PRINTED: 03/23/2021

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES								
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/02/2021				
	PROVIDER OR SUPPLIED	R LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE			
E 0000									
Bldg		paredness Survey was ndiana Department of Health in 2 CFR 483.475.	E 0000						
	Survey Date: 03/02	2/21							
	Facility Number: (Provider Number: AIM Number: 200	15G723							
	Community Altern compliance with En Requirements for M	Preparedness survey, Res Care atives SE IN was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR							
	I -	pertified beds. All 6 beds are aid. At the time of the survey,							
	The requirement at NOT MET as evident	42 CFR, Subpart 483.475 is enced by:							
	Quality Review con	mpleted on 03/04/21							

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

403.748(d), 416.54(d), 418.113(d),

484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d),

491.12(d), 494.62(d) **EP Training and Testing**

441.184(d), 482.15(d), 483.475(d), 483.73(d),

*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under

E 0036

Bldg. --

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.

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

PRINTED: 03/23/2021 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULT: A. BUILD B. WING		NSTRUCTION	(X3) DATE : COMPL 03/02/	ETED
	F PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	1:	3009 H	DDRESS, CITY, STATE, ZIP COD ORIZON DR IS, IN 47143		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	§486.360, RHC/F (d) Training and to develop and main preparedness traithat is based on the in paragraph (a) consistency assessment at passection, policies at (b) of this section, plan at paragraph training and testing reviewed and upded testing. The LTC maintain an emergand testing programmergency plans this section, risk at (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergand testing programmergency plans this section, risk at (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/II maintain an emergand testing programmergency plans this section, risk at (a)(1) of this section. The train must be reviewed 2 years. The ICF/IIIDs at § 100 communication plasection. The train must be reviewed 2 years. The ICF/IIIDs at § 100 communication plasection. The train must be reviewed 2 years. The ICF/IIIDs at § 100 communication plasection. The train must be reviewed 2 years. The ICF/IIDs at § 100 communication plasection. The train must be reviewed 2 years. The ICF/IIDs at § 100 communication plasection. The train must be reviewed 2 years. The ICF/IIDs at § 100 communication plasection.	esting. The [facility] must tain an emergency ning and testing program ne emergency plan set forth of this section, risk ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years. 6.73(d):] (d) Training and facility must develop and gency preparedness training am that is based on the et forth in paragraph (a) of issessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ining and testing program and updated at least 6.483.475(d):] Training and (D) must develop and gency preparedness training am that is based on the et forth in paragraph (a) of issessment at paragraph (b) of this ining and testing program and updated at least east of this section, and the an at paragraph (c) of this ining and testing program and updated at least every					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì			ľ í	ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		15G723	B. WI	NG		03/02/	2021
NAME OF I	PROVIDER OR SUPPLIER	?	•		ADDRESS, CITY, STATE, ZIP COD		
					HORIZON DR		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	at §483.470(i).						
	*IFor ESPD Facili	ities at §494.62(d):]					
	Training, testing, and orientation. The dialysis facility must develop and maintain an						
		redness training, testing					
		ation program that is based					
		/ plan set forth in paragraph					
		, risk assessment at					
	paragraph (a)(1)	of this section, policies and					
	procedures at par	agraph (b) of this section,					
		cation plan at paragraph (c)					
		ne training, testing and					
		m must be evaluated and					
	updated at every						0.4/0.4/0.004
		view and interview, the facility	E 00	E 0036 1.The administrator will ensure			04/01/2021
	_	nd maintain an emergency			the emergency plan policies and		
		ng and testing program that updated at least every two			procedures annual emergency		
		e with 42 CFR 483.475(d). This			training and testing program is implemented in all locations as		
	1 *	ould affect all occupants.			evidence of the annual training		
	deficient practice es	ourd affect aff occupants.			testing is present in the EPP	y and	
	Findings include:				manual.		
	8				2.The area supervisor and		
	Based on review of	Res Care Community			program manager will train all	staff	
		"Emergency/Disaster			on the annual training and		
	Preparedness Manu	ual" documentation dated			testingand the training and tes	ting	
	03/27/20 with the th	hree Direct Services Providers			documentation will be present	in	
		d review from 11:00 a.m. to			the Emergency Disaster		
	_	2/21, the facility's training and			Preparedness Manual for		
		mentation failed to include			reference as needed. The		
	_	will be trained on the			associate executive director w		
		dness program. The facility's			review the training documenta		
		policy documentation stated			to ensure it has been complete	ed	
		rained on the disaster			and is present. The safety	_4_	
		and ready to carry it out at any			committee will review and upd	ate	
	time. New employees must be oriented to the plan						
					annually as needed.	in	
	and procedures at the	he beginning of their ed on interview at the time of			3. This information is located section 22 of the Emergency	in	

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

PRINTED: 03/23/2021 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COM	E SURVEY PLETED 2/2021
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIF HORIZON DR PHIS, IN 47143	PCOD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	failure with existing perform them, at a ragreed the facility's documentation faile existing staff will be preparedness progra	viewed with the three DSP's		4.The program mal supervisor, residentia will ensure initial train conducted during on orientation and annucomplete. 5.The AED will in s Program Manager, A Supervisor and Reside Manager on the requiemergency prepared	al manager hing is the job al training is service the trea dential dential	
				DATE OF COMPLET 1, 2021 Persons Responsible Program Manager, A Supervisor, and Resi Manager, DSP	e: AED, urea	
E 0037 Bldg	441.184(d)(1), 482. 483.73(d)(1), 484. 485.68(d)(1), 485. 486.360(d)(1), 497. EP Training Progr *[For RNCHIs at § Hospitals at §482. HHAs at §484.102 §485.727, OPOs at §491.12:] (1) T [facility] must do a	am 403.748, ASCs at §416.54, 15, ICF/IIDs at §483.475, 2, "Organizations" under at §486.360, RHC/FQHCs raining program. The				

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723			A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/02/2021	
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD	•		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN			IS, IN 47143			
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION	
TAG	training at least e	R LSC IDENTIFYING INFORMATION	1	AG	DEFICIENCE!		DATE	
	_	documentation of all						
	emergency prepa							
		rate staff knowledge of						
	emergency proce	dures.						
	, ,	ergency preparedness						
	1 .	edures are significantly						
	1	lity] must conduct training						
	on the updated	policies and procedures.						
	*IFor Hospices at	: §418.113(d):] (1) Training.						
		t do all of the following:						
	•	ling in emergency						
		licies and procedures to all						
	1 ' '	hospice employees, and						
	individuals p	roviding services under						
	arrangement, cor	nsistent with their expected						
	roles.							
	1 ' '	rate staff knowledge of						
	emergency proce							
	* *	emergency preparedness						
	training at least e	ally review and rehearse its						
	1 ' '	aredness plan with hospice						
	1	ding nonemployee staff),						
		nasis placed on carrying out						
	the procedures no	ecessary to protect patients						
	and others.							
		documentation of all						
	emergency prepa	<u> </u>						
		ergency preparedness						
	1 '	edures are significantly						
		pice must conduct training policies and procedures.						
	on the updated	policies and procedures.						
	*[For PRTFs at &	441.184(d):] (1) Training						
	-	TF must do all of the						
	following:							
	1	ing in emergency						
	preparedness pol	licies and procedures to all						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/02/2021	
	PROVIDER OR SUPPLIEI	R LTERNATIVES SE IN		13009 H	DDRESS, CITY, STATE, ZIP COD ORIZON DR IS, IN 47143		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	E ACTION SHOULD BE	
TAG		R LSC IDENTIFYING INFORMATION	,	ΓAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
TAG	new and existing services undo volunteers, consist roles. (ii) After initial emergency preparty years. (iii) Demonstructure (iv) Maintain emergency proce (iv) Maintain emergency preparty (v) If the emergency prepar	staff, individuals providing er arrangement, and stent with their expected all training, provide aredness training every 2 rate staff knowledge of dures. documentation of all aredness training. Ergency preparedness edures are significantly if must conduct training on policies and procedures. Les at §483.73(d):] (1) The LTC facility must do all ing in emergency icies and procedures to all		ΓAG			DATE
	services under volunteers, consist role. (ii) Provide el training at least al (iii) Maintain emergency prepa (iv) Demonst emergency proce *[For CORFs at § CORF must do al (i) Provide init preparedness pol new and existing	documentation of all redness training. rate staff knowledge of dures. 485.68(d):](1) Training. The I of the following: itial training in emergency icies and procedures to all					
		onsistent with their					

