STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/02/21 Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230 At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 4. The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by: Quality Review completed on 03/04/21	E 0000		
E 0036 Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(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 *[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			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants. Findings include: Based on review of Res Care Community Alternatives SE IN "Emergency/Disaster Preparedness Manual" documentation dated 03/27/20 with the three Direct Services Providers (DSP) during record review from 11:00 a.m. to 12:40 p.m. on 03/02/21, the facility's training and testing policy documentation failed to include when existing staff will be trained on the emergency preparedness program. The facility's training and testing policy documentation stated "All staff must be trained on the disaster preparedness plan and ready to carry it out at any time. New employees must be oriented to the plan and procedures at the beginning of their employment". Based on interview at the time of record review, the DSP #1 stated the facility	E 0036	1.The administrator will ensure the emergency plan policies and procedures annual emergency training and testing program is implemented in all locations and evidence of the annual training and testing is present in the EPP manual. 2.The area supervisor and program manager will train all staff on the annual training and testingand the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review and update annually as needed. 3.This information is located in section 22 of the Emergency Disaster Preparedness Manual	04/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conducts drills such as bomb threat or power failure with existing staff and is required to perform them, at a minimum, every 6 months but agreed the facility's training and testing policy documentation failed to include how often existing staff will be trained on the emergency preparedness program. This finding was reviewed with the three DSP's during the exit conference.		4.The program manager, area supervisor, residential manager will ensure initial training is conducted during on the job orientation and annual training is complete. 5.The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of emergency preparedness training **DATE OF COMPLETION: April 1, 2021** Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to ensure staff received training in regard to emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of Res Care Community Alternatives SE IN "Emergency/Disaster Preparedness Manual" documentation dated 03/27/20 with the three Direct Services Providers (DSP) during record review from 11:00 a.m. to 12:40 p.m. on 03/02/21, the facility lacked documentation of staff training on the emergency	E 0037	**E 037 EP Training Program:** 1.The administrator will ensure the emergency plan policies and procedures initial training in emergency preparedness policies and procedures to all new and existing staff, annual emergency training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed and present in the EPP manual. The ResCare “On The Job” training checklist will be updated to include initial training in emergency preparedness of all new employees. The annual training requirements list will also be updated to include the training of all existing employees. 2.The residential manager, area supervisor and program manager will provide initial training to all new staff and the ResCare trainer will provide annual training to	04/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	preparedness plan within the most recent two year period. Review of "Emergency Preparedness Plan Required Training" and "Emergency Preparedness Testing" documentation indicated the most recent documented staff training on emergency preparedness policies and procedures occurred on 12/27/18. Based on interview at the time of record review, the DSP #1 stated the main office might have updated staff training documentation but agreed staff training documentation on emergency preparedness policies and procedures within the most recent two year period was not available for review at the time of the survey. This finding was reviewed with the three DSP's during the exit conference.		existing staff. Testing results will be available to demonstrate staff knowledge of emergency procedures. The training and testing documentation will be present in the Emergency Disaster Preparedness Manual/HR personnel files for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review and update annually as needed. 3.This information is located in section 22 of the Emergency Disaster Preparedness Manual 4.The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of emergency preparedness training **DATE OF COMPLETION: April 1, 2021** Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP.	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements *[For RNCHI at §403.748, ASCs at §416.54,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	HHAs at §484.102, CORFs at §485.68, 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 that requires activation of the 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 (B) A mock disaster drill; or (C) A tabletop 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 messages, or prepared questions designed to challenge an emergency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do 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 an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise 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 a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop 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 messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/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 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop 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 messages, or prepared questions designed to challenge an emergency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the	E 0039	1.The administrator will ensure the participation in a full-scale community based exercise and a table top exercise is present in the EPP manual. 2.The area supervisor and program manager will ensure documentation of the table top exercise and the community based exercise are present in the	04/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of Res Care Community Alternatives SE IN "Emergency/Disaster Preparedness Manual" documentation dated 03/27/20 with the three Direct Services Providers (DSP) during record review from 11:00 a.m. to 12:40 p.m. on 03/02/21, documentation of a second emergency preparedness exercise within the most recent twelve month period was not available for review. A tabletop exercise on "Critical Power Failure" was included as part of the emergency prepared manual but it was not dated. Based on interview at the time of record review, the DSP #1 stated the facility is currently experiencing an actual natural emergency due to Covid-19 and produced documentation of the policies and procedures currently in effect for the pandemic. The DSP #1 stated the main office might have the date of the tabletop exercise but agreed the facility		Emergency Disaster Preparedness Manual for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review and update annually as needed. 3.This information is located in section 22 of the Emergency Disaster Preparedness Manual 4.Dated Documentation will be provided showing the completion 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 community based exercise and maintaining documentation **DATE OF COMPLETION: April 1, 2021** Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING -- B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	has not documented a second community based disaster drill or conducted a tabletop exercise within the most recent twelve month period and agreed additional testing documentation was not available for review at the time of the survey. This finding was reviewed with the three DSP's during the exit conference.			
