PRINTED: 05/04/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G080		A. BUILDING 01  B. WING			COMPL	COMPLETED  04/18/2022		
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL			STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN 47031					
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		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	
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
TAG K 0000 Bldg. 01	A Post Survey Revi Code Recertification 03/01/22 was condu Department of Heal CFR 483.470(j).  Survey Date: 04/18  Facility Number: 0 Provider Number: AIM Number: 1000 At this PSR survey, Alternatives South 0 compliance with Re in Medicaid, 42 CFI Safety from Fire an National Fire Protect 101, Life Safety Co Existing Residentia Occupancies.  This one story build facility has a fire ala smoke detection in a reas and none in th facility has a capaci at the time of this su Calculation of the E	sit (PSR) to the Life Safety in Survey conducted on icted by the Indiana th in accordance with 42  3/22  00623 15G080 233870  Res Care Community Central was found not in equirements for Participation R Subpart 483.470(j), Life d the 2012 Edition of the etion Association (NFPA) de (LSC), Chapter 33, I Board and Care  ling was not sprinklered. The arm system with hard wired corridors, in common living the resident bedrooms. The ty of 8 and had a census of 7	K 0	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	Approaches to Life facility Slow with a	Safety, Chapter 6, rated the						

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<u> </u>			COMPL	COMPLETED	
15G080			B. WING 04/18/2022				
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST AL MILAN, IN 47031  ID (X5)				
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT	E	DATE
		ESC IDENTIFIEND IN ORGANITORY		1710			DATE
K S100 Bldg. 01	Section 33.1 or 33 that are not address K-tags, but are detalong with the app NFPA standard cit on Form CMS-256 Based on record reversacility failed to ensure emergency lights we the testing maintains provisions of Chapter LSC 4.6.12.3 states obvious to the public Code, shall either because LSC 7.9.3.1.1 testing lighting systems share conducted as follows (1) Functional testing monthly, with a min maximum of 5 week than 30 seconds.  (2) The test interval extended beyond 30 authority having jur (3) Functional testing annually for a mining emergency lighting (4) The emergency lighting (4) The emergency fully operational for (5) Written records tests shall be kept by for the authority hav This deficient practicand staff if the facility	RKS section any LSC 3.2 General Requirements seed by the provided ficient. This information, blicable Life Safety Code or tation, should be included 57.  Friew and interview, the sure 2 of 2 interior ere tested and the records of ed. LSC 33. 1.1.3 states the er 4, General, shall apply. existing life safety features c, if not required by the emaintained or removed. If go frequired emergency all be permitted to be a days with approval of the insdiction.  The shall be conducted mum of 1 ½ hours if the is battery powered. If ghting equipment shall be the duration of the test. Of visual inspections and by the owner for inspection	KS	100	K0100: General Requirement  Corrective Action:  The Program Manager submitted a work order to Aramark to have the maintenatech perform testing on the emergency lights in the facility 30 seconds monthly and 90 minutes annually. This test was completed on 4-4-22 by the Aramark maintenance technician. (Attachment A)  Program Manager update the tracking form to note the ty of test being performed on the emergency lights. (Attachment B)  Site Reviews are done monthly by Rescare Managementhis includes all required testin including the emergency lights (Attachment C)  Monitoring of Corrective Action:  Program Manager will	nce for as ed pe t ent, g	04/30/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	01	COMPL	ETED	
15G080		B. WIN	IG		04/18/	/2022	
		.0000			-	0 17 107	
NAME OF P	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	No vident on sort eith			725 CA	RR ST		
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL				MILAN,	IN 47031		
ava ib	CID O ( DV C	TATEL (EVE OF DEPLOYED LOVE)		ID.			(77.5)
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					contact Aramark for all issues	with	
	Findings include:				emergency lights and testing o	of	
	-				the emergency lights.		
	Based on review of	"Emergency Light Testing"			· Site Reviews are entered		
		The Lead during record			into the CRM database and		
		p.m. to 12:15 p.m. on			tracked by the Quality Assurar	nce	
		inute annual functional testing			Manager to ensure completion		
	-	all facility battery operated			and follow up on all issues with		
					-	1 1116	
	-	thin the most recent twelve			Program Manager.		
