STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 05/12/2021 Facility Number: 011595 Provider Number: 15G749 AIM Number: 200905630 At this Emergency Preparedness survey, RES CARE Southeast Indiana was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 4 certified beds. All 4 beds are certified for Medicaid. At the time of the survey, the census was 4. Quality Review completed on 05/18/21 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(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			

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures (PP) include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (ii) Alternate sources of energy to maintain - (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review on 05/12/2021 between 10:15 a.m. to 12:40 p.m. with the Area Supervisor (AS), documentation of the policies and procedures did not include a plan for the temporary loss of or need during sheltering in place for sewage and waste disposal. Based on interviews with the AS, telephone numbers of service providers were kept in the office. The AS acknowledged that a policy and/or procedure addressing sewage and waste disposal was not included in the PP. This deficiency was reviewed during the Exit Conference.	E 0015	1.The administrator will ensure the emergency plan policies and procedures includes the updated Shelter-In-Place policy which addresses 1) alternative sources of energy, 2) emergency lighting, 3) fire detection, extinguishing and alarms, and 4) proper disposal of sewage and waste. 2.The area supervisor and program manager will train all staff on the updated Shelter-In-Place policy and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The Administrator will update the emergency plan to include the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, to include sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). 4.The Administrator will update the emergency plan to include a plan for the temporary loss of or need during sheltering in place for sewage and waste disposal. **5.This information is located in section 21 of the Emergency Disaster Preparedness Manual** **6.The corrective action will**	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			be monitored and reviewed for effectiveness at a minimum bi-annual **7.The Executive Director will review and approve the shelter in place policy the quality assurance manager and program manager will ensure the most current Shelter in Place policy is in the Emergency Preparedness Manual** Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP	
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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:]

[(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, 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.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, 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 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.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants.	E 0018	1.The administrator will ensure the emergency plan policies and procedures addresses the tracking of staff and clients, whether they evacuate or shelter in place. Including the consideration of care and treatment needs of evacuees, staff responsibilities; transportation; identification of evacuation locations; and primary and means of communication with external assistance.	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on record review on 05/12/2021 between at 10:15 a.m. and 12:40 p.m. with the Area Supervisor, there was nothing in the Emergency Preparedness Plan Policy and Procedures which addressed a system to track the whereabouts of staff and clients during an emergency. Based on interview concurrent with record review the AS indicated that he had the contact information of all clients and staff on his telephone. The AS acknowledged that there was no written policy and procedure which addressed the tracking of staff and clients. This issue was reviewed with the AS during the Exit Conference.		2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0026 Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(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:]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants. Findings include: During review of the Emergency Preparedness documentation on 05/12/2021 between 10:15 a.m. and 12:40 p.m. with the Area Supervisor (AS), there was nothing in the emergency preparedness manual which addressed compliance with the 1135 waiver declared by the Secretary. Based on interview at the time of record review with the AS, there was nothing in the plan that addressed the 1135 waiver.	E 0026	**1.The administrator will ensure the table of contents for the emergency disaster preparedness manual is updated to include the location of the policy on the Roles of the facility Under a Waiver declared by Secretary is in the emergency preparedness manual.** **2.The area supervisor and program manager will train all staff on the table of contents, the policy and procedure, where to locate the policy, and the policy will be placed in the Emergency Disaster Preparedness Manual for reference as needed.** **3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual** **4.The Quality Assurance Manager will review the table of contents, the quality**	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			assurance manager and program manager will ensure the most current table of contents is in the Emergency Preparedness Manual. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 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 §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness program (EPP) training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated,	E 0037	1.The administrator will ensure the emergency plan policies and procedures initial training in emergency preparedness policies and procedures to all new and existing staff, annual emergency training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed and present in the EPP manual. The ResCare “On The Job” training checklist will be updated to include initial training in emergency preparedness of all	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on record review and interviews on 05/12/2021 between 10:15 a.m. and 12:40 p.m. with the Area Supervisor, the documented training of staff was dated 9/24/2019. Documentation of new staff training hired since 09/24/2019 was not available. The AS reviewed the documents for one staff member hired since 09/24/2019 and could not find the training information. The AS acknowledged that documentation of training was not available. This deficiency was discussed during the Exit Conference.		new employees. The annual training requirements list will also be updated to include the training of all existing employees. 