STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/08/2023	
	RE COMMUNITY A	R ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE 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 APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
E 0000 Bldg	An Emergency Preconducted by the I accordance with 42 Survey Date: 11/0 Facility Number: Provider Number: AIM Number: 100 At this Emergency Community Altern compliance with E Requirements for Participating Provid83.475.  The facility has 8 ocertified for Medic the census was 8.  Quality Review control The requirement at NOT MET as evid 403.748(d)(2), 484 A85.68(d)(2), 485 A86.360(d)(2), 485	paredness Survey was adiana Department of Health in 2 CFR 483.475.  8/23  000775  15G2553 0248960  Preparedness survey, Res Care atives SE IN was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR  Pertified beds. All 8 beds are aid. At the time of the survey,  mpleted on 11/09/23  142 CFR, Subpart 483.475 is enced by:  6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 3.102(d)(2), 485.625(d)(2), 3.727(d)(2), 485.920(d)(2), 3.112(d)(2), 494.62(d)(2) irements  18.113(d)(2), §441.184(d)(2),	E 00		DEFICIENCY		DATE
	§483.475(d)(2), §	82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) ), §494.62(d)(2).					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Anna Brison **Program Director** 11/17/2023

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		15G255	B. W	ING		11/08	/2023
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
				154 CH			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		VERSA	ILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:  (2) Testing. The [facility] must conduct						
	` '	he emergency plan					
	annually. The [fac	ility] must do all of the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based every 2 years; or						
	•	nunity-based exercise is					
	not accessible, conduct a facility-based						
		e every 2 years; or					
	(B) If the [faci	ility] experiences an actual					
	natural or man-ma	ade emergency that requires					
		mergency plan, the [facility]					
	· ·	gaging in its next required					
	-	or individual, facility-based					
		e following the onset of the					
	actual event.	ditional avancias at least					
	` '	ditional exercise at least					
		posite the year the full-scale cise under paragraph (d)(2)					
		s conducted, that may					
	• •	limited to the following:					
		scale exercise that is					
	• •	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	, ,	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	tements, directed					
		pared questions designed					
	to challenge an er						
	(iii) Analyze the [fa	acility's] response to and					

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PRINTED: 11/28/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION		TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	_	COM	IPLETED	
		15G255	B. WIN	IG		11/0	08/2023	
NAME OF			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CO	)D		
NAME OF	PROVIDER OR SUPPLIEI	K		154 CH				
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		VERSAILLES, IN 47042				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE PROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		ntation of all drills, tabletop						
		nergency events, and revise						
	the [facility's] eme	ergency plan, as needed.						
	*[For Hospices at	418.113(d):]						
		ospices that provide care in						
	the patient's home	e. The hospice must						
	conduct exercises	s to test the emergency						
	plan at least annu	ally. The hospice must do						
	the following:							
	(i) Participate in a	a full-scale exercise that is						
	community based	l every 2 years; or						
	(A) When a comn	nunity based exercise is not						
	accessible, condu	ıct an individual facility						
		exercise every 2 years; or						
	1 ' '	experiences a natural or						
		ency that requires activation						
		plan, the hospital is						
	1	aging in its next required full						
	1	based exercise or individual						
	1	ctional exercise following the						
	onset of the emer							
	1 ' '	dditional exercise every 2						
		ne year the full-scale or						
		e under paragraph (d)(2)(i) conducted, that may						
		limited to the following:						
		-scale exercise that is						
		or a facility based						
	functional exercis							
	(B) A mock disas							
		ercise or workshop that is						
		and includes a group						
	discussion using	<del>-</del> -						
	_	emergency scenario, and a						
	1	atements, directed						
	1	pared questions designed						

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to challenge an emergency plan.

(3) Testing for hospices that provide inpatient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/08/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP COD HAD DR AILLES, IN 47042	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
TAG	care directly. The exercises to test the per year. The hose (i) Participate in a that is community. (A) When a commaccessible, conduct facility-based functions of the emergency exempt from engated full-scale community. (ii) Conduct an activate may include, following:  (A) A second full-community-based functional exercises (B) A mock disassication (C) A tabletop exemptication of the emergency scenarior and the emergency plan.  (iii) Analyze the himaintain documer exercises, and emergency and the emergency and emerge	cunity-based exercise is not ct an annual individual tional exercise; or experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the dittional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion	TAG	DEFICIENCY	DATE
	§482.15(d), CAHs (2) Testing. The [F conduct exercises	41.184(d), Hospitals at at §485.625(d):] PRTF, Hospital, CAH] must to test the emergency r. The [PRTF, Hospital,			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		15G255	B. W	ING		11/08	2023
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP COD		
				154 CH			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		VERSA	ILLES, IN 47042		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	CAH] must do the	_					
		nn annual full-scale exercise					
	that is community	nunity-based exercise is not					
	1 ' '	ct an annual individual,					
		ctional exercise; or					
	1	Hospital, CAH] experiences					
		or man-made emergency					
		ation of the emergency					
		is exempt from engaging in					
		ull-scale community based					
	· ·	ty-based functional exercise					
		et of the emergency event.					
	_	an [additional] annual					
		at may include, but is not					
	limited to the follo	-					
		scale exercise that is					
	community-based						
	facility-based fund	ctional exercise; or					
	(B) A mo	ock disaster drill; or					
	(C) A tabletor	exercise or workshop that					
	is led by a facilitat	or and includes a group					
	discussion, using	a narrated,					
	1	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	. , ,	he [facility's] response to					
		umentation of all drills,					
	•	s, and emergency events					
		cility's] emergency plan, as					
	needed.						
	*[For PACE at §46	30 84(d)·1					
	l -	PACE organization must					
	l ' '	to test the emergency					
	plan at least annu	- ·					
	organization must	-					
		an annual full-scale exercise					
	that is community						