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/02/21 Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230 At this Life Safety Code survey, Res Care Community Alternatives SE IN was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, bedrooms and all living areas. The attic was not used for living purposes, storage or fuel-fired equipment and was provided with a heat detection system to activate the fire alarm system. The facility has a capacity of 6 and had a census of 4 at the time of this survey.	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.1. Quality Review completed on 03/04/21			
K S100 Bldg. 02	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview; the facility failed to document maintenance at intervals of not more than one year for 1 of 3 portable fire extinguishers located in the facility. LSC 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the	K S100	1.ResCare Maintenance will conduct monthly inspections of all facility fire extinguishers. Documented test dates will be kept onsite and with maintenance manager for review. 2.The AED met with ResCare Maintenance Manager on March 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 Manager to ensure documentation of Fire Extinguisher Inspections are being completed as required and available for review. If documentation is not available the Program Manager, Area Supervisor or Residential Manager	04/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	work, and identifies the name of the agency performing the work. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Director Services Provider (DSP) #3 during a tour of the facility from 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 January through October crossed out on the face of the tag. Monthly inspections on the opposite side of the tag were recorded for the ten month period of January through October. It appeared that the purpose of the tag was to record the date of annual maintenance on the front of the card and record monthly inspections on the opposite side of the tag. As a result, it could not be determined what date annual maintenance was performed. Review of "Fire & Safety System Checks" documentation on a clipboard hanging on the laundry room wall indicated the date monthly inspections were performed on portable fire extinguishers in the facility but it was not itemized by location and it did not record the date of annual maintenance. Based on interview at the time of the observations, the DSP #3 agreed it could not be determined what date annual maintenance was performed within the most recent twelve month period for the laundry room portable fire extinguisher. This finding was reviewed with the DSP #1, DSP #2, and DSP #3 during the exit conference.		will contact Aramark (844)-RESCARE and create a service order and follow up to ensure completion within 5 days. 4.The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of inspecting Fire Extinguishers and maintaining proper documentation. 5.Random Monthly site visits will be conducted by the management team to verify the inspecting Fire Extinguishers and maintaining proper documentation. UPDATE Below March 19, 2021 to include issue not addressed in original POC 1.Concerning annual maintenance of Fire Extinguisher The Associate Executive Director contacted Eric Grey with Koorsen Fire and Security on March 17, 2021 to schedule annual maintenance for all the facilities Fire Extinguisher. The Scope of work has been updated to ensure the inclusion of annual maintenance for portable fire extinguishers and required documentation. The Program Manager, Area Supervisor and Direct Support Lead have been in-serviced on the requirement and if a deficiency is noted the Program Manager, Area Supervisor or Direct Support Lead will contact (844) ResCare to create a service order. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Director Services Provider (DSP) #3 during a tour of the facility from 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 and monthly inspections were documented through February 2020. The second tag, a white and red tag, had 2020 handwritten on the face of the tag and had		Associate Executive Director contacted Joe Moore with Aramark Services on March 17, 2021 the Facilities maintenance vendor to ensure the scope of work for Koorsen Fire and Security included the annual maintenance of portable fire extinguishers and required documentation will be made available for review. DATE OF COMPLETION: April 1, 2021 Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the ten month period of January through October crossed out on the face of the tag. Monthly inspections on the opposite side of the tag were recorded for the ten month period of January through October. Monthly inspections for November and December 2020 and January 2021 were not available for review. Review of "Fire & Safety System Checks" documentation on a clipboard hanging on the laundry room wall indicated the date monthly inspections were performed on portable fire extinguishers in the facility but it was not itemized by location. Based on interview at the time of the observations, the DSP #3 agreed monthly inspections for the laundry room portable fire extinguisher for November and December 2020 and January 2021 were not available for review. This finding was reviewed with the DSP #1, DSP #2, and DSP #3 during the exit conference.			