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Event ID:

TZON21 Facility ID: 004615

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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	JILDING	<u></u>	COMPL	ETED
		15G723	B. W	ING		03/02	/2021
		1		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	₹			HORIZON DR		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN			HIS, IN 47143		
INLO OAI		ETERNATIVEO DE IIV		IVILIVII I			_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` '	mergency preparedness					
	training at least every 2 years. (iii) Maintain documentation of the training.						
		rate staff knowledge of					
		dures. All new personnel					
		and assigned specific					
		es regarding the CORF's					
		vithin 2 weeks of their first					
		ning program must include ocation and use of alarm					
		als and firefighting					
	equipment.	als and menghing					
		ergency preparedness					
	1 ' '	edures are significantly					
	1 '	RF must conduct training on					
		policies and procedures.					
		от по					
	*[For CAHs at §48	35.625(d):] (1) Training					
	-	H must do all of the					
	following:						
	(i) Initial train	ing in emergency					
	preparedness pol	icies and procedures,					
	including prompt i	reporting and extinguishing					
	of fires, protecti	on, and where necessary,					
	1	ents, personnel, and					
	guests, fire preve	ntion, and cooperation with					
		nd disaster authorities, to all					
	_	staff, individuals providing					
	services under an						
		onsistent with their expected					
	roles.						
	, ,	mergency preparedness					
	training at least e						
		documentation of the					
	training.	rote staff knowledge of					
	, ,	rate staff knowledge of					
	emergency proce						
	1 ' '	ergency preparedness					
	Policies and proce	edures are significantly					

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CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPI	LETED	
		15G723	B. WII	NG		03/02	/2021	
				CED FEET	A DODDESC COMM. CTA TO TID COD			
NAME OF 1	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD HORIZON DR			
DES CAI		LTERNATIVES SE IN			HIS, IN 47143			
NES CAI		LIERNATIVES SE IN		IVILIVIF				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		I must conduct training on						
	the updated p	policies and procedures.						
	-	485.920(d):] (1) Training.						
	The CMHC must	provide initial training in						
	emergency prepa	redness policies and						
	procedures to all	new and existing staff,						
	· ·	ing services under						
		volunteers, consistent with						
	their expected role							
		the training. The CMHC						
		e staff knowledge of						
		dures. Thereafter, the						
	CMHC must provi							
		ning at least every 2 years.						
		view and interview, the facility	E 00	37	E 037 EP Training Program:		04/01/2021	
		ff received training in regard to			1.The administrator will ensu			
		dness policies and procedures.			the emergency plan policies a	nd		
		y must do all of the following: (i)			procedures initial training in			
		ing in emergency preparedness			emergency preparedness poli			
		ures to all new and existing			and procedures to all new and			
	_	roviding services under			existing staff, annual emergen	-		
		olunteers, consistent with their			training, documentation of the			
	expected roles; (ii)				training and staff demonstration	on of		
		ng at least every two years;			knowledge of the emergency			
	` '	mentation of the training; (iv)			procedures is completed and			
		knowledge of emergency			present in the EPP manual. T			
	1 -	rdance with 42 CFR 483.475(d)			ResCare "On The Job" training	g		
	(1). This deficient practice could affect all				checklist will be updated to			
	occupants.				include initial training in			
	Findings 1 1 1				emergency preparedness of a	all .		
	Findings include:				new employees. The annual			
	D 1	CD C C			training requirements list will a			
		Res Care Community			be updated to include the train	ııng		
		"Emergency/Disaster			of all existing employees.			
		al" documentation dated			2.The residential manager, a			
		hree Direct Services Providers			supervisor and program mana			
	(DSP) during recor	d review from 11:00 a.m. to			will provide initial training to al	ı	1	

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12:40 p.m. on 03/02/21, the facility lacked

documentation of staff training on the emergency

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new staff and the ResCare trainer

will provide annual training to

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

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/02/2021	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	13009	TADDRESS, CITY, STATE, ZIP COD HORIZON DR PHIS, IN 47143	
(X4) ID PREFIX TAG	PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION preparedness plan within the most recent two year period. Review of "Emergency Preparedness Plan Required Training" and "Emergency Preparedness		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) existing staff. Testing results be available to demonstrate knowledge of emergency	DATE s will
	Testing" documentar documented staff transpreparedness policies on 12/27/18. Based record review, the I might have updated but agreed staff train	es and procedures occurred on interview at the main office staff training documentation on liness policies and procedures		procedures. The training an testing documentation will be present in the Emergency Disaster Preparedness Manipersonnel files for reference needed. The associate executive director will review the training documentation to ensure it he	e ual/HR as cutive ng
	within the most reco available for review	ent two year period was not at the time of the survey.		been completed and is present the safety committee will remand update annually as need 3. This information is locate section 22 of the Emergency Disaster Preparedness Manually A. The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement emergency preparedness training to the safety of the sa	ent. view ded. ed in vual he
				DATE OF COMPLETION: A 1, 2021 Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP.	pril
E 0039 Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 49 EP Testing Requii	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 03.748, ASCs at §416.54,			

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN X3 ID	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/02/2021	
SLIMMARY STATEMENT OF DEFICIENCE SLIMMARY STATEMENT OF DEFICIENCE CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDENS PLANDED SINCELD BY COMPLETED AT THOS SINCELD BY COMPLETED AT THE SINCELD BY C				13009	HORIZON DR	•
PREFIX TAG HAHAS at \$484 1.02; CORFs at \$495.02, OPO, 'Organizations' under \$485.727, CMHC at \$485.920, RHC/FQHC at \$491.12, ESRD Facilities at \$494.62); (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed	TKLO O/ II	KE OOMMONTT 7			1110, 114 47 140	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION HHAs at \$484.102, CORFs at \$485.68, OPO, "Organizations" under \$485.727, CMHC at \$485.980, RHC/FOHC at \$495.920, RHC/FOHC at \$491.12, ESRD Facilities at \$494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility]-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise that is community-based or individual, facility-based functional exercise in the year the full-scale or functional exercise at least every 2 years, opposite the year the full-scale or functional exercise that is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed						ON
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group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed		, ,	· · · · · · · · · · · · · · · · · · ·			
clinically-relevant emergency scenario, and a set of problem statements, directed						
and a set of problem statements, directed						
		-	- ·			
messages, or prepared questions		· ·				
designed to challenge an emergency			•			

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Event ID:

TZON21

Facility ID: 004615

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		A. BUILDING COM			TE SURVEY MPLETED 02/2021	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO	DD .	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		HORIZON DR HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE PPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	plan.					
		ze the [facility's] response				
		ocumentation of all drills,				
	tabletop exercises					
		evise the [facility's]				
	emergency plan, a	as needed.				
	*[For Hospices at	418.113(d):1				
	-	spices that provide care in				
		e. The hospice must				
		to test the emergency				
	plan at least annu	ally. The hospice must do				
	the following:					
	(i) Participate	e in a full-scale exercise				
	that is community	based every 2 years; or				
	(A) Wher	n a community based				
	exercise is not acc	cessible, conduct an				
	-	pased functional exercise				
	every 2 y					
	, ,	hospice experiences a				
		ade emergency that requires				
		mergency plan, the				
	-	empt from engaging in its				
	•	scale community-based				
	exercise or individ	_				
		e following the onset of the				
	emergency event.	an additional exercise every				
		the year the full-scale or				
		e under paragraph (d) (2)				
		s conducted, that may				
	` '	limited to the following:				
	•	cond full-scale exercise that				
		ed or a facility based				
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		oletop exercise or workshop				
	, ,	cilitator and includes a				
	group discussion					
		vant emergency scenario,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TZON21