2.The Administrator will update the emergency preparedness program (EPP) training and testing program to include a training program. The training and documentation will include Initial training in emergency preparedness policies and procedures for all new and existing staff. 3.The Administrator will provide emergency preparedness training at least every two years. The Facility will maintain documentation of all emergency preparedness training. The Facility will document staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d) (1). 4.The residential manager, area supervisor and program manager will provide initial training to all new staff and the ResCare trainer will provide annual training to existing staff. Testing results will be available to demonstrate staff knowledge of emergency procedures. The training and testing documentation will be present in the Emergency Disaster Preparedness Manual/HR personnel files for reference as needed. The associate executive director will review the training documentation to ensure it has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING -- B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			been completed and is present. The safety committee will review and update annually as needed. 5.This information is located in section 22 of the Emergency Disaster Preparedness Manual Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 05/12/2021 Facility Number: 011595 Provider Number: 15G749 AIM Number: 200905630 At this Life Safety Code survey, RES CARE Southeast Indiana was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building was determined to be protected by an automatic sprinkler system. The facility has a monitored fire alarm system with smoke detection in sleeping rooms and living areas. Documentation indicates that a heat detector is installed in the attic which is not used for living, storage, or fuel burning equipment. The	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility has a capacity of 4 and had a census of 4 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.1. Quality Review completed on 05/18/21			
K S300 Bldg. 01	NFPA 101 Protection - Other Protection - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	1. Based on observation and interview, the facility failed to maintain 1 of 4 portable fire extinguishers located in the facility at intervals of not more than one year. LSC 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month	K S300	1.ResCare Maintenance will conduct monthly inspections of all facility fire extinguishers. Documented test dates will be kept onsite and with maintenance manager for review. 2.The AED met with ResCare Maintenance Manager on May 26, 2021 to ensure monthly checks are being performed. 3.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	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation during the facility tour between 12:40 p.m. and 1:15 p.m. on 05/12/2021 with the Area Supervisor (AS), the portable fire extinguisher located in the cabinet under the kitchen sink had a hanging tag indicating the date of the annual maintenance on the device was in February 2020. As of the day of this assessment, the annual service is more than two months overdue. No maintenance was performed within the most recent twelve month period. Based on interview at the time of observation, the AS stated that the other fire extinguishers had been serviced and that the kitchen device must have been overlooked. No other documentation of annual service for the kitchen fire extinguisher was available for review. The AS acknowledged documentation of annual maintenance performed for the kitchen portable fire extinguisher within the most recent twelve month period was not available for review. This deficiency was reviewed during the Exit Conference. 2. Based on record review, observation, and interview, the facility failed to ensure 2 of 2 interior emergency lights were tested and the records of the annual 90-minute testing maintained. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be		Program Manager, Area Supervisor or Residential Manager will contact Aramark (844)-RESCARE and create a service order and follow up to ensure completion within 5 days. 4.The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of inspecting Fire Extinguishers and maintaining proper documentation. 5. Random Monthly site visits will be conducted by the management team to verify the inspecting Fire Extinguishers and maintaining proper documentation. 6. The Administrator will ensure the portable fire extinguisher located in the cabinet under the kitchen sink is inspected annual along with all portable fire extinguisher in the facility. 7. Concerning annual maintenance of Fire Extinguisher The Associate Executive Director contacted Eric Grey with Koorsen Fire and Security on May 26, 2021 to schedule annual maintenance for all the facilities Fire Extinguisher. The Scope of work has been updated to ensure the inclusion of annual maintenance for portable fire extinguishers and required documentation. The Program Manager, Area Supervisor and Direct Support Lead have been in-serviced on the requirement and if a deficiency is noted the Program Manager, Area	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. (2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the test. (5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction. This deficient practice could affect all occupants if the facility were required to evacuate in an emergency during a loss of normal power. Findings include: Based on observation during the tour of the facility on 05/12/2021 between 12:40 p.m. and 1:15 p.m. with the Area Supervisor (AS), there were two battery power emergency lights observed in the facility. Based on record review with the AS on 05/12/2021 between 10:15 a.m. and 12:40 p.m., the facility used a log sheet entitled "Monthly Fire & Safety Systems Check" to document the testing of the emergency light fixtures. The log did not indicate the month of the annual 90-minute test of the devices. Based on interview at the time of record review, the AS acknowledged there was no written record of an annual 90-minute test of the battery-operated emergency lights.		Supervisor or Direct Support Lead will contact (844) ResCare to create a service order. The Associate Executive Director contacted Aramark Services on May 26, 2021 the Facilities maintenance vendor to ensure the scope of work for Koorsen Fire and Security included the annual maintenance of portable fire extinguishers and required documentation will be made available for review. 8. The Facility will ensure interior emergency lights are tested, maintained, and records of testing are maintained. 9. The Facility will ensure interior emergency lights are tested at a minimum of 3 weeks and a maximum of 5 weeks for no less than 30 seconds, records of test will be maintained by the facility. 10. The facility will ensure a functional test is conducted annually for a minimum of 1 ½ hour for all battery powered interior emergency lights, records of the test will be maintained by the facility. 11. The Program Manager will schedule a service order with Koorsen Fire and Security to repair or replace the emergency light Persons Responsible: Program Manager, Area Supervisor, and Residential Manager, DSP. Koorsen Fire And Security,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Aramark	