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G255		A. BUILDING B. WING		COMPLETED 11/08/2023		
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO	)D	
RES CAF	RE COMMUNITY AL	TERNATIVES SE IN		HAD DR AILLES, IN 47042		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG	(A) When a commaccessible, conductable facility-based functions of the endictivation on the endictivation of the e	unity-based exercise is not ct an annual individual, tional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE gaging in its next required ity based or individual, tional exercise following the gency event.  In additional exercise every the year the full-scale or exercise that is or individual, a facility exercise; or exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed exercise to and exercise that is exercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed exercise to and exercise exercise exercises and revise exercise.  It is a set §483.73(d):]  It is a set §483.73(d):]	TAG	CROSS-REFERENCED TO THE AFDEFICIENCY)	PROPRIATE	DATE

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Event ID:

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Facility ID: 000775

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		15G255	B. W	ING		11/08	/2023
NAME OF I	PROVIDER OR SUPPLIEI		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
				154 CH			
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		VERSA	ILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ROSS-REFERENCED TO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ıct an annual individual,					
	facility-based fund						
		cility] facility experiences an					
		man-made emergency that					
		n of the emergency plan, the mpt from engaging its next					
		alle community-based or					
	· ·	based functional exercise					
		et of the emergency event.					
	_	dditional annual exercise					
		but is not limited to the					
	following:						
	(A) A second full-scale exercise that is						
		l or an individual, facility					
	based functional exercise; or						
	(B) A mock disas	ter drill; or					
		ercise or workshop that is					
	led by a facilitator	— ·					
	discussion, using						
		emergency scenario, and a					
		tements, directed					
		pared questions designed					
	to challenge an e						
		LTC facility] facility's naintain documentation of					
		exercises, and emergency					
	·	e the [LTC facility] facility's					
	emergency plan,						
	g, p.s.//,						
	*[For ICF/IIDs at §	§483.475(d)]:					
	(2) Testing. The I	CF/IID must conduct					
		he emergency plan at least					
		ne ICF/IID must do the					
	following:						
		n annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
		ıct an annual individual,					
		ctional exercise; or.					
	(R) It the ICF/IID	experiences an actual					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPLETED	
		15G255	B. W	NG		11/08	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	R		154 CH			
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN			ILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ade emergency that requires					
		mergency plan, the ICF/IID					
	is exempt from engaging in its next required						
	full-scale community-based or individual,						
	1	ctional exercise following the					
	onset of the emer						
	, ,	Iditional annual exercise					
	that may include, but is not limited to the following:						
	(A) A second full-	scale exercise that is					
	community-based	l or an individual,					
	facility-based fund	ctional exercise; or					
	(B) A mock disaster drill; or						
	(C) A tabletop exe	ercise 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 sta	tements, directed					
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
		CF/IID's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and en	nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48						
	(d)(2) Testing. The	e HHA must conduct					
	exercises to test t	he emergency plan at					
	least annually. Th	e HHA must do the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based	l; or					
	(A) When a c	ommunity-based exercise					
		conduct an annual					
	individual, facility-	based functional exercise					
	every 2 years; or.						
	(B) If the HH	A experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the HHA is					
	exempt from engage	aging in its next required					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G255		(X2) MULTIPLE CO A. BUILDING B. WING	e survey pleted 18/2023			
NAME OF	PROVIDER OR SUPPLIEF	•		ADDRESS, CITY, STATE, ZIP COI	)	
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		IAD DR IILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS OF THE APPENDED TO THE APPENDEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY		DATE
		nity-based or individual,				
	1	tional exercise following the				
	onset of the emer	ditional exercise every 2				
	1 ' '	e year the full-scale or				
		e year the full-scale of or of the under paragraph (d)(2)(i)				
	of this section is c					
		limited to the following:				
		full-scale exercise that is				
	community-based					
		tional exercise; or				
	1	isaster drill; or				
	(C) A tableton	exercise or workshop that				
	is led by a facilitat	or and includes a group				
	discussion, using	a narrated,				
	clinically-relevant	emergency scenario, and a				
	set of problem sta	tements, directed				
		pared questions designed				
	to challenge an er	- · ·				
	1 ' '	HA's response to and				
		ntation of all drills, tabletop				
		nergency events, and revise				
	the HHA's emerge	ency plan, as needed.				
	*[For OPOs at §48	36.360]				
	(d)(2) Testing. The	e OPO must conduct				
	exercises to test t	he emergency plan. The				
	OPO must do the	<del>-</del>				
	1 ''	er-based, tabletop exercise				
	-	ast annually. A tabletop				
		a facilitator and includes a				
		using a narrated, clinically				
	_	cy scenario, and a set of				
		ts, directed messages, or				
		is designed to challenge an				
		f the OPO experiences an				
		nan-made emergency that				
		of the emergency plan, the				
	1	om engaging in its next xercise following the onset				
i e	T required testilid e	versise ioliowing the onset	I	1		I