K S345 Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to ensure all fire alarm system initiating devices were inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72.	K S345	1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, heat detectors, release devices, and fire alarm boxes is	04/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6 unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Table 14.3.1 at 9(f) states heat detectors shall be visually inspected semiannually. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Initial/Reacceptance testing shall be performed at the time of installation. Table 14.4.5 at 15(e) states the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with 14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year. NFPA 72, 2010 Edition, Table 14.4.2.2 at 14(d)(2) states fixed-temperature, nonrestorable line type heat detectors functionality shall be tested mechanically and electrically. Loop resistance shall be measured and recorded. Changes from acceptance test shall be investigated. Records shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Systems Service" documentation dated 02/12/20 with the three Direct Services Providers (DSP) from 11:00 a.m. to		performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. **3.The Program Manager will meet with a representative from Koorsen Fire and Security, a tentative date has been set for March 23, 2021 pending the status of the COVID-19 response and suspense of none essential travel. The Facility will require schedule required testing and request copies of inspections and testing mailed to the program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany IN 47150.** 4.The Program Manager spoke with the Kris Carney from Koorsen Fire and Security effective immediately all sites will have an annual functional fire alarm inspection in the Month of February and a semiannual fire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12:40 p.m. on 03/02/21, documentation of fire alarm system initiating device testing and inspection within the most recent twelve month period was not available for review. In addition, smoke detectors and heat detectors were not documented as being visually inspected or tested semiannually. The 02/12/20 documentation did not include an itemized listing by location and the results for initiating device testing. Initial/Reacceptance testing for heat detectors performed at the time of installation was not available for review. Based on interview at the time of record review, the DSP #1 stated additional fire alarm system testing and inspection documentation for the most recent twelve month period might be available at the main office but was not available for review and agreed semiannual visual inspection documentation for all smoke detectors and heat detector initiating devices in the facility was not available for review. Based on observations with the Director Services Provider (DSP) #3 during a tour of the facility from 12:40 p.m. to 1:20 p.m. on 03/02/21, one heat detector was installed in the attic as determined by use of a ladder for attic access in the south hall bedroom closet. This finding was reviewed with the DSP #1, DSP #2, and DSP #3 during the exit conference. 2. Based on record review and interview, the facility failed to ensure all facility smoke detectors were within their listed and marked sensitivity range. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5.3.1 states detector		alarm visual inspection completed in August. Repair of the devices that failed the sensitivity test has been scheduled to be completed no later than April 1,2021. Access to the device will be made available and that device will be tested no later than April 1, 2021. Koorsen Fire and Security was notified of ResCare's "In Scope Services Agreement" that automatically authorizes repair/service of fire systems. Koorsen will notify the Program Manger upon completion of all inspections to ensure any deficiencies are properly tracked and repaired. Koorsen will send documentation of all inspections, services and repair to ResCare main office at 4341 Security Parkway STE. 101 New Albany IN 47150 with in 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required. **DATE OF COMPLETION: April 1, 2021** Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its 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 its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Systems Service"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation dated 02/12/20 with the three Direct Services Providers (DSP) from 11:00 a.m. to 12:40 p.m. on 03/02/21, an itemized list of the sensitivity testing of all smoke detectors within the most recent two year period was not available for review. The 02/12/20 documentation stated "sensitivity testing on smoke detectors. See report for details" but no detailed report was available for review. Based on interview at the time of record review, the DSP #1 stated additional sensitivity testing documentation might be available at the main office but agreed additional sensitivity testing documentation was not available for review. This finding was reviewed with the DSP #1, DSP #2, and DSP #3 during the exit conference.			