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review, observation and interview; the facility failed to ensure documentation of all fire alarm system initiating devices were maintained in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review on 05/12/2021 between	K S345	1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, heat detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. **3.The Program Manager will meet with a representative from Koorsen Fire and**	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10:15 a.m. to 12:40 p.m. with the Area Supervisor (AS), documentation of the annual fire alarm inspection and testing was not available for review. Based on observations made during the facility tour on 05/12/2021 between 12:40 p.m. and 1:15 p.m. with the AS, a service tag was found on the cover of the fire alarm control panel indicating that inspection and testing had been performed in February 2021. Based on interview at the time of record review and observation, the AS stated that documentation of the results and report of the annual inspection and test were not available for review. This deficiency was reviewed during the Exit Conference.		**Security, a tentative date has been set for May 26, 2021 pending the status of the COVID-19 response and suspense of none essential travel. The Facility will require schedule required testing and request copies of inspections and testing mailed to the program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany IN 47150.** 4.The Program Manager spoke with the Kris Carney from Koorsen Fire and Security effective immediately all sites will have an annual functional fire alarm inspection in the Month of February and a semiannual fire alarm visual inspection completed in August. Repair of the devices that failed the sensitivity test has been scheduled to be completed no later than June 11,2021. Access to the device will be made available and that device will be tested no later than June 11, 2021. Koorsen Fire and Security was notified of ResCare's "In Scope Services Agreement" that automatically authorizes repair/service of fire systems. Koorsen will notify the Program Manger upon completion of all inspections to ensure any deficiencies are properly tracked and repaired. Koorsen will send documentation of all inspections,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			services and repair to ResCare main office at 4341 Security Parkway STE. 101 New Albany IN 47150 with in 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative	
K S351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with Section 9.6, as modified below. The adequacy of the water supply shall be documented. In Prompt Evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.1, 33.2.3.5.3.3, 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7			
	Based on observation and interview, the facility failed to adequately protect the bathroom with 94	K S351	1.The Facility will ensure the installation an additional automatic	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	SF of floor area with the automatic sprinkler system. This deficient practice could affect all residents and staff within the facility. Findings include: Based on observation during the facility tour on 05/12/2021 with the Area Supervisor (AS), the sprinkler in the bathroom is located three inches from the 14 inch deep bulkhead separating the bathroom entry from the shower and lavatory space. The sprinkler is also located 21 inches from the 14 inch deep bulkhead that separates the bathroom entry from the toilet area. There are no additional sprinklers in the bathroom. The obstructions of the sprinkler by the bulkheads will not allow full coverage of the bathroom greater than 55 SF in area. The obstruction of the sprinkler in the bathroom was acknowledged by the AS at the times of the observations. The deficiency was reviewed during the Exit Conference.		sprinkle head to adequately protect the bathroom. 2.Koorsen Fire and Security was notified by the Program Manager on May 26, 2021 to schedule the installation of an additional automatic sprinkler in the bathroom and are added to the inspection and testing of the Sprinkler System. 3.The Program Manager contacted Aramark on May 26, 2021 and submitted a work order to have ResCare Maintenance verify install the installation required by LSC and add the inspection and testing to Koorsen's scope of work. Persons Responsible: Aramark Maintenance Manager, Program Manager, Area Supervisor, and Residential Manager, DSP.	
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. ____________________ B. Show who provided the service. ____________________ C. Note the source of the water supply for the automatic sprinkler system. ____________________ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system annual testing and inspections were documented in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, anti-freeze solutions are tested annually. This deficient practice could affect all clients and staff. Findings include: Based on record review on 05/12/2021 between 10:15 a.m. and 12:40 p.m. with the Areas Supervisor, the documentation of annual sprinkler inspection and testing was not available for review. The quarterly testing and inspection reports indicate the testing of the anti-freeze had not been completed at that time. Based on an interview at the time of record review, the AS confirmed there were no annual inspection and testing sprinkler paperwork for the last year. This deficiency was reviewed during the Exit	K S353	1.The Program Manager will ensure monthly sprinkler gauge inspections and monthly control valve inspections are conducted by the ResCare maintenance coordinator, documentation will be maintained on site and a copy kept with ResCare Maintenance Manager. 2.The program manager will conduct random monthly inspections to ensure monthly and quarterly inspections are being preformed as required. 3.The AED met with ResCare Maintenance Manager on May 26, 2021 to ensure monthly checks are being performed. 4.The AED contacted Aramark on May 26, 2021 and submitted a work order to have ResCare Maintenance inspect sprinkler	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Conference.		gauges, and maintain written documentation on site available for review. Persons Responsible: Aramark Maintenance Manager, Program Manager, Area Supervisor, and Residential Manager, DSP.	
