Program Manager, Area Emergency Plan. Supervisor, and Residential This deficiency was reviewed with the Program Manager Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m. E 0037 403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), Bldg. --483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program

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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 15G157	· /	ULTIPLE CON JILDING ING	<u>-</u>	(X3) DATE SURVEY COMPLETED 08/03/2021	
NAME OF	PROVIDER OR SUPPLIEF	t			DDRESS, CITY, STATE, ZIP ACHE DR	CODE	
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	SONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	<ul> <li>(1), §441.184(d)(1</li> <li>§482.15(d)(1), §44</li> <li>(1), §484.102(d)(1</li> <li>§485.625(d)(1), §4</li> <li>(1), §486.360(d)(1</li> <li>*[For RNCHIs at §</li> <li>§416.54, Hospital</li> <li>§483.475, HHAs a</li> <li>"Organizations" ut</li> <li>§486.360, RHC/F</li> <li>(1) Training progrations and process training at least even (iii) Maintain docu preparedness training at least even (iii) Maintain docu preparedness training at least and procedures a the [facility] must and procedures at the [facility] must and process at the process a</li></ul>	33.73(d)(1), §483.475(d) ), §485.68(d)(1), 485.727(d)(1), §485.920(d) ), §491.12(d)(1). 403.748, ASCs at s at §482.15, ICF/IIDs at at §484.102, nder §485.727, OPOs at QHCs at §491.12:] ram. The [facility] must do : n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. ency preparedness very 2 years. mentation of all emergency ning. staff knowledge of dures. cy preparedness policies re significantly updated, conduct training on the and procedures. §418.113(d):] (1) Training. do all of the following: n emergency preparedness edures to all new and mployees, and individuals a under arrangement,					
	<ul> <li>(ii) Demonstrate s</li> <li>emergency proces</li> <li>(iii) Provide emergency</li> </ul>	-					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	Α.	BUILDING WING		(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIEF			3011 A	ADDRESS, CITY, STATE, ZIP C PACHE DR	ƏDE	
	•	LTERNATIVES SE IN		JEFFEI	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	emergency prepa employees (includ with special emph the procedures ne and others. (v) Maintain docur preparedness trai (vi) If the emerger and procedures a	view and rehearse its redness plan with hospice ling nonemployee staff), asis placed on carrying out cessary to protect patients mentation of all emergency ning. ncy preparedness policies re significantly updated, conduct training on the					
	program. The PR following: (i) Initial training in policies and proce existing staff, indivi- under arrangemen consistent with the (ii) After initial train preparedness trai (iii) Demonstrate s emergency proce (iv) Maintain docu preparedness trai (v) If the emergen and procedures a the PRTF must co updated policies a *[For PACE at §40 organization must (i) Initial training in policies and proce	mentation of all emergency ning. cy preparedness policies re significantly updated, onduct training on the					

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	ì í	JILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIEI	LTERNATIVES SE IN		STREET A 3011 AF JEFFER	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR participants, and	TATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION) VOlunteers, consistent with		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	training at least ev (iii) Demonstrate a emergency proce participants of wh whom to contact ii (iv) Maintain docu (v) If the emerged and procedures a the PACE must or updated policies a *[For LTC Facilitie Training Program all of the following (i) Initial training in policies and proce existing staff, indi- under arrangeme consistent with the (ii) Provide emerged training at least and (iii) Maintain docu preparedness traif (iv) Demonstrate emergency proce *[For CORFs at § The CORF must of (i) Provide initial the preparedness pol new and existing services under arr consistent with the (ii) Provide emerged training at least ev (iii) Maintain docu	ency preparedness very 2 years. staff knowledge of dures, including informing at to do, where to go, and n case of an emergency. imentation of all training. ncy preparedness policies re significantly updated, onduct training on the and procedures. es at §483.73(d):] (1) . The LTC facility must do g: n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected role. gency preparedness nnually. mentation of all emergency ning. staff knowledge of dures. 485.68(d):](1) Training. do all of the following: raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. gency preparedness					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	r í	JILDING NG	nstruction	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		STREET A 3011 AF JEFFER	DE		
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	must be oriented a responsibilities re- emergency plan w workday. The train instruction in the I systems and sign- equipment. (v) If the emerge and procedures a the CORF must of updated policies a *[For CAHs at §48 program. The CAI following: (i) Initial training in policies and proce reporting and exti protection, and wh of patients, person prevention, and ca and disaster authe existing staff, indi- under arrangement consistent with the (ii) Provide emergent training at least ev (iii) Maintain docu (iv) Demonstrate a emergency proce (v) If the emergent and procedures a the CAH must cor updated policies a *[For CMHCs at § The CMHC must emergency propa	35.625(d):] (1) Training H must do all of the n emergency preparedness edures, including prompt nguishing of fires, nere necessary, evacuation nnel, and guests, fire coperation with firefighting porities, to all new and viduals providing services nt, and volunteers, eir expected roles. ency preparedness very 2 years. mentation of the training. staff knowledge of dures. ncy preparedness policies re significantly updated, nduct training on the					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