	_	not available for review. The					
		cumentation stated battery					
		e functional tested monthly					
	-	ut did not state when 90			Completion Date: 4/30/22		
		tional testing was conducted.					
	Based on interview	at the time of record review,					
	The Lead stated add	ditional battery light testing					
	documentation was	not available for review and					
	agreed 90 minute as	nnual functional testing					
	documentation for a	all facility battery operated					
		thin the most recent twelve					
	-	not available for review.					
	month period was n	iot available for feview.					
	This finding was re	viewed with The Lead during					
	the exit conference.						
	the exit conference.	•					
	7E1 ' 1 C' '	: 1 02/01/22 FI					
	_	s cited on 03/01/22. The					
		plement a systemic plan of					
	correction to prever	nt recurrence.					
K S345	NFPA 101						
	Fire Alarm Systen	n - Testing and					
Bldg. 01	Maintenance						
	Fire Alarm Systen	n - Testing and					
	Maintenance						
	2012 EXISTING (	Prompt)					
	,	m is tested and maintained					
	_	h an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
	ı ıvalıonal Fire Aları	m and Signaling Code.					

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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>01</u>			COMPLETED		
		15G080	B. WI	NG		04/18/2022	
NAME OF F	ROVIDER OR SUPPLIER	8		l	ET ADDRESS, CITY, STATE, ZIP CODE		
					CARR ST		
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL			-	MILA	N, IN 47031		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Records of systen	n acceptance, maintenance					
	and testing are re						
	9.7.5, 9.7.7, 9.7.8	-					
		view and interview, the	KS	345	K0345: Testing and		04/30/2022
	facility failed to ens	sure 1 of 1 manual fire alarm			Maintenance		
	•	nined in accordance with					
	-	n 9.6.1.3 states a fire alarm			Corrective Action:		
	system shall be inst	alled, tested and maintained			· Program Manager contact	cted	
	-	the applicable requirements			Aramark to contact Koorsen to		
		nal Fire Alarm Code. NFPA			ensure when functional testing	j is	
	72, 2010 Edition, S	ection 14.4.5 states testing			completed on the fire alarm		
	shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 states all				system that all reports are		
					complete including whether th	e	
	initiating devices shall be functional tested				items tested pass or fail the te	st.	
	annually. This defi	cient practice could affect all			(Attachment D)		
	clients, staff and vis	sitors.			· Program Manager contact	cted	
					Koorsen to provide documenta	ation	
	Findings include:				on the heat detector test that v	vas	
					completed. (Attachment D)		
	Based on review of	the fire alarm system					
	inspection contracto	or's "Systems Service"					
	documentation date	ed 12/14/21 with The Lead			Monitoring of Corrective		
	during record revie	w from 10:55 a.m. to 12:35			Action:		
	p.m. on 03/01/22, d	ocumentation of an itemized					
	list of the location a	and results of functional			· Program Manager will fol	low	
	testing all fire alarn	n system initiating devices in			up with Aramark to ensure all		
	-	he most recent twelve month			documents are received as		
	period was not avai	lable for review. The			completed and all inspections	are	
		ation stated under the "Job			completed as scheduled.		
	Description" section	n of the report "test heat			Aramark will send complete	eted	
	detectors in the attic" but it did not state the				reports to Rescare Program		
		Additional fire alarm system			Manager to ensure all reports	are	
	-	ng documentation within the			in the facility.		