Facility ID: 004615

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPI	
		15G723	B. W	ING		03/02	/2021
NAME OF D	PROVIDER OR SUPPLIER	?	-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
		em statements, directed					
	messages, or prepared questions						
		challenge an emergency					
	plan.						
	(3) Testing for hospices that provide inpatient						
	1 ' '	hospice must conduct					
	I	he emergency plan twice					
		spice must do the following:					
	l	e in an annual full-scale					
		ommunity-based; or					
	(A) Whei	n a community-based					
	exercise is not ac	cessible, conduct an					
	annual individual	facility-based functional					
	exercise; or						
	(B) If the	hospice experiences a					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the					
	hospice is ex	empt from engaging in its					
	next required full-	scale community based or					
	facility-based fund	ctional exercise					
	_	et of the emergency event.					
	` ′	an additional annual					
	· ·	include, but is not limited					
	to the following:						
	` '	econd full-scale exercise that					
	I	ed or a facility based					
	functional exercise						
	1 ' '	ock disaster drill; or					
	` ′	bletop exercise or workshop					
	I	that includes a group					
	discussion using a						
	I	vant emergency scenario,					
	I	em statements, directed					
	messages, or pre						
	l .	challenge an emergency					
	plan.	4h a h a a sia ala ma a si a si 4 -					
	1 ' ' -	the hospice's response to					
		umentation of all drills,					1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TZON21 Facility ID: 004615

If continuation sheet

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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 COMPLETED			
		15G723	B. W	ING		03/02/	/2021
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
NAME OF I	ROVIDER OR SUPPLIER	C.			HORIZON DR		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e hospice's emergency plan,					
	as needed.						
	*IFor PRFTs at 84	l41.184(d), Hospitals at					
	§482.15(d), CAHs						
	- , ,	PRTF, Hospital, CAH] must					
		to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the						
	· -	e in an annual full-scale					
		ommunity-based; or					
	(A) Whei	n a community-based					
	exercise is not ac	cessible, conduct an					
	annual individual, facility-based functional						
	exercise	; or					
	(B) If the	[PRTF, Hospital, CAH]					
	experiences an ad	ctual natural or man-made					
		equires activation of					
		cy plan, the [facility] is					
		aging in its next required					
	full-scale commun	-					
		cility-based functional					
	exercise following						
	emergency event.						
		n [additional] annual					
		at may include, but is not					
	limited to the follo	•					
	, ,	cond full-scale exercise that					
	is community-bas						
	facility-based fund	ock disaster drill; or					
		eletop exercise or workshop					
		cilitator and includes a					
	group discussion,						
	- '	vant emergency scenario,					
	1	em statements, directed					
	messages, or pre						
		challenge an emergency					
	plan.						
		he [facility's] response to					

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CENTERS FO	R MEDICARE & MEDIC					OM	4B NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u></u>	COMPLETED		
		15G723	B. W	B. WING			03/02/2021	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	R			HORIZON DR			
RES CA	RE COMMUNITY A	LTERNATIVES SE IN			HIS, IN 47143			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE	
IAU				TAU			DATE	
		umentation of all drills,						
	· ·	s, and emergency events						
		e [facility's] emergency plan,						
	as needed.							
	*[[TO [: :tis	t \$402 72/d\.1						
	*[For LTC Facilitie	- , , -						
	I ` '	ity] must conduct exercises						
	_	ency plan at least twice per						
		announced staff drills using						
	1	ocedures. The [LTC facility,						
	ICF/IID] must do t	_						
	1 ' '	e in an annual full-scale						
		ommunity-based; or						
	, ,	n a community-based						
		cessible, conduct an						
		facility-based functional						
	exercise							
	, ,	[LTC facility] facility						
	•	ctual natural or man-made						
		equires activation of the						
		lan, the LTC facility is						
		aging its next required a						
	full-scale commun							
		cility-based functional						
	exercise following							
	emergency event							
	` '	an additional annual						
	•	include, but is not limited						
	to the following:	and full and a system that						
	1 ' '	econd full-scale exercise that						
	_	ed or an individual, facility						
	based functional e							
	` '	ock disaster drill; or						
	1 ' '	bletop exercise or workshop						
	1	cilitator includes a group						
	discussion, using							
		vant emergency scenario,						
		em statements, directed						
	messages, or pre	pared questions						

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designed to challenge an emergency

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		15G723	B. W	ING		03/02	2021
NAME OF I	PROVIDER OR SUPPLIER	}	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	plan.	the ILTC facility I facility Is					
	, ,	the [LTC facility] facility's naintain documentation of					
	all drills, tabletop						
	· ·						
	events, and revise the [LTC facility] facility's emergency plan, as needed.						
	Ciricigonoy pian, a	as needed.					
	*[For ICF/IIDs at §	§483.475(d)]:					
	(2) Testing. The IC	CF/IID must conduct					
	exercises to test the emergency plan at least						
	twice per year. The ICF/IID must do the						
	following:						
	(i) Participate in an annual full-scale						
	exercise that is community-based; or						
	, ,	n a community-based					
		cessible, conduct an					
		facility-based functional					
	exercise;						
	, ,	ICF/IID experiences an					
		nan-made emergency that					
	-	n of the emergency					
	-	/IID is exempt from engaging					
	in its next required						
	-	or individual, facility-					
	onset of the emer	nal exercise following the					
	· ·	gency event. In additional annual exercise					
	` '	but is not limited to the					
	following:	but is not innited to the					
		cond full-scale exercise that					
	, ,	ed or an individual,					
		ctional exercise; or					
		ock disaster drill; or					
	, ,	eletop exercise or workshop					
	' '	cilitator and includes a					
	group discussion,						
		vant emergency scenario,					
	-	em statements, directed					
	messages, or pre						
		hallenge an emergency					

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039			
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G723	A. BUILDING B. WING		COMPLETED 03/02/2021			
		136723			03/02/2021			
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD				
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		13009 HORIZON DR MEMPHIS, IN 47143				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)			
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION			
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE			
	plan.							
	(iii) Analyze t	he ICF/IID's response to and						
	maintain docume	ntation of all drills, tabletop						
	exercises, and en	nergency events, and						
	revise the ICF/IID	's emergency plan, as						
	needed.							
	*IF a # ODO a a # \$ 4	00 0001						
	*[For OPOs at §4	e OPO must conduct						
	` ' ' '	he emergency plan. The						
	OPO must do the							
		paper-based, tabletop						
	` '	hop at least annually. A						
		is led by a facilitator and						
		oup discussion, using a						
	_	/ relevant emergency						
	·	et of problem statements,						
		sages, or prepared						
	questions designe	ed to challenge an						
	emergency plan.	If the OPO experiences an						
	actual natural c	or man-made emergency that						
		n of the emergency plan, the						
	· · · · · · · · · · · · · · · · · · ·	om engaging in its next						
	<u> </u>	ng exercise following the						
	onset of the emer	• •						
	. , ,	ne OPO's response to and						
		ntation of all tabletop						
		nergency events, and revise and OPO's] emergency						
	plan, as needed.	and Or O sjemergency						
	1 .	view and interview, the facility	E 0039	1.The administrator will ensu	ure 04/01/2021			
		least two exercises to test the	L 0037	the participation in a full-scale	07/01/2021			
		an annual basis using the		community based exercise and	d a			
		res. The ICF/IID facility must		table top exercise is present in				
		ing: (i) participate in a full-scale		EPP manual.				
		munity-based or when a		2.The area supervisor and				
		exercise is not accessible, an		program manager will ensure				
		based. If the ICF/IID facility		documentation of the table top	ı			
		ial natural or man-made		exercise and the community				