 PRINTED:
 09/01/2021

 FORM APPROVED

 OMB NO. 0938-0391

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 15G157	r í	JILDING NG		(X3) DATE SURVEY COMPLETED 08/03/2021
	PROVIDER OR SUPPLIEI RE COMMUNITY A	LTERNATIVES SE IN		3011 A	ADDRESS, CITY, STATE, ZIP CODE PACHE DR RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF individuals provid arrangement, and their expected rol documentation of must demonstrate	TATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ng services under volunteers, consistent with es, and maintain the training. The CMHC e staff knowledge of dures. Thereafter, the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE (X5) COMPLETIC DATE
	CMHC must prov preparedness trai Based on record re- facility failed to en preparedness progr program includes a facility must do all emergency prepare two years; maintair emergency prepare staff knowledge of accordance with 42 deficient practice c Findings include: Based on record re- 08/03/2021 betwee with the Program D training or testing of documented in the Based on interview the Program Direct only specifically re training at the time This deficiency wa Director during the	de emergency ning at least every 2 years. view and interview, the sure the emergency am (EPP) training and testing training program. The ICF/IID of the following: provide dness training at least every a documentation of all dness training; demonstrate emergency procedures in CFR 483.475(d) (1). This build affect all occupants.	E 00	037	<ul> <li>/p&gt; 1. The administrator will ensure the emergency plan policies and procedures initial training in emergency preparedness policies and procedures to all new and ex staff, annual emergency train documentation of the training staff demonstration of the training staff demonstration of knowled of the emergency procedures completed in accordance with CFR 483.475(d)(1) and preset the EPP manual.</li> <li>2. The area supervisor and program manager will provide initial training to all existing staff and the training testing documentation will be present in the Emergency Disaster Preparedness Manureference as needed.</li> <li>3. The corrective action with monitored and reviewed for effectiveness at a minimum bi-annual</li> </ul>	isting ning, nand edge s is h ent in d e taff g and
					The persons responsible w be the, Program Manager, A Supervisor, and Residential	vrea

	R MEDICARE & MEDI				NETRICTION		MB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULI A. BUILI		NSTRUCTION	, í	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI B. WING		COMPLETED		
		15G157	B. WING			08/03/2021	
NAME OF	PROVIDER OR SUPPLI	EB	S	TREET A	DDRESS, CITY, STATE, ZIP CODE		
					PACHE DR		
RES CA	RE COMMUNITY	ALTERNATIVES SE IN	J	EFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		D			(X5)
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TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)	Т	AG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	RIATE	DATE
					Manager		
E 0039		16.54(d)(2), 418.113(d)(2),					
Dida		82.15(d)(2), 483.475(d)(2),					
Bldg		4.102(d)(2), 485.625(d)(2), 5.727(d)(2), 485.920(d)(2),					
		91.12(d)(2), 494.62(d)(2)					
	EP Testing Requ						
		418.113(d)(2), §441.184(d)					
		2), §482.15(d)(2),					
		483.475(d)(2), §484.102(d)					
		2), §485.625(d)(2),					
	§485.727(d)(2),	§485.920(d)(2), §491.12(d)					
	(2), §494.62(d)(2	2).					
	*IFor ASCs at &/	16.54, CORFs at §485.68,					
		tions" under §485.727,					
		.920, RHCs/FQHCs at					
		RD Facilities at §494.62]:					
	(2) Testing. The	[facility] must conduct					
	exercises to test	the emergency plan					
		cility] must do all of the					
	following:						
	(i) Participate in	a full-scale exercise that is					
		d every 2 years; or					
		imunity-based exercise is					
		conduct a facility-based					
		se every 2 years; or					
		cility] experiences an actual					
		nade emergency that					
		on of the emergency plan,					
		empt from engaging in its					
		mmunity-based or individual,					
		nctional exercise following					
	the onset of the						
	(ii) Conduct an a	dditional exercise at least					

AND PLAN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIEI RE COMMUNITY A	R LTERNATIVES SE IN		STREET A 3011 AI JEFFEF	ODE			
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	every 2 years, op full-scale or functi paragraph (d)(2)(i conducted, that m limited to the follo (A) A second full- community-based functional exercis (B) A mock disast (C) A tabletop exe led by a facilitator discussion using a clinically-relevant a set of problem s messages, or pre to challenge an en (iii) Analyze the [f. maintain document exercises, and en the [facility's] eme *[For Hospices at (2) Testing for ho the patient's home conduct exercises at least annually. following: (i) Participate in a community based (A) When a comm accessible, condu based functional e (B) If the hospice man-made emerg activation of the e is exempt from en full scale communi individual facility-l following the onse	posite the year the onal exercise under i) of this section is hay include, but is not wing: scale exercise that is I or individual, facility-based e; or ter drill; or ercise or workshop that is r and includes a group a narrated, emergency scenario, and statements, directed pared questions designed mergency plan. acility's] response to and ntation of all drills, tabletop mergency events, and revise ergency plan, as needed.						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	r í			CON 08/	te survey Mpleted 03/2021
NAME OF	PROVIDER OR SUPPLIEF	ξ.			DDRESS, CITY, STATE, ZIP C PACHE DR	ODE	
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	SONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE APPROPRIATE	COMPLETIC
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e year the full-scale or					
		e under paragraph (d)(2)(i)					
	of this section is c	onducted, that may					
	include, but is not	limited to the following:					
	(A) A second full-	scale exercise that is					
	community-based	or a facility based					
	functional exercise	e; or					
	(B) A mock disas						
	• •	ercise or workshop that is					
		and includes a group					
	discussion using a	<b>U</b>					
	-	emergency scenario, and					
		statements, directed					
		pared questions designed					
	to challenge an er						
	(3) Testing for hos	spices that provide inpatient					
	care directly. The	hospice must conduct					
	exercises to test t	he emergency plan twice					
	per year. The hos	spice must do the following:					
	(i) Participate in a	an annual full-scale					
		ommunity-based; or					
		nunity-based exercise is					
		nduct an annual individual					
		stional exercise; or					
		experiences a natural or					
		ency that requires					
	-	mergency plan, the					
		t from engaging in its next					
		community based or					
		tional exercise following					
	the onset of the en						
	( )	dditional annual exercise					
	-	but is not limited to the					
	following:						
	• •	scale exercise that is					
	-	or a facility based					
	functional exercise						
	(B) A mock disas	ter drill; or					
	$(\mathbf{C})$ A tablatan av	ercise or workshop led by a	1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. \*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NFV121 Facility ID: 000693 If continuation sheet Page 31 of 55

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) discussion, 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. \*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 32 of 55

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. \*[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 33 of 55

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. \*[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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/IID's response to and FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NFV121 Facility ID: 000693 If continuation sheet Page 34 of 55