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Event ID:

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Facility ID: 000775

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M				DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		15G255	B. W	ING		11/08/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	t.		154 CH	AD DR		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		VERSA	ILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	of the emergency						
	(ii) Analyze the OPO's response to and						
		ntation of all tabletop					
		nergency events, and revise					
	_	OPO's] emergency plan, as					
	needed.						
	*CDNOL!! + 0.40	7401					
	*[ RNCHIs at §400	=					
		e RNHCI must conduct					
	RNHCI must do the	he emergency plan. The					
		er-based, tabletop exercise					
		A tabletop exercise is a					
	-	led by a facilitator, using a					
	- '	r-relevant emergency					
		et of problem statements,					
		s, or prepared questions					
	_	enge an emergency plan.					
	_	NHCI's response to and					
		ntation of all tabletop					
		nergency events, and revise					
		rgency plan, as needed.					
		view and interview, the facility	E 0	)39	E039: EP Testing Requireme	ents	11/24/2023
		least two exercises to test the					11/2 1/2023
		an annual basis using the			Corrective action:		
		res. The ICF/IID facility must			Mock Drill form updated b	у	
	do all of the follow	ing: (i) Participate in an annual			the Program Director to includ	•	
	full-scale exercise t	hat is community-based; or			what emergency preparednes		
	a. When a commun	ity-based exercise is not			policy or procedure was tested		
	accessible, conduct	an annual individual,			and the Mock Drill must includ	е	
	facility-based funct	ional exercise.			an after action report of the dri	ill.	
		cility experiences an actual			(Attachment A)		
		e emergency that requires			The facility will conduct a	t	
		nergency plan, the ICF/IID			least two full scale or one full		
		om engaging its next required			scale exercise and a table top		
		ty-based or individual,			exercise to test the emergency		
		cale functional exercise for 1			plan at least annually and will		
		onset of the actual event.			the Mock Drill Form (Attachme		
	1 1	itional exercise that may			A&B) for completion and proof	f of	
	include, but is not l	imited to the following:			the exercise.		

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Facility ID: 000775

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

PRINTED: 11/28/2023 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/08/2023
	OF PROVIDER OR SUPPLIE	LTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP COI HAD DR AILLES, IN 47042	)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION (X5) ULD BE COMPLETION PROPRIATE DATE
TAG	a. A second full-secommunity-based of functional exercises b. A mock disaster c. A tabletop exerc facilitator that inche a facilitator, using emergency scenarious statements, directed questions designed plan.  (iii) Analyze the IC maintain document exercises, and eme ICF/IID facility's e accordance with 42 This deficient praction of the provided of the provided for the provided	ale exercise that is or an individual, facility-based drill; or ise or workshop that is led by a ides a group discussion led by a narrated, clinically-relevant o, and a set of problem dimessages, or prepared to challenge an emergency of the control of all drills, tabletop regency events, and revise the emergency plan, as needed in the CFR 483.475(d)(2). Since could affect all occupants.	TAG	Area Supervisor and Manager trained to ensufacility will conduct at leascale or one full scale exand a table top exercise the emergency plan at leannually and will use the Mock Drill Form (Attachment for completion and proof exercise.  Staff will be tested at the EPP. (Attachment Described of the completion of the completion of the completion of the EPP binder in the fact that EPP binder in the fact that EPP binder a sent to Human Resource remain in staff file.  Completion Date: 11/24	d Program are the ast two full acercise to test east e updated ment C) f of the annual on  )  re leted drills am emain in cility. ts will be and will be et to