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emergency that requires activation of the

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based exercise are present in the

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	ľ	UILDING	NSTRUCTION	(X3) DATE : COMPL 03/02/	ETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	engaging in a comm facility-based full-s following the onset conduct an addition but is not limited to full-scale exercise t individual, facility- that includes a grou facilitator, using a r emergency scenario statements, directed questions designed plan; (iii) analyze thand maintain docur exercises, and emer ICF/IID facility's en accordance with 42 deficient practice of	e ICF/IIC facility is exempt from nunity-based or individual, cale exercise for 1 year of the actual event; (ii) all exercise that may include the following: (A) a second that is community-based or based. (B) a tabletop exercise up discussion led by a narrated, clinically-relevant to challenge an emergency me ICF/IID facility's response to mentation of all drills, tabletop regency events, and revise the mergency plan, as needed in CFR 483.475(d)(2). This could affect all occupants.			Emergency Disaster Preparedness Manual for reference as needed. The associate executive director v review the training documents to ensure it has been complet and is present. The safety committee will review and upour annually as needed. 3. This information is located section 22 of the Emergency Disaster Preparedness Manu 4. Dated Documentation will provided showing the comple of a tabletop exercise 5. The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of conducting an annual commu based exercise and maintaini documentation	ation red date date di in de	
	Alternatives SE IN Preparedness Manu 03/27/20 with the th (DSP) during recor 12:40 p.m. on 03/0/2 emergency preparer recent twelve mont review. A tabletop Failure" was includ prepared manual bu interview at the tim stated the facility is actual natural emery produced document procedures currentl The DSP #1 stated	"Emergency/Disaster lal" documentation dated here Direct Services Providers dereview from 11:00 a.m. to 2/21, documentation of a second deness exercise within the most he period was not available for exercise on "Critical Power led as part of the emergency let it was not dated. Based on le of record review, the DSP #1 currently experiencing an ligency due to Covid-19 and latation of the policies and ly in effect for the pandemic. lethe main office might have the exercise but agreed the facility			DATE OF COMPLETION: Ap 1, 2021 Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP.	oril	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		A. BUILDING B. WING	COMPLETED 03/02/2021		
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR PHIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	disaster drill or cond within the most rece agreed additional tes available for review This finding was rev	a second community based ducted a tabletop exercise ent twelve month period and sting documentation was not at the time of the survey.			
K 0000	during the exit confo	erence.			
Bldg. 02	-	/21 04615 15G723	K 0000		
	Community Alterna compliance with Re Medicaid, 42 CFR S from Fire and the 20 Protection Associati	Code survey, Res Care tives SE IN was found not in quirements for Participation in Subpart 483.470(j), Life Safety 012 Edition of the National Fire ton (NFPA) 101, Life Safety er 33, Existing Residential supancies.			
	sprinklered. The fact with smoke detectional living areas. The purposes, storage or provided with a hear the fire alarm system	ing was determined to be fully cility has a fire alarm system in corridors, bedrooms and e attic was not used for living fuel-fired equipment and was at detection system to activate in. The facility has a capacity as of 4 at the time of this			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 03/02/2021			
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K S100	(E-Score) using NF Approaches to Life facility Prompt with Quality Review con NFPA 101 General Requirem	npleted on 03/04/21			
Bldg. 02	General Requirem 2012 EXISTING List in the REMAR Section 33.1 or 33 that are not address. K-tags, but are de along with the app NFPA standard cit on Form CMS-2561. Based on observatialed to document more than one year extinguishers locate states the provisions apply. LSC 4.6.12. equipment, system, of protection, fire-recother feature requirinspection, or opera shall be tested, inspin applicable NFPA Standard for Portab Edition, Section 7.3 shall be subject to more than one year, or when specifically Section 7.3.3 states have a tag or label sindicates the month	RKS section any LSC 3.2 General Requirements seed by the provided ficient. This information, plicable Life Safety Code or tation, should be included 57. Attion and interview; the facility maintenance at intervals of not for 1 of 3 portable fire and in the facility. LSC 33.1.1.3 sof Chapter 4, General, shall 4 requires any device, condition, arrangement, level esistive construction, or any	K S100	1.ResCare Maintenance will conduct monthly inspections of facility fire extinguishers. Documented test dates will be kept onsite and with maintenant manager for review. 2.The AED met with ResCare Maintenance Manager on Marc 10, 2021 to ensure monthly checks are being performed. 3.The Facility will conduct random monthly inspections by the Residential Manager, Area Supervisor or Program Manage ensure documentation of Fire Extinguisher Inspections are be completed as required and available for review. If documentation is not available Program Manager, Area Supervisor or Residential Manager, Area Supervisor or Residential Manager.	ece ech er to eing

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING			
	PROVIDER OR SUPPLIEI	R LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	work, and identifies	s the name of the agency		will contact Aramark (844)-	
	performing the wor	k. This deficient practice could		RESCARE and create a service)
	affect all clients, sta	aff, and visitors.		order and follow up to ensure	
				completion within 5 days.	
	Findings include:			4.The AED will in service the	
				Program Manager, Area	
		ons with the Director Services		Supervisor and Residential	
	Provider (DSP) #3	during a tour of the facility from		Manager on the requirement of	
	12:40 p.m. to 1:20 p.m. on 03/02/21, the ABC type portable fire extinguisher in the laundry room had two affixed maintenance tags. The yellow tag indicated the most recent annual maintenance was performed in February 2019. The second tag, a white and red tag, had 2020 handwritten on the face of the tag and had the ten month period of			inspecting Fire Extinguishers ar	nd
				maintaining proper documentati	ion.
				5.Random Monthly site visits	
				will be conducted by the	
				management team to verify the	
				inspecting Fire Extinguishers ar	nd
				maintaining proper documentati	
		ctober crossed out on the face		UPDATE Below March 19, 202	1 to
		y inspections on the opposite		include issue not addressed in	
	_	e recorded for the ten month		original POC	
	1 -	hrough October. It appeared			
		the tag was to record the date		1.Concerning annual	
		nce on the front of the card		maintenance of Fire Extinguishe	
		inspections on the opposite		The Associate Executive Direct	
	_	a result, it could not be		contacted Eric Grey with Koorse	en
		ate annual maintenance was		Fire and Security on March 17,	
	1 ^	v of "Fire & Safety System		2021 to schedule annual	
		ation on a clipboard hanging		maintenance for all the facilities	
	1	m wall indicated the date		Fire Extinguisher. The Scope of	
		s were performed on portable		work has been updated to ensu	re
	_	n the facility but it was not		the inclusion of annual	
	1	n and it did not record the date		maintenance for portable fire	
		nce. Based on interview at the		extinguishers and required	
		tions, the DSP #3 agreed it		documentation. The Program	
		nined what date annual		Manager, Area Supervisor and	
	_	erformed within the most		Direct Support Lead have been	
		h period for the laundry room		in-serviced on the requirement	and
	portable fire exting	uisner.		if a deficiency is noted the	
	Th:- £:- 1	i1i4-4 DCD #1 DCD		Program Manager, Area	1
		eviewed with the DSP #1, DSP		Supervisor or Direct Support Le	ad
	#2, and DSP #3 dui	ring the exit conference.	- 1	will contact (844) ResCare to	