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	(X2) MULT A. BUILI B. WING	DING	STRUCTION	CO	(X3) DATE SURVEY COMPLETED 08/03/2021	
NAME OF	PROVIDER OR SUPPLIE	ËR		STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR				
RES CARE COMMUNITY ALTERNATIVES SE IN		J	JEFFERSONVILLE, IN 47130					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	Т	CAG	DEFICIENCY)		DATE	
	exercises, and e	entation of all drills, tabletop mergency events, and revise ergency plan, as needed.						
	*[For HHAs at §4 (d)(2) Testing. Th							
	least annually. The following:	he HHA must do the						
	community-base (A) When a							
	individual, facility every 2 years; or	-based functional exercise						
	natural or man-m	nade emergency that on of the emergency plan,						
	required full-scal	pt from engaging in its next e community-based or v based functional exercise						
	following the ons (ii) Conduct an a	et of the emergency event. dditional exercise every 2						
		he year the full-scale or se under paragraph (d)(2)(i) conducted, that may						
	include, but is no (A) A second	t limited to the following: d full-scale exercise that is						
	facility-based fun (B) A mock of	d or an individual, ictional exercise; or disaster drill; or						
	is led by a facilita discussion, using							
	a set of problem messages, or pre	t emergency scenario, and statements, directed epared questions designed						
		emergency plan. HHA's response to and entation of all drills, tabletop						

AND PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DA 	FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 08/03/2021	
NAME OF	PROVIDER OR SUPPLIEI	λ.	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR				
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		JEFFER	SONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	exercises, and en	nergency events, and revise ency plan, as needed.						
	exercises to test to OPO must do the (i) Conduct a pape or workshop at lea exercise is led by group discussion, relevant emergen problem statemen prepared question emergency plan. actual natural or n requires activation the OPO is exemp required testing e of the emergency (ii) Analyze the O maintain document exercises, and em	e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of its, directed messages, or its designed to challenge an if the OPO experiences an nan-made emergency that n of the emergency plan, ot from engaging in its next xercise following the onset						
	exercises to test t RNHCI must do th (i) Conduct a pap	e RNHCI must conduct he emergency plan. The						
	narrated, clinically scenario, and a se directed message designed to challe (ii) Analyze the RI maintain docume	led by a facilitator, using a -relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop mergency events, and revise						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		NSTRUCTION	COMPL	
	OF CORRECTION	15G157	B. WIN				
		15G157	D. WIN			08/03/	2021
NAME OF	PROVIDER OR SUPPLIEF	ł			ADDRESS, CITY, STATE, ZIP CODE		
					PACHE DR		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-c	COMPLETI
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	L	DATE
	the RNHCI's eme	rgency plan, as needed.					
	Based on record rev	view and interview, the	E 003	39	1. The administrator will ens	ure	09/02/20
	facility failed to con	nduct an additional exercise			the emergency plan policies ar	nd	
	to test the emergence	cy plan at least once per year.			procedures includes the		
	The ICF/IID facility	y must conduct an additional			participation in a full-scale		
	-				community based exercise and	a	
					table top exercise in accordance	ce	
	-	le exercise that is			with CFR 483.475(d)(2) and		
	community-based of	r an individual, facility-based			present in the EPP manual.		
	functional exercise.				2. The area supervisor and		
	b. A mock disaster	drill; or			program manager will conduct	the	
	c. A tabletop exerci	se or workshop that is led by			table top exercise and ensure		
	a facilitator that inc	ludes a group discussion led			documentation of the table top		
					exercise and the community		
		-			based exercise are present in	the	
	of problem stateme	nts, directed messages, or			Emergency Disaster		
	prepared questions	designed to challenge an			Preparedness Manual for		
	emergency plan.				reference as needed.		
	(iii) Analyze the IC	F/IID facility's response to					
	and maintain docum	nentation of all drills, tabletop					
	exercises, and emer	gency events, and revise the					
	ICF/IID facility's er	nergency plan, as needed in			3. The Program Manager w	ill	
	accordance with 42	CFR 483.475(d)(2).			schedule a training event with		
	This deficient pract	ice could affect all			community based services the		
	occupants.				Area Supervisor, and Resident	tial	
	<ul> <li>the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct an additional exercise to test the emergency plan at least once per year. The ICF/IID facility must conduct an additional exercise that may include, but is not limited to the following: <ul> <li>a. A second full-scale exercise that is</li> <li>community-based or an individual, facility-based functional exercise.</li> <li>b. A mock disaster drill; or</li> <li>c. A tabletop exercise or workshop that is led by a facilitator, using a narrated,</li> <li>clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</li> <li>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2).</li> <li>This deficient practice could affect all occupants.</li> </ul> </li> <li>Findings include:</li> <li>Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, documentation of an additional exercise was not available for review, the Program Director it was determined that the EPP did not include scheduled testing or an additional exercise. The Program Director</li> </ul>				Manager ensure the facility tak	es	
	Findings include:	Cl's emergency plan, as needed. record review and interview, the led to conduct an additional exercise emergency plan at least once per year. ID facility must conduct an additional hat may include, but is not limited to ing: d full-scale exercise that is y-based or an individual, facility-based exercise. disaster drill; or op exercise or workshop that is led by or that includes a group discussion led tator, using a narrated, relevant emergency scenario, and a set n statements, directed messages, or puestions designed to challenge an y plan. ze the ICF/IID facility's response to ain documentation of all drills, tabletop and emergency events, and revise the icility's emergency plan, as needed in e with 42 CFR 483.475(d)(2). ient practice could affect all nclude: record review and interview on 1 between 10:50 a.m. to 12:30 p.m. rogram Director, documentation of an exercise was not available for review. interview at the time of record review, m Director it was determined that the ot include scheduled testing or an exercise. The Program Director lges that an additional exercise was not		part in the training.			
	Based on record rev	view and interview on			4. The Program Manager w	ill	
					contact local community based		
		-			services to schedule a commu		
	-				based table top exercise befor	•	
					October 21, 2021.		
					, , , , , , , , , , , , , , , , , , , ,		
	-				Persons Responsible: Progra	am	
		0			Manager, Area Supervisor, and		
					Residential Manager.		
	accomplished.						
	This deficiency was	s reviewed with the Program					