K S353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	system was maintained in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Table 5.1.1.2 states fire department connections shall be inspected and tested in accordance with Table 13.1.1.2. Table 13.1.1.2 states hose connections shall be tested every 5 years in accordance with Section 13.5.2.2. Section 13.5.2.2 states a full flow test shall be conducted on each valve at 5-year intervals and shall be compared to previous test results. This deficient practice could affect all clients, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Systems Service" documentation dated 05/19/20 with the three Direct Services Providers (DSP) from 11:00 a.m. to 12:40 p.m. on 03/02/21, the "Fire Department Connection (FDC) is due for hydrostatic test" was stated in the "Problems Found" section of the 05/19/20 report. Based on interview at the time of record review, the DSP #1 stated the main office may have additional contractor inspection reports but agreed FDC testing documentation on or after 05/19/20 was not available for review at the time of the survey. Based on observations with the Director Services Provider (DSP) #3 during a tour of the facility from 12:40 p.m. to 1:20 p.m. on 03/02/21, one FDC was noted outside on the north wall of the facility. This finding was reviewed with the DSP #1, DSP #2 and DSP #3 during the exit conference.		1.Concerning sprinkler head location on the ceiling in the north bedroom by the bathroom with a missing escutcheon plate which left a two inch opening in the ceiling. The Associate Executive Director contacted Eric Grey with Koorsen Fire and Security on March 17, 2021 to schedule work order for the installation of an escutcheon plate for the sprinkler head in the north bedroom by the bathroom. The Program Manager, Area Supervisor and Direct Support Lead have been in-serviced on the requirement of monthly visual inspections for all Fire alarm and Sprinkler components and if a deficiency is noted the Program Manager, Area Supervisor or Direct Support Lead will contact (844) ResCare to create a service order. The Associate Executive Director contacted Joe Moore with Aramark Services on March 17, 2021 the Facilities maintenance vendor to ensure the scope of work for Koorsen Fire and Security for the installation of the missing escutcheon plate for the north bedroom by the bathroom. Upon completion no later than April 14, 2021 documentation will be made available for review. 2.Concerning missing documentation for a 5 year hydrostatic test of the fire department connection valve. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Associate Executive Director contacted Eric Grey with Koorsen Fire and Security on March 17, 2021 to schedule work order for a 5 year hydrostatic test of the fire department connection valve and required documentation sent to the facility available for review. The Program Manager, Area Supervisor and Direct Support Lead have been in-serviced on the requirement for a 5 year hydrostatic test of the fire department connection valve if a deficiency is noted the Program Manager, Area Supervisor or Direct Support Lead will contact (844) ResCare to create a service order. The Associate Executive Director contacted Joe Moore with Aramark Services on March 17, 2021 the Facilities maintenance vendor to ensure the scope of work for Koorsen Fire and Security for a 5 year hydrostatic test of the fire department connection valve is included. Upon completion no later than April 14, 2021 documentation will be made available for review DATE OF COMPLETION: April 1, 2021 Persons Responsible: AED, Program Manager, Area Supervisor, and Residential	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Manager, DSP Koorsen Fire and Security Representative	