create a service order. The

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZI HORIZON DR HIS, IN 47143	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	failed to ensure 1 of located in the facility monthly and the instance including the date a performing the inspersions of Chapt 4.6.12.3 requires exthe public, such as a maintained or remoster for Portable Fire Exterion 7.2.1.2 state inspected either man electronic monitoring of 30-day intervals. inspections are condinspection was performing the recorded. Where monitoring the conducted, records be kept on a tag or leaving uisher, on an maintained on file, and Records shall be keep the last 12 monthly performed. This declients, staff, and virus Findings include: Based on observation Provider (DSP) #3 of 12:40 p.m. to 1:20 prortable fire extinguisher was affixed mainter indicated the most reperformed in Februarinspections were do 2020. The second to	ation and interview, the facility of 3 portable fire extinguishers by were inspected at least pections were documented and initials of the person ection. LSC 33.1.1.3 states the er 4, General, shall apply. LSC isting LSC features obvious to fire extinguishers, to be either wed. NFPA 10, the Standard tinguishers, 2010 Edition, as fire extinguishers shall be an unally or by means of an ang device/system at a minimum. Where monthly manual ducted, the date the manual formed and the initials of the the inspection shall be annual inspections are for manual inspections are for manual inspections shall abel attached to the fire inspection checklist for by an electronic method. Put to demonstrate that at least inspections have been ficient practice could affect all sitors. The summary of the facility from form on 03/02/21, the ABC type whisher in the laundry room had hance tags. The yellow tag eccent annual maintenance was ary 2019 and monthly cumented through February and an the face of the tag and had		Associate Executive contacted Joe Moore Aramark Services or 2021 the Facilities methods for Koorsen Firincluded the annual of portable fire exting required documental made available for responsible for the DATE OF COMPLET 2021 Persons Responsible Program Manager, A Supervisor, and Responsible Manager, DSP	e with In March 17, Inaintenance It is scope of It is and Security Imaintenance Iguishers and Ition will be Ition will be Ition will April 1, Ition is a pril 1, Itin is a	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 02 COMPLETED B. WING 03/02/2021				
RES CAF		LTERNATIVES SE IN	13009 I MEMPI	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIC DATE	ON
K S345 Bldg. 02	the ten month period crossed out on the finspections on the orecorded for the ten through October. Movember and December and December of a variable of Safety System Check Clipboard hanging of indicated the date of the performed on portal facility but it was not on interview at the the DSP #3 agreed month laundry room portal November and December and December and December of a variable of the performed on portal November and December and December and December and December and DSP #3 during the performance with a performance of the performan	d of January through October ace of the tag. Monthly pposite side of the tag were month period of January Monthly inspections for ember 2020 and January 2021 for review. Review of "Fire & eks" documentation on a son the laundry room wall monthly inspections were pole fire extinguishers in the cot itemized by location. Based the pole fire extinguisher for ember 2020 and January 2021 for review. Wiewed with the DSP #1, DSP ing the exit conference. In - Testing and Prompt) In is tested and maintained in an approved program are requirements of NFPA 70, code, and NFPA 72, in and Signaling Code. In acceptance, maintenance addily available.	K S345	1.The administrator will ensuannual functional testing for initiating devices such as smo detectors, heat detectors, reledevices, and fire alarm boxes	ure 04/01/20 ke ase	021

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 03/02/2021		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN		HORIZON DR HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		.4.1 states a manual fire alarm		performed by Koorsen Fire ar		
		vided in accordance with he provisions of 33.2.3.4.1.1 or		Security on the fire alarm sys	tem	
		LSC Section 9.6.1.3 states a		and that reports of the	a in	
		equired for life safety shall be		tests/inspections are available the facility for review.	e III	
		d maintained in accordance		2.The administrator will ens	ure	
		requirements of NFPA 70,		sensitivity testing of the fire al		
		ode and NFPA 72, National Fire		system is completed by Koors		
		g Code. NFPA 72, 2010		Fire and Security every altern		
		1 at 9(f) states heat detectors		year after install and that repo		
	shall be visually inspected semiannually. NFPA			of the tests/inspections are		
	72, 2010 Edition, Section 14.4.5 states testing shall			available in the facility for revi	iew.	
	be performed in accordance with the schedules in			Koorsen Fire and Security wil	I I	
	Table 14.4.5. Initial/Reacceptance testing shall be			also forward inspection report	ts to	
	-	ne of installation. Table 14.4.5		the QA Manager for monitoring	ng of	
		equirements of 14.4.5.5 shall		completion.		
		ors. Section 14.4.5.5 states		3.The Program Manager w	ill	
		perature, spot-type heat		meet with a representative		
		sted in accordance with		from Koorsen Fire and		
		4.4.5.5.4. Two or more		Security, a tentative date ha	S	
		sted on each initiating circuit		been set for March 23, 2021		
	•	detectors shall be tested each 10 Edition, Table 14.4.2.2 at		pending the status of the		
	•	l-temperature, nonrestorable		COVID-19 response and suspense of none essential		
		tors functionality shall be		travel. The Facility will requi	iro	
		and electrically. Loop		schedule required testing ar		
		neasured and recorded.		request copies of inspection		
	Changes from accep			and testing mailed to the		
		ds shall be kept by the		program manager upon		
	-	cifying which detectors have		completion to the Program		
	been tested. Within	5 years, each detector shall		Manager at 4341 Security		
	have been tested. T	his deficient practice could		PKWY Suite 101 New Albany	y IN	
	affect all clients, sta	ff, and visitors.		47150.		
				4.The Program Manager sp		
	Findings include:			with the Kris Carney from Koo	orsen	
				Fire and Security effective		
		the fire alarm system		immediately all sites will have	an	
	•	or's "Systems Service"		annual functional fire alarm		
		d 02/12/20 with the three		inspection in the Month of		
	Direct Services Pro	viders (DSP) from 11:00 a.m. to		February and a semiannual fi	re	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
IAU	12:40 p.m. on 03/02 system initiating de within the most recond available for revidetectors and heat documented as bein semiannually. The not include an itemiresults for initiating Initial/Reacceptance performed at the tin available for review time of record review fire alarm system te documentation for the period might be available for semiannual visual in all smoke detectors devices in the facility Based on observation Provider (DSP) #3 of 12:40 p.m. to 1:20 p.m. t	2/21, documentation of fire alarm vice testing and inspection ent twelve month period was view. In addition, smoke electors were not g visually inspected or tested 02/12/20 documentation did zed listing by location and the	IAG	alarm visual inspection compination in August. Repair of the devict that failed the sensitivity test been scheduled to be completed in a later than April 1,2021. Access to the device will be made available and that device be tested no later than April 2021. Koorsen Fire and Section was notified of ResCare's "In Scope Services Agreement" automatically authorizes repair/service of fire systems Koorsen will notify the Program Manger upon completion of a inspections to ensure any deficiencies are properly trace and repaired. Koorsen will see documentation of all inspections ervices and repair to ResCamain office at 4341 Security Parkway STE. 101 New Albat 47150 with in 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required. DATE OF COMPLETION: A 1, 2021 Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire Security Representative	oleted ces has eted ice will 1, curity that i. am all sked end ons, are any IN gram sure

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>02</u>	COM	e survey pleted 2/2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COI HORIZON DR HIS, IN 47143)	
	T			T		T
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT A COLOR SHOW		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE		DATE
		checked within 1 year of				
		ery alternate year thereafter.				
		quired calibration test, if icate that the detector has				
		listed and marked sensitivity				
		-				
range, the length of time between calibration tests shall be permitted to be extended to a maximum of						
5 years. If the frequency is extended, records of						
detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke						
	detector is within it	s listed and marked sensitivity				
	range, it shall be tes	sted using any of the methods:				
	(1) Calibrated test r					
	(2) Manufacturer's	calibrated sensitivity test				
	instrument.					
	(3) Listed control e	quipment arranged for the				
	purpose.					
	` '	fire alarm control unit				
	_	by the detector causes a signal				
		where its sensitivity is outside				
	its listed sensitivity	_				
		l sensitivity method acceptable				
	to the authority hav	have sensitivity outside the				
		•				
	cleaned and recalib	ensitivity range shall be				
		ivity cannot be tested or				
		y spray device that administers				
		centration of aerosol into the				
	detector.	and an arrange in the same				
		ice could affect all clients,				
	staff, and visitors.	,				
	Findings include:					
	Based on review of	the fire alarm system				
		or's "Systems Service"				