PRINTED: 09/01/2021 FORM APPROVED OMB NO. 0938-0391

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

STATEME AND PLAN	OF CORRECTION	x1) provider/supplier/clia identification number: 15G157	(X2) M A. BU B. WI	JILDING NG	<u></u>	-	ATE SURVEY MPLETED 103/2021
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN		3011 AF	ADDRESS, CITY, STATE, ZIP C PACHE DR RSONVILLE, IN 47130	ODE	
(X4) ID PREFIX TAG	(EACH DEFICI REGULATORY (	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
	Ũ	e Exit Conference held on een 2:30 p.m. and 3:00 p.m.					
K 0000							
Bldg. 03	conducted by the	de Recertification Survey was Indiana Department of Health h 42 CFR 483.470(j). 03/2021	K 0	000			
	Facility Number: Provider Number AIM Number: 10	000693 : 15G157					
	Community Alter compliance with in Medicaid, 42 C Safety from Fire a National Fire Pro 101, Life Safety C	y Code survey, Res Care natives SE IN was found not in Requirements for Participation CFR Subpart 483.470(j), Life and the 2012 Edition of the tection Association (NFPA) Code (LSC), Chapter 33, ial Board and Care					
	fully sprinklered. an exterior door a means of escape. found to be V(000 system with smol living areas. The for living space, s The attic is protect connected to the	ilding was determined to be Each story of the building has t grade serving as the primary The construction type was )). The facility has a fire alarm the detection in corridors and all attic of the facility is not used torage, or fuel-fired equipment. the by heat detector(s) fire alarm control panel. The actity of 8 and had a census of 8 survey.					
	Calculation of the	Evacuation Difficulty Score					

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	A. BUILDING <u>03</u> COM B. WING <u>08/0</u>		DATE SURVEY OMPLETED 8/03/2021
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	3011 /	ADDRESS, CITY, STATE, ZIP CODE APACHE DR ERSONVILLE, IN 47130	
(X4) ID		STATEMENT OF DEFICIENCIES			(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Approaches to Lif	FPA 101A, Alternative The Safety, Chapter 6, rated the th an E-Score of 0.9.			
	Quality Review co	ompleted on 08/10/21			
K S100	NFPA 101 General Require	ments - Other			
	Section 33.1 or 3 that are not addr K-tags, but are d along with the ap NFPA standard of on Form CMS-23 Based on observat failed to ensure 4 located in the faci monthly and the in including the date performing the ins the provisions of 0 LSC 4.6.12.3 requ obvious to the put to be either mainta the Standard for P 2010 Edition, Sec extinguishers shal or by means of an device/system at a Where monthly m conducted, the date performing the ins	tion and interview, the facility of 4 portable fire extinguisher lity was inspected at least inspections were documented and initials of the person spection. LSC 33. 1.1.3 states Chapter 4, General, shall apply. tires existing LSC features olic, such as fire extinguishers, ained or removed. NFPA 10, ortable Fire Extinguishers, tion 7.2.1.2 states fire 1 be inspected either manually electronic monitoring in minimum of 30-day intervals. anual inspections are the manual inspection was e initials of the person spection shall be recorded.	K S100	<ol> <li>ResCare Maintenance will conduct monthly inspections of all facility fire extinguishers.</li> <li>Documented test dates will be kep onsite and with maintenance manager for review.</li> <li>The AED met with ResCare Maintenance Manager on August 20, 2021 to ensure monthly checks are being performed.</li> <li>The Facility will conduct random monthly inspections by the Residential Manager, Area Supervisor or Program Manager to ensure documentation of Fire Extinguisher Inspections are being completed as required and available for review. If documentation is not available the</li> </ol>	09/02/2021
	records for manua tag or label attach	pections are conducted, l inspections shall be kept on a ed to the fire extinguisher, on cklist maintained on file, or by		Program Manager, Area Supervisor or Residential Manager will contact Aramark (844)- RESCARE and create a	

