

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

PRINTED: 01/16/2018
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 12/20/2017	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 1337 E SOUTHVIEW LN PAOLI, IN 47454			
(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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 12/20/17</p> <p>Facility Number: 000695 Provider Number: 15G159 AIM Number: 100243150</p> <p>At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 7 certified beds, with a current census of 7.</p> <p>Quality Review completed on 12/21/17 - DA</p> <p>The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:</p>			E 0000			
E 0036 Bldg. --							

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 01/16/2018
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2017	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1337 E SOUTHVIEW LN PAOLI, IN 47454			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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. 02	<p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Emergency/Disaster Preparedness Manual on 12/20/17 between 12:45 p.m. and 2:00 p.m. with the Area Supervisor present, there was no documentation available to show the facility had an emergency preparedness training and testing program. Based on interview at the time of record review, the Area Supervisor said there was no emergency preparedness training and testing program documentation available for review.</p>			E 0036	<p>The administrator will ensure documentation of emergency preparedness training and testing is in the location for review. The QA manager will train the area supervisor who will then train all staff on the emergency preparedness program including the risk assessment, policies and procedures, and communication plan.</p>		01/19/2018
	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 12/20/17</p> <p>Facility Number: 000695</p>			K 0000			

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

PRINTED: 01/16/2018
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2017	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 1337 E SOUTHVIEW LN PAOLI, IN 47454			
(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
	<p>Provider Number: 15G159 AIM Number: 100243150</p> <p>At this Life Safety Code survey, Res Care Community Alternatives SE IN was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) 2012 Edition, Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridor and common living areas. The facility has a capacity of seven and had a census of seven at the time of this survey.</p> <p>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 0.28.</p> <p>Quality Review completed on 12/21/17 - DA</p>						