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	· ′	LDING	nstruction 02	(X3) DATE : COMPL 03/02/	ETED
	ROVIDER OR SUPPLIER	TERNATIVES SE IN		13009 H	DDRESS, CITY, STATE, ZIP COD HORIZON DR HS, IN 47143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K S353 Bldg. 02	Direct Services Prov 12:40 p.m. on 03/02 sensitivity testing of the most recent two for review. The 02/ "sensitivity testing of report for details" by available for review time of record review sensitivity testing do available at the main sensitivity testing do available for review. This finding was review, and DSP #3 during NFPA 101 Sprinkler System—Sprinkler System—Sprinkler System—2012 EXISTING (FINFPA 13 and 13RIA) All sprinkler system with NFPA 13, State Sprinkler Systems for the Installation Residential Occup Four Stories in He and maintained in Standard for Inspendintenance of With System. NFPA 13D System Sprinkler systems with NFPA 13D, Sof Sprinkler System Sprinkler Sy	Maintenance and Testing Maintenance and Testing Maintenance and Testing Prompt) Systems Installed in accordance Indard for the Installation of Indard for the Installation Indard for the Installation Installed in accordance Installed in accordance Installed in accordance Installed in accordance Installation In					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY		SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		15G723	B. W	ING		03/02	/2021
N. 1	DOLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	ζ		13009 H	HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	NFPA 25:						
1. Control valves inspected monthly (NFPA							
	25, section 13.3.2						
		ected monthly (NFPA 25,					
	section 13.2.71).	s inspected quarterly					
	(NFPA 25, section						
		s tested semiannually					
	(NFPA 25, section	-					
		isory switches tested					
		PA 25, section 13.3.3.5).					
		lers inspected annually					
	((NFPA 25, sectio						
	* * *	nspected annually (NFPA					
	25, section 5.2.2).	· · · · · · · · · · · · · · · · · · ·					
	8. Visible pipe h	angers inspected annually					
	(NFPA 25, section	า 5.2.3).					
	9. Buildings insp	pected annually prior to					
	freezing weather t	for adequate heat for water					
	filled piping (NFP)	A 25, section 5.2.5).					
		ative sample of fast					
		rs are tested at 20 years					
	(NFPA 25, section	•					
		ative sample of dry pendant					
		ed at 10 years (NFPA 25,					
	section 5.3.1.1.15	•					
		olutions are tested annually					
	(NFPA 25, section						
		es are operated through d returned to normal					
		5, section 13.3.3.1).					
	- '	tems of OS&Y valves are					
		y (NFPA 25, section					
	13.3.4).	y (141 1 71 20, 3000011					
	· ·	stems extending into					
		_					
	unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).						
	· · · · · · · · · · · · · · · · · · ·	system last checked and					
	necessary mainte	-					

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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 COMPLETED 02 B. WING 03/02/2021 15G723 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 13009 HORIZON DR RES CARE COMMUNITY ALTERNATIVES SE IN MEMPHIS, IN 47143 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 1. Based on observation and interview, the facility K S353 04/01/2021 1.The Program Manager will failed to ensure 1 of over 10 sprinkler heads in the ensure monthly sprinkler gauge facility was maintained. NFPA 13, Standard for inspections and monthly control the Installation of Sprinkler Systems, 2010 Edition, valve inspections are conducted Section 6.2.7.1 states plates, escutcheons, or other by the ResCare maintenance devices used to cover the annular space around a coordinator, documentation will be sprinkler shall be metallic or shall be listed for use maintained on site and a copy around a sprinkler. This deficient practice could kept with ResCare Maintenance affect all clients and staff in the facility. Manager. 2.The program manager will Findings include: conduct random monthly inspections to ensure monthly and Based on observations with the Director Services quarterly inspections are being Provider (DSP) #3 during a tour of the facility from preformed as required. 12:40 p.m. to 1:20 p.m. on 03/02/21, the sprinkler 3.The AED met with ResCare head location on the ceiling in the north bedroom Maintenance Manager on March by the bathroom was missing its escutcheon plate 10, 2021 to ensure monthly which left a two inch opening in the ceiling. checks are being performed Based on interview at the time of the 4.The AED contacted Aramark observations, the DSP #3 agreed the on 3/15/2021 and submitted a aforementioned sprinkler head location was work order to have ResCare missing its escutcheon plate which left a two inch Maintenance inspect sprinkler opening in the ceiling. gauges, and maintain written documentation on site available for This finding was reviewed with the DSP #1, DSP review. #2 and DSP #3 during the exit conference. UPDATE Below March 19, 2021 2. Based on record review, observation and to include issues not addressed interview; the facility failed to ensure the sprinkler in original POC

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		15G723	B. W	ING	_	03/02/2021	
				_			
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					HORIZON DR		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	system was maintai	ined in accordance with NFPA					
	25. LSC 9.7.5 requ	ires all sprinkler systems shall			1.Concerning sprinkler head		
	be inspected, tested	l, and maintained in			location on the ceiling in the n	orth	
	accordance with NI	FPA 25, Standard for the			bedroom by the bathroom with		
		, and Maintenance of			missing escutcheon plate which		
	Water-Based Fire F	Protection Systems. NFPA 25,			left a two inch opening in the		
		e 5.1.1.2 states fire department			ceiling. The Associate Executi	ve	
		e inspected and tested in			Director contacted Eric Grey v		
		ible 13.1.1.2. Table 13.1.1.2			Koorsen Fire and Security on		
	states hose connect	ions shall be tested every 5			March 17, 2021 to schedule w	ork	
		e with Section 13.5.2.2. Section			order for the installation of an		
13.5.2.2 states a full flow test shall be conducted				escutcheon plate for the sprint	kler		
on each valve at 5-year intervals and shall be				head in the north bedroom by			
		bus test results. This deficient			bathroom. The Program Man		
		et all clients, staff and visitors.			Area Supervisor and Direct	5,	
	1	,			Support Lead have been		
	Findings include:				in-serviced on the requiremen	t of	
					monthly visual inspections for		
	Based on review of	the sprinkler system			Fire alarm and Sprinkler		
		or's "Systems Service"			components and if a deficience	cv is	
	-	ed 05/19/20 with the three			noted the Program Manager,	-	
		oviders (DSP) from 11:00 a.m. to			Supervisor or Direct Support L		
		2/21, the "Fire Department			will contact (844) ResCare to		
	•	is due for hydrostatic test" was			create a service order. The		
		ems Found" section of the			Associate Executive Director		
		ased on interview at the time of			contacted Joe Moore with		
	_	DSP #1 stated the main office			Aramark Services on March 1	7.	
	· · · · · · · · · · · · · · · · · · ·	al contractor inspection reports			2021 the Facilities maintenant		
		ting documentation on or after			vendor to ensure the scope of		
		vailable for review at the time of			work for Koorsen Fire and Sec		
		on observations with the			for the installation of the missi	•	
		rovider (DSP) #3 during a tour			escutcheon plate for the north	•	
		12:40 p.m. to 1:20 p.m. on			bedroom by the bathroom. Up		
		was noted outside on the north			completion no later than April		
	wall of the facility.				2021 documentation will be m		
					available for review.		
	This finding was re	viewed with the DSP #1, DSP			2.Concerning missing		
	#2 and DSP #3 during the exit conference.				documentation for a 5 year		
	Z and Bor no dur				hydrostatic test of the fire		
					department connection valve.	The	
	1		1		Lachariment connection valve.	1116	I