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 15G157	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 03	COM	) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	3011	ADDRESS, CITY, STATE, ZIP COE APACHE DR ERSONVILLE, IN 47130	DE		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	TION JLD BE ROPRIATE	(X5) COMPLETIO DATE	
	demonstrating that inspections have b practice could affer visitors. Findings include: Based on observat 08/03/2021 betwee with the Program I extinguishers have the inspectors initi date. This pattern I months. Based on observation, the Pr that the inspector I month on which the This deficiency wa Director during the	od. Records shall be kept at least the last 12 monthly een performed. This deficient ct all clients, staff and to during the facility tour on en 12:30 p.m. and 2:00 p.m. Director, portable fire been marked each month with als without noting a specific nas been in place for the last 12 interview at the time of ogram Director acknowledged had not provided the date of the e inspection was performed. as reviewed with the Program e Exit Conference held on en 2:30 p.m. and 3:00 p.m.		<ul> <li>service order and follow i ensure completion within</li> <li>4. The AED will in ser</li> <li>Program Manager, Area</li> <li>Supervisor and Resident</li> <li>Manager on the requirem</li> <li>inspecting Fire Extinguish</li> <li>maintaining proper</li> <li>documentation.</li> <li>5. Random Monthly si</li> <li>will be conducted by the</li> <li>management team to ver</li> <li>inspecting Fire Extinguish</li> <li>maintaining proper docur</li> <li>Persons Responsible: A</li> <li>Program Manager, Area</li> <li>Supervisor, and Reside</li> <li>Manager, DSP Koorsen</li> <li>and Security Represent</li> </ul>	5 days. vice the ial nent of hers and ite visits rify the hers and mentation AED, ntial Fire		
K S345 Bldg. 03	in accordance wi complying with th 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	m - Testing and (Prompt) em is tested and maintained th an approved program te requirements of NFPA 70, Code, and NFPA 72, rm and Signaling Code. m acceptance, maintenance eadily available.	K S345	<ol> <li>The administrator w annual functional testing</li> </ol>		09/02/202	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 03 COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) the annual testing of all devices connected to 1 initiating devices such as smoke of 1 fire alarm system was complete. NFPA 72, detectors, heat detectors, release devices, and fire alarm boxes is National Fire Alarm Code, the 2010 Edition, at performed by Koorsen Fire and 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that Security on the fire alarm system includes the following information regarding and that reports of the tests/inspections are available in tests and all the applicable information requested in Figure 14.6.2.4: the facility for review. The administrator will ensure (1) Date 2. sensitivity testing of the fire alarm (2) Test frequency (3) Name of property system is completed by Koorsen Fire and Security every alternate (4) Address (5) Name of person performing inspection, year after install and that reports of the tests/inspections are maintenance, tests, or combination thereof, and available in the facility for review. affiliation, business address, and telephone number Koorsen Fire and Security will (6) Name, address, and representative of also forward inspection reports to the QA Manager for monitoring of approving agency (ies) (7) Designation of the detector(s) tested completion. (8) Functional test of detectors (9)\*Functional test of required sequence of 3. The Program Manager will meet with a representative from operations (10) Check of all smoke detectors Koorsen Fire and Security, a (11) Loop resistance for all fixed-temperature, tentative date has been set for August 16, 2021 The Facility will line-type heat detectors (12) Functional test of mass notification system require schedule required testing control units and request copies of inspections (13) Functional test of signal transmission to and testing mailed to the program manager upon completion to the mass notification systems (14) Functional test of ability of mass Program Manager at 4341 Security PKWY Suite 101 New notification system to silence fire alarm notification appliances Albany IN 47150. (15) Tests of intelligibility of mass notification 4. The Program Manager system speakers (16) Other tests as required by the equipment spoke with the Kris Carney from Koorsen Fire and Security manufacturer's published instructions (17) Other tests as required by the authority effective immediately all sites will have an annual functional fire having jurisdiction (18) Signatures of tester and approved authority alarm inspection in the Month of representative February and a semiannual fire

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

Event ID: NF

NFV121 Facility I

Facility ID: 000693

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>03</u>	(X3) DATE SURVEY COMPLETED 08/03/2021
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		3011 A	ADDRESS, CITY, STATE, ZIP CODE PACHE DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES 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)	DATE
	test (e.g., system of corrected/successf abandoned in plac This deficient prac- in the facility. Findings include: Based on record re 08/03/2021 betwe with the Program the fire alarm insp available for revie the facility tour or p.m. and 2:00 p.m hanging tag was fo panel dated 02/21/ time of record revi acknowledged tha alarm inspection a the facility. Recor- are maintained at the This deficiency we	f problems identified during owner notified, problem fully retested, device e) etice could affect all occupants eview and interview on en 10:50 a.m. to 12:30 p.m. Director, no documentation of ection and testing was w. Based on observation during 0.08/03/2021 between 12:30 . with the Program Director, a bound at the fire alarm control 21. Based on interview at the iew, the Program Director t the written reports of the fire nd testing were not available at ds of the inspections and tests the corporate office. as reviewed with the Program e Exit Conference held on en 2:30 p.m. and 3:00 p.m.		alarm visual inspection complet in August. Repair of the device that failed the sensitivity test h been scheduled to be complet no later than August 31,2021. Access to the device will be m available and that device will b tested no later than August 31 2021. Koorsen Fire and Secu was notified of ResCare's "In Scope Services Agreement" th automatically authorizes repair/service of fire systems. Koorsen will notify the Progran Manger upon completion of all inspections to ensure any deficiencies are properly track and repaired. Koorsen will sen documentation of all inspection services and repair to ResCare main office at 4341 Security Parkway STE. 101 New Alban 47150 within 30 days of completed service. The Progra Manager will follow up to ensu work is completed and documented as required. /b>	es as ed as ed an ade pe as as as as ed an ade pe as
K S347 Bldg. 03	accordance with the following exis	(Prompt) alarms shall be provided in 9.6.2.10, unless either of			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 03 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) 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 guick-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. 1.The Program Manager will Based on observation and interview; the facility K S347 09/30/2021 failed to ensure smoke alarms shall be installed ensure the installation of a smoke in 1 of 6 sleeping rooms. This deficient practice alarm in the sleeping room could affect all clients, staff and visitors. LSC formerly the garage is installed. section 33.2.3.4.3.1 Approved smoke alarms The Program manager contacted ResCare maintenance coordinator shall be provided in accordance with 9.6.2.10, unless otherwise indicated in Dave Danzo to create a work 33.2.3.4.3.6 and 33.2.3.4.3.7. LSC section order for the installation of the 9.6.2.10.1.2 The installation of smoke alarms in device by Koorsen Fire and sleeping rooms shall be required where required Security no later than September by Chapters 11 through 43. 30, 2021. Installation may be delayed due to COVID 19 shelter FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 43 of 55