		month period was not					
		7. Based on interview at the					
		ew, The Lead agreed					
		n itemized listing of the			Completion Date: 4/30/22		
		of functional testing for all					
		nitiating devices in the facility					
	within the most reco	ent twelve month period was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA Q AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G080		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01		LETED			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL			STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN 47031					
(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO 1	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE			
Based on record rev 12:10 p.m. to 12:15 fire alarm system in documentation on or documented an item results of functional initiating devices, in not available for rev This finding was rev during the exit conformation of the finding was reversed to the first firs	iew with The Lead from p.m. on 04/18/22, additional spection and testing r after 12/14/21 which sized list of the location and testing all fire alarm system acluding heat detectors, was riew.  Viewed with the The Lead erence.  cited on 03/01/22. The olement a systemic plan of at recurrence.  all of the following  e provided with latches or a suitable for keeping the suitable for keeping the closing the door.  e self-closing or in accordance with 7.2.1.8 than those protected approved automatic in accordance with with leaves required to ion of egress travel are teed annually per 7.2.1.15.	K \$363	K0363: Corridor D	oors	04/30/2022			
		K S363	KU363: Corridor D	oors	04/30/2022			
	ROVIDER OR SUPPLIER RE COMMUNITY AL  SUMMARY ST  (EACH DEFICIENT REGULATORY OR  not available for rev  12:10 p.m. to 12:15 fire alarm system in documentation on o documented an item results of functional initiating devices, ir not available for rev  This finding was rev during the exit conform  This deficiency was facility failed to imperorection to preven  NFPA 101  Corridor - Doors Doors shall meet a requirements:  1. Doors shall b other mechanisms door closed. 2. No doors shall b other mechanisms door closed. 2. No doors shall b automatic-closing in buildings other t throughout by an a sprinkler system in 33.2.3.5. Door assemblies w swing in the direct inspected and test 33.2.3.6.4, 33.7.7 Based on observation	ROVIDER OR SUPPLIER  RE COMMUNITY ALTERNATIVES SOUTH CENTRAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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.	ROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SOUTH CENTRAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  not available for 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.  NFPA 101  Corridor - Doors  Corridor - Doors  Corridor - Doors  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 3.2.3.5.  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  K S363	ROYLDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SOUTH CENTRAL  SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  NFPA 101 Corridor - Doors Corridor - D	ROYUDER OR SUPPLIER  RE COMMUNITY ALTERNATIVES SOUTH CENTRAL  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR I.SC IDENTIFYING INFORMATION)  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.  NFPA 101  Corridor - Doors  Corridor - 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. Door 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  K S363  K0363: Corridor Doors			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G080			ĺ	UILDING	ONSTRUCTION  01	(X3) DATE : COMPL 04/18/	ETED
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL				725 CA	ADDRESS, CITY, STATE, ZIP CODE RR ST IN 47031	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ooms had no impediment to		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Corrective Action:	TE	(X5) COMPLETION DATE
	b. 1 of 5 client bedr automatic closing for	into the door frame. rooms was self-closing or or a non-sprinklered facility. ice could affect all clients,			All staff trained on not propping fire doors open with chairs, backpacks or any obje at all that is not an approved magnetic closure. (Attachmer E)     Rescare Management will complete environmental checkless.	n <b>t</b>	
	tour of the facility of p.m. on 04/18/22, the northwest bedroom position with a backfront of the door. To bedroom was propped with a wedged place. The corridor door to bathroom did not see door frame when te The door was equiped device. Based on it observations, The Lead to the corridor need times but agreed the	ons with The Lead during a from 12:15 p.m. to 12:30 he corridor door to the was propped in the fully open a pack placed on the floor in the corridor door to the north ped in the fully open position he do not he floor under the door. To the south bedroom by the elf-close and latch into the sted to close multiple times. To pped with a self-closing interview at the time of the dead stated the client in the disto have supervision at all he aforementioned bedroom			times weekly to ensure there is nothing blocking the fire doors and preventing them from closs and latching properly.  (Attachment F)  Program Manager completed a work order and so to Aramark for a door closure be added to the bedroom door that it will close properly and to ensure the safety of all clients living in the facility. (Attachment G)  Site Reviews are complet monthly at the facility by Rescondance.	ent to r so cent ted are	
	into the door frame latch into the door to this finding was re the exit conference.  This deficiency was	s cited on 03/01/22. The plement a systemic plan of			environmental issues and doo are not propped open.  (Attachment C)  Monitoring of Corrective Action:  All maintenance requests are called in to Aramark for re and follow up is completed by Program Manager.  Aramark will send complereports to Rescare Program Manager to ensure all reports	s pair the eted	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 01			COMPLETED	
15G080		B. WING			04/18/2022			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL				725 CA	ADDRESS, CITY, STATE, ZIP CODE RR ST IN 47031			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	\\\L	DATE	
					in the facility.  Completion Date: 4/30/22			

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