K S362 Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING (Prompt) Unless otherwise indicated below, corridor walls shall meet all of the following: * Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier. * Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 sleeping. 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			
	Based on observation and interview, the facility failed to ensure 2 of 4 sleeping room doors were capable of resisting smoke through gaps and clearance with the door closed. This deficient practice affects 2 of 4 clients who reside in client sleeping rooms #3 and #4. Findings include: Based on observations during the facility tour on 05/12/2021 between 12:40 p.m. and 1:15 p.m. with the Areas Supervisor (AS), the doors to client sleeping room #3 has a clearance between the bottom of the door and the finished floor greater	K S362	1.The AED met with ResCare Maintenance Manager on March 10, 2021 to ensure all doors in the facility meet or exceed LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	than one inch and the door to client sleeping room #4 has a gap on the latch side between the face of the door and rabbet and edge of the door and frame greater than 1/8-inch. This was verified by the home manager at the time of observations. These deficiencies were reviewed with the AS during the Exit Conference.		of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 4.8.4.2 states the clearance under the bottom of a door shall be a maximum of 3/4 inch. 1.The Administrator will ensure the doors to client sleeping room #3 and client sleeping room #4 are replaced and new doors are installed to meet the standard.. 2.The AED met with ResCare Maintenance Manager on May 26, 2021 to ensure all bedroom doors are at a minimum 1-3/4 inches thick, solid bonded wood core construction or of other construction of equal or greater stability and fire integrity 3.The AED contacted Aramark on May 26, 2021 and submitted a work order to have ResCare Maintenance noncompliant doors will be removed and compliant door will be installed as soon as suitable replacement doors can be purchased by contractor. Due to construction material shortages the estimated installation time is greater than 90 days. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Security Representative	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)			
	Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters and 1 of 2 shifts over the past year. This deficient practice could affect all clients. Findings include:	K S712	1.All staff at the Facility will be re-trained on conducting fire drills quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train the Area Supervisor and the Area	06/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on a record review of Emergency Evacuation Drill (Fire) Reports on 05/12/2021 between 10:15 a.m. and 12:40 p.m. with the Area Supervisor (AS), there was no record of a fire drill conducted on the first shift for the third quarter of the year 2020. Based on an interview with the AS, there was no other documentation available for review to indicate the missed drill had been conducted. This was verified by the AS at the time of record review. This deficiency was reviewed during the Exit Conference.		Supervisor will train all facility staff. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date. 1.The Residential Manager will submit monthly drills to the QA Department upon completion. The QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required. 1.The Area supervisor will ensure drills are completed as required. 1.The program manager will conduct random monthly inspections to ensure drills are being completed as required. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP	
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G749	A. BUILDING 01 B. WING	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review, observation and interview; the facility failed to maintain a copy of the smoking policy for a facility. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review on 05/12/2021 between 10:15 a.m. and 12:40 p.m. with the Area Supervisor (AS), documentation of a facility smoking policy was not available for review. Based on interview at the time of record review, the AS stated that none of the clients smoked and that one staff person smoked and did so on the front porch. During the facility tour on 05/12/2021 between 12:40 p.m. and 1:15 p.m. with the AS a noncombustible cigarette receptacle was provided near the front porch. A copy of the Policy & Practice Manual, dated 03/01/11, provided electronically after the close of the survey by the facility's Quality Assurance Manager indicated that the facility was a smoke-free workplace. The lack of a policy available for review was acknowledged by the AS. The issue was reviewed during the Exit Conference.	K S741	1.All staff at the home will be re-trained the Facilities smoking policy, and use of the designated smoking area. 2.The Facility will in service staff on the use of the smoking tower used to dispensing cigarette butts. 3.All staff in the facility will be inserviced on ensure smoking materials are deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design 4.The Facility will ensure the smoking area is cleaned and all cigarette butts are removed from the ground and disposed of properly 5.The Program Manager, Area Supervisor, and Residential Manager will randomly inspect the facility monthly to ensure the proper use of the smoking tower and that cigarette butts are not being thrown on the ground. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance Manager.	06/11/2021