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	03	COMPLET	ΈD
		15G157	B. WING		08/03/20	)21
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	ER	3011 A	PACHE DR		
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	Findings include:			in place.		
				2.The program manager w		
				verify the installation of the s		
				alarm and verify functionality 3.The Associate Executive		
				Director contacted Eric Grey	with	
	•			Koorsen Fire and Security or		
				August 17, 2021 to verify the		
		-		installation of a smoke detect		
		-		the sleeping room that was		
		C		formally the garage. Upon		
	This deficiency wa	as reviewed with the Program		completion no later than		
	Director during the	e Exit Conference held on		September 30, 2021		
	08/03/2021 betwee	en 2:30 p.m. and 3:00 p.m.		documentation will be made		
				available for review.		
				Persons Responsible: Prog	ram	
				Manager, Area Supervisor,		
				Residential Manager, DSP,		
				ARAMARK, Maintenance		
				Manager.		
K S362	NFPA 101					
NAME OF PROVIDER OR SUPPLIER       3011 A         RES CARE COMMUNITY ALTERNATIVES SE IN       JEFFE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG         Based on observation during the facility tour on       08/03/2021 between 12:30 p.m. and 2:00 p.m.       with the Program Director, no smoke alarms was         found in the sleeping room formerly the garage.       A heat detector was noted in the room. Based on       interview at the time of observation, the Program         Director acknowledged the lack of a smoke       alarm in the sleeping room.       This deficiency was reviewed with the Program         Director during the Exit Conference held on       08/03/2021 between 2:30 p.m. and 3:00 p.m.       108/03/2021 between 2:30 p.m.						
		0				
		-				
	-					
	other constructio	n of equal or greater				
	1			1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 03 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) stability and fire integrity. \* Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are wired glass not exceeding 9 square feet each in area and installed in approved frames. This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels. In Prompt Evacuation facilities, all sleeping rooms shall be separated from the escape route by smoke partitions in accordance with 8.2.4. Sleeping arrangements that are not located in sleeping rooms shall be permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleepina. In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms shall be separated from escape routes by walls and doors that are smoke resistant. 33.2.3.6 1. Based on observation and interview, the K S362 1. The AED will meet with 11/30/2021 facility failed to ensure 5 of 5 sleeping room **ResCare Maintenance Manager** doors were substantial construction: 1 3/4 inches on August 30, 2021 to ensure all doors in the facility meet or thick, solid bonded wood core construction or of other construction of equal or greater stability exceed LSC 8.3.3.1 states and fire integrity. This deficient practice could openings required to have a fire affect 7 consumers sleeping on the second story, protection rating by Table 8.3.4.2 shall be protected by approved, staff and visitors. listed. labeled fire door assemblies and fire window assemblies and Findings include: FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 45 of 55

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 03 B. WING 08/03/2021 15G157 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) their accompanying hardware, Based on observation during the facility tour on including all frames, closing 08/03/2021 between 12:30 p.m. and 2:00 p.m. devices, anchorage, and sills in accordance with the requirements with the Program Director, the 5 sleeping room of NFPA 80, Standard for Fire doors are hollow core wood construction. Based on interview at the time of observation, the Doors and Other Opening Program Director stated the doors were existing Protectives, except as otherwise specified in this Code. NFPA 80, and had not been replaced since the last survey. Standard for Fire Doors and Other Opening Protectives, 2010 This deficiency was reviewed with the Program Director during the Exit Conference held on Edition. Section 4.8.4.2 states the 08/03/2021 between 2:30 p.m. and 3:00 p.m. clearance under the bottom of a door shall be a maximum of 3/4 inch. 2. Based on observation and interview, the 1.The AED will meet with facility failed to ensure 1 of 6 sleeping rooms was separated using a minimum 1/2-hour fire ResCare Maintenance Manager resistance rated assembly. This deficient practice on August 30, 2021 to schedule could affect 1 consumers sleeping on the first the replacement of 5 of 5 sleeping story. doors. Work will be delayed due to a COVID 19 Shelter In Place. Findings include: This will delay measuring and ordering door. Without measurements the vendor has Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. given a tentative delivery date with the Program Director, the one consumer between 6 and 12 weeks due to sleeping room (area) on the first floor was supply chain issues. Upon delivery door will be installed with separated from the remainder of the story using a curtain suspended from a curtain track. Based on in 2 weeks. Estimated install date interview at the time of observation, the Program will be no later than November 30, Director stated that sleeping area provided the 2021 consumer with a quiet space and the condition 2. The installation of a minimum had been unchanged in the last 12 months. 1/2-hour fire resistance rated assembly for the first floor sleeping area, installation will be This deficiency was reviewed with the Program Director during the Exit Conference held on complete no later than September 08/03/2021 between 2:30 p.m. and 3:00 p.m. 30,2021 there will be a delay in installation due to COVID 19 Shelter in place. 3. The program manager will verify the installation upon Event ID: **NFV121** Facility ID: 000693 If continuation sheet Page 46 of 55

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	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	II TIPLE CO	NSTRUCTION	(X3) DATE	IB NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER: 15G157	· /	ILDING	<u>03</u>	COMPI 08/03	LETED
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN			PACHE DR RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	) BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					completion. Persons Responsible: AE Aramark Program Manag Area Supervisor, and Residential Manager, DSI	er,	
< S363 Bldg. 03	NFPA 101 Corridor - Doors Corridor - Doors						
	Doors shall meet requirements: 1. Doors shall other mechanism door closed. 2. No doors sh the occupant from 3. Doors shall automatic-closing in buildings other throughout by an sprinkler system 33.2.3.5. Door assemblies swing in the direct inspected and ter 33.2.3.6.4, 33.7.1				1 The Program Manage	or will	11/20/202
	facility failed to er sleeping rooms do	vation and interview, the asure 1 of 5 consumer ors was provided with a latch. trice could affect the occupant	KS	363	<ol> <li>The Program Manage ensure clients bedroom do positively latch to the fram</li> <li>The maintenance coordinator will ensure all bedroom doors will positive as required.</li> </ol>	oors e. clients	11/30/202
	08/03/2021 betwee with the Program	ion during the facility tour on en 12:30 p.m. and 2:00 p.m. Director, the door to bedroom l open and the strike and door			1.The AED will meet with ResCare Maintenance Ma on August 30, 2021 to sch	nager	