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/08/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1	54 CH/	DDRESS, CITY, STATE, ZIP COD AD DR LLES, IN 47042		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	mock drill, worksho exercise within the period and agreed a documentation was time of the survey.	not available for review at the	T	AG	DEFICIENCY)		DATE
K 0000							
Bldg. 02	conducted by the In accordance with 42  Survey Date: 11/08  Facility Number: 0 Provider Number: AIM Number: 1002  At this Life Safety Community Alterna compliance with Re Medicaid, 42 CFR S from Fire and the 20 Protection Associate Code (LSC), Chapte Board and Care Occ  This one story build sprinklered. The fawith smoke detecticall living areas. The purposes, storage or provided with a heat the fire alarm syster	200775 15G2553 248960 Code survey, Res Care atives SE IN was found not in equirements for Participation in Subpart 483.470(j), Life Safety 2012 Edition of the National Fire ion (NFPA) 101, Life Safety er 33, Existing Residential	K 0000				

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Event ID:

PPJ621

Facility ID: 000775

If continuation sheet Page 12 of 15

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED	
		15G255	B. W	ING		11/08/	2023
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN		154 CH	ADDRESS, CITY, STATE, ZIP COD AD DR ILLES, IN 47042		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	(E-Score) using NF						
K S712	NFPA 101						
Bldg 02	Fire Drills						
Bldg. 02	Fire Drills	t hold avecuation drills at					
	-	t hold evacuation drills at each shift of personnel and					
	under varied cond						
		Il personnel on all shifts are					
	trained to perform						
	-	Il personnel on all shifts are					
	familiar with the us						
	emergency and di	_					
	procedures.	•					
	2. The facility mus	t:					
	a. Actually evac	uate clients during at least					
	one drill each year	r on each shift;					
	b. Make special	provisions for the					
	evacuation of clier	nts with physical					
	disabilities;						
	-	nd evaluation on each drill;					
	•	problems with evacuation					
	_	cidents and take corrective					
	action; and						
	_	lls, clients may be					
		fe area in facilities certified					
		Care Occupancies Chapter					
	of the Life Safety						
		meet the requirements of					
		and (2) of this section for					
	-	ef staff that they utilize.					
	42 CFR 483.470(i)	) review and interview, the	IZ C	712	K0712: Fire Drills		11/24/2022
		vide documentation of a fire	KS	5712	NUT12: FIRE DITHIS		11/24/2023

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Event ID:

PPJ621

Facility ID: 000775

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED		
15G255		B. WI	B. WING			2023	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042					
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	DECLIDED OF AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	JLATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	drill conducted on the first shift for 1 of 4 quarters. This deficient practice affects all clients, staff and visitors.  Findings include:						
					Corrective Action:		
					·Program Director completed an inservice with the all staff over the		
	Based on review of "Emergency Evacuations Drill:				drill schedule and proper time	s to	
		n with the Direct Services			conduct the drills including us	ing	
		ing record review from 10:15			varied times. (Attachment E)		
		on 11/08/23, documentation of a			·Quality Assurance Manage		
		on the first shift in the fourth			records all drills into a databas		
		ovember, December) 2022 was view. Based on interview at the			monitor completion and sends		
		ew, the DSP stated the facility			monthly to notify managemen any drills not completed.	LOI	
		s per day, additional fire drill			·Area Supervisor will comple	ate a	
	_	not available for review and			weekly check to ensure drills		
		on of a fire drill conducted on			conducted as scheduled and	a10	
	l -	fourth quarter 2022 was not			under varied		
	available for review				situations. (Attachment F)		
					·Rescare Administration will		
		e reviewed with the DSP			complete monthly site reviews	s to	
	during the exit conference.			ensure all drills are complete		las	
					scheduled. (Attachment G)		
		review and interview, the					
	1	nduct fire drills under varied					
		aird shift for 3 of 4 quarters.					
	1	ice affects all clients, staff and			Monitoring of Correction		
	visitors.				Monitoring of Corrective Action:		
	Findings include:				Action.		
	Based on review of	"Emergency Evacuations Drill:			·The Area Supervisor will		
		n with the Direct Services			conduct a weekly check to en	sure	
	Provider (DSP) dur	ing record review from 10:15			scheduled completions of the		
		on 11/08/23, three of four third			and send to the Program		
		lucted within the most recent			Manager.		
	_	d on 01/06/23, 04/09/23 and			·Quality Assurance tracks a		
		lucted at, respectively, 5:42			drills for all locations and send		
		5:51 a.m. Based on interview at			out to all Rescare Manageme		
l	I the time of record re	eview, the DSP stated the	- 1		I weekly to remind them and to		

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

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AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/08/2023		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	the aforementioned conducted under va	re reviewed with the DSP		ensure completion.  The Safety Committee will monitor quarterly for completi scheduled drills.  Rescare Administration Sit Reviews wills be sent to the Program Director and Execut Director once completed.  Completion Date: 11/24/23	on of e		

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