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

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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 02			COMPLETED	
		15G723	B. WI	NG		03/02/	2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	-	13009 F	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWING BY AN OR COMMON		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	Associate Executive Director contacted Eric Grey with Koorseire and Security on March 17 2021 to schedule work order for 5 year hydrostatic test of the findepartment connection valve a required documentation sent to the facility available for review. The Program Manager, Area Supervisor and Direct Support Lead have been in-serviced or requirement for a 5 year hydrostatic test of the fire department connection valve in deficiency is noted the Program Manager, Area Supervisor or Direct Support Lead will contal (844) ResCare to create a servorder. The Associate Executiv Director contacted Joe Moore Aramark Services on March 17 2021 the Facilities maintenancy vendor to ensure the scope of work for Koorsen Fire and Sector a 5 year hydrostatic test of fire department connection valincluded. Upon completion no than April 14, 2021 documental will be made available for review	sen for a re and o the the fa m ct vice e with 7, ce curity the lye is later ation	DATE
					DATE OF COMPLETION: Ap 2021	ril 1,	
					Persons Responsible: AED, Program Manager, Area Supervisor, and Residential		

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	OF CORRECTION	IDENTIFICATION NUMBER 15G723	A. BUILDING B. WING	02	COM	PLETED 02/2021
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZII HORIZON DR HIS, IN 47143	PCOD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
				Manager, DSP Koors Security Representa		
K S362	NFPA 101	undian of Malla				
Bldg. 02	walls shall meet al * Walls separatir minimum 1/2-hour which is considere partitioning is finish and plaster or mat thermal barrier. * Sleeping room doors, such as the solid-bonded wood construction of equifire integrity. * Any vision pan assemblies in accor wired glass not ex in area and installed. This requirement is walls that are smo with 8.4 and that a sprinklers in accor both sides of the w instances, there sl type or size of glas In Prompt Evacual rooms shall be sep route by smoke pa 8.2.4. Sleeping arrangen sleeping rooms sh nonresident staff in audibility of the ala	uction of Walls Prompt) ndicated below, corridor I of the following: ng sleeping rooms have a fire resistance rating, ed to be achieved if the hed on both sides with lath erials providing a 15-minute doors are substantial use of 1-3/4 inch thick, d-core construction or other ual or greater stability and els are fixed fire window ordance with 8.3.4 or are ceeding 9 square feet each ed in approved frames. Shall not apply to corridor ke partitions in accordance ure protected by automatic dance with 33.2.3.5 on wall and door. In such hall be no limitation on the				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		15G723	B. W	ING		03/02/2021	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			HORIZON DR		
DES CAI		LTERNATIVES SE IN			HIS, IN 47143		
INLO UAI		ETERNATIVES SE III		IVILIVII			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	sleeping.						
		roved facilities, where the					
	- '	n E-score of three or less					
	_	nd care methodology of					
	NFPA 101A, Guid						
		e Safety, sleeping rooms					
		d from escape routes by					
		nat are smoke resistant.					
	33.2.3.6						
		ation and interview, the facility	K S	362	1.The AED met with ResCar	_	04/01/2021
		f 6 sleeping room doors were			Maintenance Manager on Mar		
		smoke for at least 1/2 hour.			10, 2021 to ensure all doors in	n the	
		openings required to have a fire			facility meet or exceed LSC		
		Table 8.3.4.2 shall be			8.3.3.1 states openings requir		
		ved, listed, labeled fire door			to have a fire protection rating	-	
		window assemblies and their			Table 8.3.4.2 shall be protected	-	
		lware, including all frames,			approved, listed, labeled fire d	loor	
	_	chorage, and sills in			assemblies and fire window		
		e requirements of NFPA 80,			assemblies and their		
		Ooors and Other Opening			accompanying hardware, inclu	uding	
	_	as otherwise specified in this			all frames, closing devices,		
		tandard for Fire Doors and			anchorage, and sills in		
		tectives, 2010 Edition, Section			accordance with the requirement		
		earance under the bottom of a			of NFPA 80, Standard for Fire		
		simum of 3/4 inch. This			Doors and Other Opening		
	-	ould affect all clients, staff, and			Protectives, except as otherwi		
	visitors.				specified in this Code. NFPA		
	F' 1' ' 1 1				Standard for Fire Doors and C		
	Findings include:				Opening Protectives, 2010 Ed	ition,	
	Događ om obsomrati	ons with the Director Services			Section 4.8.4.2 states the	: _	
					clearance under the bottom of		
		during a tour of the facility from			door shall be a maximum of 3	14	
		p.m. on 03/02/21, a one and a			inch.	· ·	
		or for the northeast bedroom			2.The AED met with ResCar		
		all when the door was			Maintenance Manager on Mar		
					10, 2021 to ensure all bedroor doors are at a minimum 1-3/4	11	
	observed in the fully closed position. A one and a three eighths inch gap was noted in between the					- d	
		and the floor for the north			inches thick, solid bonded woo	Ju	
					core construction or of other		
	pearoom door by th	ne bathroom in the north hall	- 1		construction of equal or greate	er	I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	02	COMPLETED
		15G723	B. W	TNG	_	03/02/2021
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	C			HORIZON DR	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HS, IN 47143	-
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE
		observed in the fully closed urements were taken with a			stability and fire integrity	- wl.
	1 ~	ne undercut gap would not			3.The AED contacted Arama on 3/15/2021 and submitted a	
		f smoke. Based on interview			work order to have ResCare	
		oservations, the DSP #3 agreed			Maintenance noncompliant do	ore
		m of the doors was not			will be removed and complian	
		the passage of smoke.			door will be installed by April 1	
	capable of resisting	the passage of shioke.			2021.	',
	This finding was re	viewed with the DSP #1, DSP				
	_	ring the exit conference.				
					DATE OF COMPLETION: Ap	ril
	2. Based on observa	ation and interview, the facility			1, 2021	
	failed to ensure 3 of	f 6 client sleeping room doors				
	were 1-3/4 inches the	hick, solid bonded wood core			Persons Responsible: AED,	
	construction or of o	ther construction of equal or			Program Manager, Area	
	greater stability and	I fire integrity. This deficient			Supervisor, and Residential	
	practice could affect	et all clients, staff, and visitors.			Manager, DSP Koorsen Fire a	and
					Security Representative	
	Findings include:					
	Based on observation	ons with the Director Services				
	Provider (DSP) #3	during a tour of the facility from				
	12:40 p.m. to 1:20 j	p.m. on $03/02/21$, the three				
	bedroom doors on t	he south side of the facility				
	were hollow doors	and were not constructed of				
	1-3/4 inches thick,	solid bonded wood core				
		ther construction of equal or				
	, .	l fire integrity. Based on				
		e of observations, the DSP #3				
	_	ntioned bedroom doors were				
		s, solid-bonded wood-core				
		er construction of equal or				
	greater stability and	I fire integrity.				
	This finding was re	viewed with the DSP #1, DSP				
	#2, and DSP #3 dur	ing the exit conference.				
	3. Based on observa	ation and interview, the facility				
		ridor doors to 1 of 6 client				
	bedrooms would re-	sist the passage of smoke.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 03/02/2021	
	RE COMMUNITY A	LTERNATIVES SE IN	13009 I	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	This deficient practistaff, and visitors.	ice could affect all clients,			
	Findings include:				
	Provider (DSP) #3 of 12:40 p.m. to 1:20 pinch gap was noted door jamb of the no latching mechanism latched. The measuremeasuring tape. Bathe observations, the the south bedroom of passage of smoke.	ons with the Director Services during a tour of the facility from o.m. on 03/02/21, a three quarter in between the door and the rtheast bedroom door near the a when fully closed and arement was taken with a used on interview at the time of the DSP #3 agreed the gap in door would not resist the			
		ing the exit conference.			
K S363	NFPA 101				
D	Corridor - Doors				
Bldg. 02	Corridor - Doors Doors shall meet a	all of the following			
	requirements:				
		e provided with latches or			
	otner mechanisms	s suitable for keeping the			
	acci ciccoa.	all be arranged to prevent			
	the occupant from	- · · · · · · · · · · · · · · · · · · ·			
	3. Doors shall b	e self-closing or			
	_	in accordance with 7.2.1.8			
	_	than those protected			
		approved automatic			
	-	n accordance with 33.2.3.5.			
		with leaves required to			
	_	ion of egress travel are ted annually per 7.2.1.15.			
	33.2.3.6.4, 33.7.7	iou ailliually pel 1.2.1.13.			
		on and interview, the facility	K S363	1.The Program Manager wi	04/01/2021