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 09/01/2021

	PROVIDER OR SUPPLIEI	R LTERNATIVES SE IN	3011 A	ADDRESS, CITY, STATE, ZIP CODE PACHE DR RSONVILLE, IN 47130	
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
REFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	frame are broken. T	The door is not equipped with		the replacement of Bedroom #1	
		Based on interview at the		#2 #3 #4 and #5 sleeping doors.	
		, the Program Director		Work will be delayed due to a	
		the door was damaged and had		COVID 19 Shelter In Place. This	6
		et. The door has been in this		will delay measuring and orderin	q
	condition for severa			door. Without measurements the	
		2		vendor has given a tentative	
	This deficiency was	s reviewed with the Program		delivery date between 6 and 12	
		Exit Conference held on		weeks due to supply chain issue	s.
	-	n 2:30 p.m. and 3:00 p.m.		Upon delivery door will be install	
				with in 2 weeks. Estimated instal	
	2. Based on observ	vation and interview, the		date will be no later than	
		sure 3 of 5 consumer		November 30, 2021.	
		ors was provided with a		2.The Program Manager will	
		that closed the door. This		train the Residential Manager an	d
		ould affect the occupants of		DSPs to inspect doors daily to	
	Bedroom #2, #3, ar	-		ensure doors operation is not	
				impeded. The Residential	
	Findings include:			manager will inspect the house	
	0			weekly to ensure bedroom door	
	Based on observation	on during the facility tour on		operate as required. Area	
		n 12:30 p.m. and 2:00 p.m.		Manager will preform random	
		Director, the door to bedroom		monthly inspections and Program	n
		mpletely upon release of the		Manager will provide quarterly	
		open position. The		inspections to ensure bedroom	
		did not apply enough		doors positively latch to frame as	;
	-	le latch to engage the strike.		required.	
	-	at the time of observation,		3.Staff will notify ResCare	
		or acknowledged that the		Maintenance upon discovery of	
	-	ed upon release of the door.		any damage that prevents Client	s
		1		Bedroom Doors from positively	
	This deficiency was	s reviewed with the Program		latching to the frame as required	
		Exit Conference held on		by calling 844-ResCare.	
	-	n 2:30 p.m. and 3:00 p.m.		Persons Responsible: Program	ı
		1 1		Manager, Area Supervisor,	
	3. Based on observ	vation and interview, the		Residential Manager, DSP,	
		sure 1 of 5 consumer		ARAMARK, Maintenance	
		rs was obstructed from		Manager.	
		ient practice could affect the			
	occupant of Bedroo	-			

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Event ID: NFV121

Facility ID: 000693

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G157	A. BUILDING B. WING	03	· •	eleted 3/2021
		130137	_	T ADDRESS, CITY, STATE, ZIP COI		5/2021
NAME OF 1	PROVIDER OR SUPPLIE	R		APACHE DR		
RES CA	RE COMMUNITY /	ALTERNATIVES SE IN	JEFFI	ERSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	Findings include:					
	Based on observat	ion during the facility tour on				
		en 12:30 p.m. and 2:00 p.m.				
	-	Director, the door to bedroom				
		g shoe rack that rubs on the				
		ng. The door did not close to 1 the strike. Based on interview				
		rvation, the Program Director				
		t the door was not closing as a				
	result of the shoe i	-				
	This deficiency wa	as reviewed with the Program				
	-	e Exit Conference held on en 2:30 p.m. and 3:00 p.m.				
S511	NFPA 101					
	Utilities - Gas an					
Bldg. 03	Utilities - Gas an					
		gas or related gas piping PA 54, National Fuel Gas				
		viring and equipment				
	complies with NF	PFA 70, National Electric				
	Code. 32.2.5.1, 33.2.5. <sup>-</sup>	1. 9.1.1. 9.1.2				
	,		K S511	1.The Program Manag	ger will	08/03/202
		ion and interview, the facility		train the area superviso		
		of 1 electrical panels was		residential manager, an		
		r work space in accordance to		on removing obstructio		
		), 2011 Edition, Article out Electrical Equipment.		combustibles from the space for electrical pan	-	
	-	ig space shall be provided and		2.All combustibles we		
		all electrical equipment to		removed from the work	-	
		afe operation and maintenance		on 8/3/2021		
	of such equipment			3.The Residential man	-	
		e. Working space for		will conduct weekly ins	-	
		ng at 600 volts, nominal, or		to ensure no combustit		
	-	likely to require examination, ing, or maintenance while		stored in the electric pa workspace. The Area	mei	
	aujusineni, servic	ing, or maintenance wille		workspace. The Aled		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DA7	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	03	COM	IPLETED
		15G157	B. WI	NG	<u></u>	- 08/0	)3/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CO	DE	
NAME OF 1	PROVIDER OR SUPPLIE	ER			PACHE DR		
RES CA	RE COMMUNITY /	ALTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	energized shall co	mply with the dimensions of			Supervisor will conduc	t	
	110.26(A)(1), (A)	(2), and (A)(3) or as required			monthly inspections to	ensure	
	or permitted elsew	here in this Code.			no combustibles are st	ored in	
	(B) Clear Spaces.	Working space required by this			the work space.		
	section shall not b	e used for storage. When			Persons Responsible:	Program	
	normally enclosed	live parts are exposed for			Manager, Area Supervi	sor,	
	inspection or servi	icing, the working space, if in a			Residential Manager, D	SP,	
	passageway or ger	neral open space, shall be					
	suitably guarded.						
	Findings include:						
	Based on observat	ion during the facility tour on					
		en 12:30 p.m. and 2:00 p.m.					
		Director, the electrical panel					
	-	et of the sleeping room					
		he garage was obstructed by					
		es. Based on interview at the					
		n, the Program Director					
		t the work space in front of the					
	panel was used for	-					
	This deficiency wa	as reviewed with the Program					
		e Exit Conference held on					
	-	en 2:30 p.m. and 3:00 p.m.					
< S711	NFPA 101						
	Evacuation and I	Relocation Plan					
Bldg. 03	Evacuation and I	Relocation Plan					
	The administration	on of every resident board					
	and care facility	shall have in effect and					
	available to all su	upervisory personnel written					
		for protecting all persons in					
		for keeping persons in					
		ating persons to areas of					
	-	vacuating person from the					
	-	cessary. The plan shall					
		taff response, including fire					
		dures needed to ensure the					
	safety of any res	ident, and shall be amended					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 03 B. WING 08/03/2021 15G157 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility. All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk. 32.7.1, 32.7.2, 33.7.1, 33.7.2 Based on record review and interview, the K S711 1.The Program Manager will 09/02/2021 retrain the staff ensure all facility administration failed to ensure all consumers are periodically instructed and drill consumers are periodically instructed and drill the use of the the use of the secondary exit from the sleeping room under the written fire safety plan. This secondary exit from the sleeping deficient practice affects all consumers. LSC room under the written fire safety section 33.7.3.4 Exits and means of escape not plan. used in any drill shall not be credited in meeting 2.QIDP will train all residents the requirements of this Code for board and care participating in the emergency facilities. plan will be trained in the proper actions to be taken in the event of Findings include: fire. Training will include proper actions to be taken if the primary Based on record review and interview on escape route is blocked. 3. The area supervisor will 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, the facility failed to monitor random fire drill to ensure schedule fire drills to practice the use of the all consumers are periodically FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: 000693 If continuation sheet **NFV121** Page 51 of 55

