STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING 01 B. WING	04/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 03/01/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 04/18/22 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 At this PSR survey, Res Care Community Alternatives South Central 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 not sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in common living areas and none in the resident bedrooms. The facility has a capacity of 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.6. Quality Review completed on 04/19/22	K 0000		

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

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K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview, the facility failed to ensure 2 of 2 interior emergency lights were tested and the records of the 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 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 clients and staff if the facility were required to evacuate in an emergency during a loss of normal power.	K S100	**K0100:** General Requirements **Corrective Action:** · The Program Manager submitted a work order to Aramark to have the maintenance tech perform testing on the emergency lights in the facility for 30 seconds monthly and 90 minutes annually. **This test was completed on 4-4-22 by the Aramark maintenance technician. (Attachment A)** · Program Manager updated the tracking form to note the type of test being performed on the emergency lights. **(Attachment B)** · Site Reviews are done monthly by Rescare Management, this includes all required testing including the emergency lights. **(Attachment C)** **Monitoring of Corrective Action:** · Program Manager will	04/30/2022

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	Findings include: Based on review of "Emergency Light Testing" documentation with The Lead during record review from 12:10 p.m. to 12:15 p.m. on 04/18/22, ninety minute annual functional testing documentation for all facility battery operated lights conducted within the most recent twelve month period was not available for review. The aforementioned documentation stated battery operated lights were functional tested monthly through 03/31/22 but did not state when 90 minute annual functional testing was conducted. Based on interview at the time of record review, The Lead stated additional battery light testing documentation was not available for review and agreed 90 minute annual functional testing documentation for all facility battery operated lights conducted within the most recent twelve month period was not available for review. This finding was reviewed with The Lead during the exit conference. This deficiency was cited on 03/01/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		contact Aramark for all issues with emergency lights and testing of the emergency lights. · Site Reviews are entered into the CRM database and tracked by the Quality Assurance Manager to ensure completion and follow up on all issues with the Program Manager. **Completion Date: 4/30/22**	
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.			

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	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 and interview, the facility failed to ensure 1 of 1 manual fire alarm systems was maintained in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm 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 states all initiating devices shall be functional tested annually. This deficient practice could affect all clients, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Systems Service" documentation dated 12/14/21 with The Lead during record review from 10:55 a.m. to 12:35 p.m. on 03/01/22, documentation of an itemized list of the location and results of functional testing all fire alarm system initiating devices in the facility within the most recent twelve month period was not available for review. The 12/14/21 documentation stated under the "Job Description" section of the report "test heat detectors in the attic" but it did not state the results of the test. Additional fire alarm system inspection and testing documentation within the most recent twelve month period was not available for review. Based on interview at the time of record review, The Lead agreed documentation of an itemized listing of the location and results of functional testing for all fire alarm system initiating devices in the facility within the most recent twelve month period was	K S345	**K0345:** Testing and Maintenance **Corrective Action:** · Program Manager contacted Aramark to contact Koorsen to ensure when functional testing is completed on the fire alarm system that all reports are complete including whether the items tested pass or fail the test. **(Attachment D)** · Program Manager contacted Koorsen to provide documentation on the heat detector test that was completed. **(Attachment D)** **Monitoring of Corrective Action:** · Program Manager will follow up with Aramark to ensure all documents are received as completed and all inspections are completed as scheduled. · Aramark will send completed reports to Rescare Program Manager to ensure all reports are in the facility. **Completion Date: 4/30/22**	04/30/2022

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	not available for review. Based on record review with The Lead from 12:10 p.m. to 12:15 p.m. on 04/18/22, additional fire alarm system inspection and testing documentation on or after 12/14/21 which documented an itemized list of the location and results of functional testing all fire alarm system initiating devices, including heat detectors, was not available for review. This finding was reviewed with the The Lead during the exit conference. This deficiency was cited on 03/01/22. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure corridor doors to:	K S363	**K0363:** Corridor Doors	04/30/2022

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	a. 2 of 5 client bedrooms had no impediment to closing and latched into the door frame. b. 1 of 5 client bedrooms was self-closing or automatic closing for a non-sprinklered facility. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with The Lead during a tour of the facility from 12:15 p.m. to 12:30 p.m. on 04/18/22, the corridor door to the northwest bedroom was propped in the fully open position with a back pack placed on the floor in front of the door. The corridor door to the north bedroom was propped in the fully open position with a wedged placed on the floor under the door. The corridor door to the south bedroom by the bathroom did not self-close and latch into the door frame when tested to close multiple times. The door was equipped with a self-closing device. Based on interview at the time of the observations, The Lead stated the client in the north bedroom needs to have supervision at all times but agreed the aforementioned bedroom doors had an impediment to closing and latching into the door frame or did not self-close and latch into the door frame when tested to close. This finding was reviewed with The Lead during the exit conference. This deficiency was cited on 03/01/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		**Corrective Action:** · All staff trained on not propping fire doors open with chairs, backpacks or any object at all that is not an approved magnetic closure. **(Attachment E)** · Rescare Management will complete environmental checks 3 times weekly to ensure there is nothing blocking the fire doors and preventing them from closing and latching properly. **(Attachment F)** · Program Manager completed a work order and sent to Aramark for a door closure to be added to the bedroom door so that it will close properly and to ensure the safety of all clients living in the facility. **(Attachment G)** · Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues and doors are not propped open. **(Attachment C)** **Monitoring of Corrective Action:** · All maintenance requests are called in to Aramark for repair and follow up is completed by the Program Manager. · Aramark will send completed reports to Rescare Program Manager to ensure all reports are	

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			in the facility. **Completion Date: 4/30/22**	