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 03/02/2021
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF failed to ensure the bedrooms had no in latched into the doo practice could affect Findings include: Based on observation Provider (DSP) #3 12:40 p.m. to 1:20 p door to the north be to latch into the doo multiple times. The latching mechanism mechanism partially position and would plate on the door fra time of the observation door was recently b been submitted for bedroom door had a latching into the doo This finding was re	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LESC IDENTIFYING INFORMATION corridor door to 1 of 6 client inpediment to closing and in frame. This deficient it all clients, staff, and visitors. ons with the Director Services during a tour of the facility from io.m. on 03/02/21, the corridor droom by the bathroom failed for frame when tested to close is door was broken at the in location with the latching in dislocated from its normal not protrude into the latching inner. Based on interview at the tions, the DSP #3 stated the roken and a work order has repair but agreed north in impediment to closing and	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADE DEFICIENCY) ensure clients bedroom doors positively latch to the frame. 2. The maintenance coordinates will ensure all clients bedroom doors will positively latch as required. 3. The North Bedroom Door be repaired by ResCare Maintenance before April 1, 2 4. The Residential Manager inspect house weekly to ensure bedroom Area Manager will preform random monthly inspections and Program Mark will provide quarterly inspection to ensure bedroom doors positively latch to frame as required. 5. Staff will notify ResCare Maintenance upon discovery any damage that prevents Clied Bedroom Doors from positively latching to the frame as required to	ator n will 020. will re nager ons
K S712 Bldg. 02	least quarterly for under varied cond	at hold evacuation drills at each shift of personnel and itions to: Il personnel on all shifts are		Persons Responsible: Progra Manager, Area Supervisor, Residential Manager, DSP. DATE OF COMPLETION: Ap 1, 2021	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ,	ULTIPLE CO	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED	
		15G723	B. Wl	NG		03/02/	/2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		13009 I	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	familiar with the use mergency and disprocedures. 2. The facility muse a. Actually evacone drill each year b. Make special evacuation of clied disabilities; c. File a report and disabilities; and disabilities; and disabilities; and disabilities and disabilities and disabilities and disabilities. Findings include: Based on review of Fire" documentation on the first shift in the November, Decembrate in November, Decembrate	Il personnel on all shifts are se of the facility's saster plans and st: uate clients during at least r on each shift; provisions for the nts with physical and evaluation on each drill; I problems with evacuation cidents and take corrective lls, clients may be fe area in facilities certified Care Occupancies Chapter Code. meet the requirements of and (2) of this section for ief staff that they utilize.	KS	712	1.All staff at the Facility will re-trained on conducting fire of quarterly on all shifts. The Residential Manager will revied drills to ensure all required dri area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff. 1.The Area Supervisor will with the home at least monthly to ensure the drills are in the homand up to date. 1.The Residential Manager	rills ew all lls n	04/01/2021

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY A. BUILDING AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED

	15G723	B. WING	03/02/2021
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR	
	RE COMMUNITY ALTERNATIVES SE IN	MEMPHIS, IN 47143	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI TAG DEFICIENCY)	DBE COMPLETION
	August, September) 2020 and in the fourth quarter 2020 was also not available for review. Based on interview at the time of record review, the DSP #1 stated the facility operates two shifts per day, additional fire drill documentation might be at the main office but was not available for review and agreed documentation of a fire drill conducted on the aforementioned shifts and quarters in 2020 was not available for review. This finding was reviewed with the DSP #1, DSP #2, and DSP #3 during the exit conference.	submit monthly drills to the Department upon complet QA Department will notify Manager and Program mathe facility has not perform monthly drills as required. 1.The Area supervisor wensure drills are complete required. 1.The program manager conduct random monthly inspections to ensure drills being completed as required. Persons Responsible: Program Manager, Area Supervisor Residential Manager, DSF	e QA ion. The the Area anager if ned vill d as will s are ed. ogram
K S741 Bldg. 02	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 1. Based on record review, observation, and interview; the facility failed to provide a smoking policy for a facility allowing client smoking. LSC Section A.33.7.4.1(2) and (3) states:	K S741 1.All staff at the home w re-trained the Facilities sm policy, and use of the desi smoking area.	noking

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(2) Smoking by residents classified as not

responsible with regard to their ability to safely

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2. The Facility will in service staff

on the use of the smoking tower

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED		
		15G723	B. WING			03/02/2021		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	3		13009 HORIZON DR				
RES CARE COMMUNITY ALTERNATIVES SE IN			_	MEMPHIS, IN 47143				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY) DATE			
	use and dispose of smoking materials should be				used to dispensing cigarette butts.			
	prohibited.			3.All staff in the facility wil				
	(3) Where a resident, as specified in A.33.7.4.1(2),			inserviced on ensure smoking		I		
	is under direct supervision by staff or by a person			materials are deposited in				
	approved by the administration, smoking might be			ashtrays and metal cont				
	permitted.			with self-closing cover devices into				
	This deficient practice affects all clients, staff, and visitors.				which ashtrays can be emptie			
					noncombustible material and safe			
	Findings include:				design 4.The Facility will ensure the	3		
	Findings include:				smoking area is cleaned and			
	Based on record review with the three Direct			cigarette butts are removed from				
	Services Providers (DSP) from 11:00 a.m. to 12:40				the ground and disposed of			
	p.m. on 03/02/21, a facility smoking policy which				properly			
	addresses staff and client smoking was not				5.The Program Manager, Area			
		v. Based on interview at the			Supervisor, and Residential	Ju		
	time of record review, the DSP #1 stated two of				Manager will randomly inspect the			
	the four clients, JM & DB, currently smokes. The				facility monthly to ensure the			
	DSP #1 stated clients and staff are allowed to				proper use of the smoking tov	ver		
	smoke outside on the back patio with staff				and that cigarette butts are not			
	supervision but a smoking assessment and a				being thrown on the ground, a			
	smoking policy which addresses staff and client				disposal receptacles are being			
	smoking was not available for review at the time of				emptied as needed.	-		
	the survey. Based on observations with the DSP							
	#3 during a tour of the facility from 12:40 p.m. to							
	1:20 p.m. on 03/02/21, a smoking tower for				Persons Responsible: Progra	am		
	dispensing cigarette butts was noted on the back				Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance			
	patio deck. Hundreds of cigarette butts were							
	strewn on the lawn surrounding all sides of the							
	back patio deck. Cigarette butts were also strewn				Manager.			
	on the ground at the front entrance and in the							
	front yard.							
	This find:	viewed with the three DCDI-						
		eviewed with the three DSP's						
	during the exit conf	terence.						
	2. Based on observa	ation and interview, the facility						
	failed to ensure smo	oking materials were deposited						
	into ashtrays and metal containers with							
	self-closing cover d	levices into which ashtrays					İ	

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

PRINTED: 03/23/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/02/2021			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
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