K S362 Bldg. 02	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING (Prompt) Unless otherwise indicated below, corridor walls shall meet all of the following: * Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier. * Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity. * Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are wired glass not exceeding 9 square feet each in area and installed in approved frames. This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels. In Prompt Evacuation facilities, all sleeping rooms shall be separated from the escape route by smoke partitions in accordance with 8.2.4. Sleeping arrangements that are not located in sleeping rooms shall be permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sleeping. In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms shall be separated from escape routes by walls and doors that are smoke resistant. 33.2.3.6 1. Based on observation and interview, the facility failed to ensure 2 of 6 sleeping room doors were capable of resisting smoke for at least 1/2 hour. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 4.8.4.2 states the clearance under the bottom of a door shall be a maximum of 3/4 inch. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Director Services Provider (DSP) #3 during a tour of the facility from 12:40 p.m. to 1:20 p.m. on 03/02/21, a one and a half inch gap was noted in between the bottom of the door and the floor for the northeast bedroom door in the north hall when the door was observed in the fully closed position. A one and a three eighths inch gap was noted in between the bottom of the door and the floor for the north bedroom door by the bathroom in the north hall	K S362	1.The AED met with ResCare Maintenance Manager on March 10, 2021 to ensure all doors in the facility meet or exceed LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 4.8.4.2 states the clearance under the bottom of a door shall be a maximum of 3/4 inch. 2.The AED met with ResCare Maintenance Manager on March 10, 2021 to ensure all bedroom doors are at a minimum 1-3/4 inches thick, solid bonded wood core construction or of other construction of equal or greater	04/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	when the door was observed in the fully closed position. The measurements were taken with a measuring tape. The undercut gap would not resist the passage of smoke. Based on interview at the time of the observations, the DSP #3 agreed the gap at the bottom of the doors was not capable of resisting the passage of smoke. This finding was reviewed with the DSP #1, DSP #2, and DSP #3 during the exit conference. 2. Based on observation and interview, the facility failed to ensure 3 of 6 client sleeping room doors were 1-3/4 inches thick, solid bonded wood core construction or of other construction of equal or greater stability and fire integrity. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Director Services Provider (DSP) #3 during a tour of the facility from 12:40 p.m. to 1:20 p.m. on 03/02/21, the three bedroom doors on the south side of the facility were hollow doors and were not constructed of 1-3/4 inches thick, solid bonded wood core construction or of other construction of equal or greater stability and fire integrity. Based on interview at the time of observations, the DSP #3 agreed the aforementioned bedroom doors were not 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity. This finding was reviewed with the DSP #1, DSP #2, and DSP #3 during the exit conference. 3. Based on observation and interview, the facility failed to ensure corridor doors to 1 of 6 client bedrooms would resist the passage of smoke.		stability and fire integrity 3.The AED contacted Aramark on 3/15/2021 and submitted a work order to have ResCare Maintenance noncompliant doors will be removed and compliant door will be installed by April 1, 2021. **DATE OF COMPLETION: April 1, 2021** Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Director Services Provider (DSP) #3 during a tour of the facility from 12:40 p.m. to 1:20 p.m. on 03/02/21, a three quarter inch gap was noted in between the door and the door jamb of the northeast bedroom door near the latching mechanism when fully closed and latched. The measurement was taken with a measuring tape. Based on interview at the time of the observations, the DSP #3 agreed the gap in the south bedroom door would not resist the passage of smoke. This finding was reviewed with the DSP #1, DSP #2, and DSP #3 during the exit conference.			