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING			CON	(X3) DATE SURVEY COMPLETED 08/03/2021	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		3011 A	ADDRESS, CITY, STATE, ZIP COI PACHE DR RSONVILLE, IN 47130	DE		
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		(X5) COMPLETION	
TAG	secondary exits of interview at the tir Program Director drills did not inclu This deficiency wa Director during the	R LSC IDENTIFYING INFORMATION) The sleeping rooms. Based on ne of record review, the acknowledged that the fire de the exit windows. as reviewed with the Program e Exit Conference held on en 2:30 p.m. and 3:00 p.m.		TAG	DEFICIENCY) instructed and drill the us secondary exit from the room under the written fi plan. Persons Responsible: I Manager, Area Supervis Residential Manager, D	se of the sleeping ire safety Program sor,	DATE	
< S712 Bldg. 03	least quarterly fo and under varied a. Ensure that trained to perform b. Ensure that familiar with the emergency and o procedures. 2. The facility mu a. Actually eva one drill each yea b. Make specia evacuation of clie disabilities; c. File a report drill; d. Investigate a drills, including a action; and e. During fire d evacuated to a s	all personnel on all shifts are n assigned tasks; all personnel on all shifts are use of the facility's disaster plans and ist: cuate clients during at least						
		r Code. r meet the requirements of ) and (2) of this section for						

### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 03 COMPLETED 15G157 B. WING 08/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3011 APACHE DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the K S712 09/02/2021 1. All staff at the Facility will be facility failed to conduct fire drills quarterly on re-trained on conducting fire drills the first shift for 2 of the last 4 calendar quarterly on all shifts. The quarters. This deficient practice could affect all Residential Manager will review all clients. drills to ensure all required drills area conducted. The Program Findings include: Manager will train the Area Based on record review and interview on Supervisor and the Area 08/03/2021 between 10:50 a.m. to 12:30 p.m. Supervisor will train all facility with the Program Director, there was no record staff. of a fire drill conducted on the first shift for the The Area Supervisor will first and second quarters of the year 2021. Based 2. visit the home at least monthly to on interview at the time of record review, the Program Director acknowledged that the ensure the drills are in the home and up to date. documentation of the drills was absent from the binder and he could not verify that the drills had occurred. 3. The Residential Manager will submit monthly drills to the QA This was verified by the program manager at the Department upon completion. The time of record review and acknowledged at the QA Department will notify the Area exit conference on 04/05/17 at 12:25 p.m. Manager and Program manager if the facility has not performed monthly drills as required. 4. The Area supervisor will ensure drills are completed as required. /p> Persons **Responsible: Program** Manager, Area Supervisor, **Residential Manager, DSP** K S741 **NFPA 101 Smoking Regulations** Bldg. 03 **Smoking Regulations**

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

AND PLAN OF CORRECTION IDENTIFICATION NU		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING <u>03</u>			(X3) DATE SURVEY COMPLETED	
		15G157	B. WING			08/03/2021	
	PROVIDER OR SUPPLIEF	R LTERNATIVES SE IN		3011 A	ADDRESS, CITY, STATE, ZIP CODE PACHE DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRI DEFICIENCY)	(X5) COMPLETIC DATE	
	administration of H occupancies. Wh noncombustible s receptacles shall locations. 32.7.4.1, 32.7.4.2 Based on record rev failed to maintain a for consumers and a practice affects all of Findings include: Based on record rev 08/03/2021 betweet with the Program D facility smoking por review. Based on i review, the Program smoking policy was but not available. This deficiency was	ons shall be adopted by the board and care ere smoking is permitted, afety type ashtrays or be provided in convenient , 33.7.4.1, 33.7.4.2 view and interview the facility smoking policy for a facility staff smoking. This deficient clients, staff and visitors. view and interview on n 10:50 a.m. to 12:30 p.m. Director, documentation of a licy was not available for nterview at the time of record n Director stated that the s in the employee handbook s reviewed with the Program Exit Conference held on n 2:30 p.m. and 3:00 p.m.	KS	741	<ol> <li>All staff at the home will re-trained the Facilities smoki policy, and use of the designal smoking area.</li> <li>The Facility will in servic staff on the use of the smokin tower used to dispensing ciga butts.</li> <li>All staff in the facility will inserviced on ensure smoking materials are deposited into ashtrays and metal container with self-closing cover device into which ashtrays can be emptied of noncombustible material and safe design</li> <li>The Facility will ensure smoking area is cleaned and cigarette butts are removed for the ground and disposed of properly</li> <li>The Program Manager, Area Supervisor, and Resider Manager will randomly inspect facility monthly to ensure the proper use of the smoking too and that cigarette butts are not being thrown on the ground.</li> </ol>	the all rom	

NTERS FOR STATEMENT	OF HEALTH AND HU MEDICARE & MEDIC T OF DEFICIENCIES DF CORRECTION		(X2) MULTIPLE C A. BUILDING	onstruction <u>03</u>	PRINTED: 09/01/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIE	15G157 R LTERNATIVES SE IN	3011 A	ADDRESS, CITY, STATE, ZIP CODE NPACHE DR RSONVILLE, IN 47130	08/03/	/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	OULD BE COMPLETION	
				Persons Responsible: Pro Manager, Area Supervisor Residential Manager, DSP	;	

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