K S363 Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility	K S363	1.The Program Manager will	04/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failed to ensure the corridor door to 1 of 6 client bedrooms had no impediment to closing and latched into the door frame. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Director Services Provider (DSP) #3 during a tour of the facility from 12:40 p.m. to 1:20 p.m. on 03/02/21, the corridor door to the north bedroom by the bathroom failed to latch into the door frame when tested to close multiple times. The door was broken at the latching mechanism location with the latching mechanism partially dislocated from its normal position and would not protrude into the latching plate on the door frame. Based on interview at the time of the observations, the DSP #3 stated the door was recently broken and a work order has been submitted for repair but agreed north bedroom door had an impediment to closing and latching into the door frame. This finding was reviewed with the DSP #1, DSP #2, and DSP #3 during the exit conference.		ensure clients bedroom doors positively latch to the frame. 2.The maintenance coordinator will ensure all clients bedroom doors will positively latch as required. 3.The North Bedroom Door will be repaired by ResCare Maintenance before April 1, 2020. 4.The Residential Manager will inspect house weekly to ensure bedroom Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure bedroom doors positively latch to frame as required. 5.Staff will notify ResCare Maintenance upon discovery of any damage that prevents Clients Bedroom Doors from positively latching to the frame as required by calling 844-ResCare. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP. **DATE OF COMPLETION: April 1, 2021**	
K S712 Bldg. 02	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)			
	Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the first shift for 1 of 4 quarters and on the second shift for 2 of 4 quarters. This deficient practice affects all clients, staff, and visitors. Findings include: Based on review of "Emergency Evacuation Drill: Fire" documentation with the three Direct Services Providers (DSP) from 11:00 a.m. to 12:40 p.m. on 03/02/21, documentation of a fire drill conducted on the first shift in the fourth quarter (October, November, December) was not available for review. Documentation of a fire drill conducted on the second shift in the third quarter (July,	K S712	1.All staff at the Facility will be re-trained on conducting fire drills quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date. 1.The Residential Manager will	04/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 QA Department upon completion. The QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required. 1.The Area supervisor will ensure drills are completed as required. 1.The program manager will conduct random monthly inspections to ensure drills are being completed as required. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP **DATE OF COMPLETION: April 1, 2021**	
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: (2) Smoking by residents classified as not responsible with regard to their ability to safely	K S741	1.All staff at the home will be re-trained the Facilities smoking policy, and use of the designated smoking area. 2.The Facility will in service staff on the use of the smoking tower	04/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	use and dispose of smoking materials should be prohibited. (3) Where a resident, as specified in A.33.7.4.1(2), is under direct supervision by staff or by a person approved by the administration, smoking might be permitted. This deficient practice affects all clients, staff, and visitors. Findings include: Based on record review with the three Direct Services Providers (DSP) from 11:00 a.m. to 12:40 p.m. on 03/02/21, a facility smoking policy which addresses staff and client smoking was not available for review. Based on interview at the time of record review, the DSP #1 stated two of the four clients, JM & DB, currently smokes. The DSP #1 stated clients and staff are allowed to smoke outside on the back patio with staff supervision but a smoking assessment and a smoking policy which addresses staff and client smoking was not available for review at the time of 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 dispensing cigarette butts was noted on the back patio deck. Hundreds of cigarette butts were strewn on the lawn surrounding all sides of the back patio deck. Cigarette butts were also strewn on the ground at the front entrance and in the front yard. This finding was reviewed with the three DSP's during the exit conference. 2. Based on observation and interview, the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays		used to dispensing cigarette butts. 3.All staff in the facility will be inserviced on ensure smoking materials are deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design 4.The Facility will ensure the smoking area is cleaned and all cigarette butts are removed from the ground and disposed of properly 5.The Program Manager, Area Supervisor, and Residential Manager will randomly inspect the facility monthly to ensure the proper use of the smoking tower and that cigarette butts are not being thrown on the ground, and disposal receptacles are being emptied as needed. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 02 B. WING	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	can be emptied of noncombustible material and safe design in 2 of 2 areas where smoking is permitted. This deficient practice could affect all clients, staff, and visitors. Findings include: 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 dispensing cigarette butts was noted on the back patio deck. Hundreds of cigarette butts were strewn on the ground surrounding all sides of the back patio deck. Cigarette butts were also strewn on the ground at the front entrance and in the front yard. No ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design were located in the front yard. This finding was reviewed with the three DSP's during the exit conference.			