STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING -- B. WING	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 06/01/2021 Facility Number: 000775 Provider Number: 15G255 AIM Number: 100248960 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 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 06/07/21	E 0000		
E 0004 Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

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
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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the	E 0004	**E004: Develop EP Plan, Review**	07/01/2021

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	facility failed to maintain an emergency preparedness plan by updating at least every two years. The plan must do all of the following: 1) Be based on and include a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach, including missing clients. 2) Include strategies for addressing emergency events identified by the risk assessment. 3) Address the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. 4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation in accordance with 42 CFR 483.475(a). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness Plan entitled "EPP-Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manger (RM), the document was dated 11/15/2017 with a reviewed on date of 01/10/2019. Individual components of the manual were also published and updated prior to 01/10/2019. Based on an interview at the time of record review the RM explained that the manual was "reviewed" at the time of each employee EPP training and the last training was documented on 01/07/2021. The RM acknowledged that documentation of the plan/manual did not reflect that it was reviewed since 01/10/2019.		**and Update Annually** **Corrective action:** ·Program Manager updates the Emergency Plan annually and as needed. ·All staff are trained and tested annually and as needed. **(Attachment A)** ·New hire staff are trained on the Emergency Plan during their OJT (on the job training). **(Attachment B)** ·Program Director updates the Risk Assessment for our facilities. **(Attachment C)** ·Program Manager updated the Shelter in Place Policy. **(Attachment D)** ·Program Manager updated the Continuity of Operations Plan. **(Attachment E)** ·Program Manager created a signature sheet for all staff to sign when trained on the EPP. **(Attachment F)** ·Program Manager created a form to track when emergency plans are reviewed and or updated. **(Attachment F)** **Monitoring of Corrective Action**: ·Area Supervisor will train all staff annually and as needed, send to the Program Manager for review and file in the EPP binder. ·Risk Assessment will be updated as needed by the Program Director. ·Rescare trainer monitors all On	

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	This issue was reviewed with the RM at the Exit Conference on 06/01/2021 at 2:30 p.m.		the Job training packets to ensure all training was complete on the new hires including training on the Emergency Plan. **Completion Date: 7/1/21**	
E 0013 Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies			

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	and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to			

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	occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "EPP- Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manger (RM), documentation for a complete emergency program reviewed by the facility within the most recent 2-year period was not available for review, the Policies and Procedures portion of the manual was dated 12/17/2018 with a reviewed on date of 01/10/2019. Based on an interview at the time of record review the RM explained that the manual was "reviewed" at the time of each employee EPP training and the last training was documented on 01/07/2021. The RM acknowledged that documentation of the plan/manual did not reflect that it was reviewed since 01/10/2019. This issue was reviewed with the RM at the Exit Conference on 06/01/2021 at 2:30 p.m.	E 0013	**E013:** Development of EP policies and Procedures **Corrective Action:** ·The Emergency Plan is updated annually and as needed. ·Area Supervisor trains all staff annually. ·All new hires are trained as part of their On the Job Training and then annually. ·Program Manager created a form to track when emergency plans are reviewed and updated. **(Attachment F)** ·Program Manager will ensure the facility has the most current plans, policies and procedures. ·Area Supervisor will review the plans in the book when emergency preparedness is reviewed during facility staff meetings. **Monitoring of Corrective Action:** ·Program Manager will update the emergency preparedness plan at least every 2 years and as needed and ensure the updated information is in the facility and sign on the updated tracking form. ·On the job training is sent to the Rescare Trainer and Human Resources for review and monitoring for completion.	07/01/2021

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			Completion Date: 7/1/21	
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2)			

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	A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and			

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	actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants. Findings include: Based on record review of the emergency preparedness plan entitled "EPP Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manager (RM), there was nothing in the manual which addressed a system to track the whereabouts of staff and clients during an emergency. Based on an interview at the time of record review, the RM indicated that policies and procedures had been given verbally to the staff at training. The RM acknowledged that there was no written policy and procedure which addressed the tracking of staff and clients in the event of an emergency. This issue was reviewed with the RM at the Exit Conference on 06/01/2021 at 2:30 p.m.	E 0018	**E018: Procedures for Tracking of Staff and Patients** **Corrective action:** ·Program Manager created a form for tracking of all staff and consumers. This form will be completed each shift and documented**. (Attachment G)** **Monitoring of Corrective Action**: ·The tracking form to track staff and consumers will be completed by the Area Supervisor and relay the information to the Administrative Management Team for continuous monitoring of all staff and consumers. Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. **Completion Date: 7/1/21**	07/01/2021

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E 0024 Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.			

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	*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: During review of the emergency preparedness documentation entitled "EPP Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manager (RM), the emergency preparedness plan did not include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on interview at the time of record review, the RM said the emergency preparedness documentation included a list of names of volunteers. The RM acknowledged that the manual did not include emergency preparedness policies and procedures for the use of volunteers in an emergency. This issue was reviewed with the RM at the Exit	E 0024	**E024: Policies/Procedures-Volunteers and Staffing** **Corrective action:** ·The ROC program is used for volunteers needed in an emergency situation, the attached packet/policy reflects the directions for all ROC volunteers **(Attachment H)** ·All staff will be tested **(Attachment I)** on the ROC Handbook Overview packet/policy. **Monitoring of Corrective Action**: ·"Rescare On Call" staff are identified and tested annually on the ROC tests. ·ROC staff would be trained on the EPP by the Administrative Management Team in the event of an emergency. **Completion Date: 7/1/21**	07/01/2021

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	Conference on 06/01/2021 at 2:30 p.m.			
E 0029 Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to maintain an emergency preparedness communication plan that complies with Federal, State, and local laws that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "EPP- Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manger (RM), documentation for a complete emergency program reviewed by the facility within the most recent 2-year period was not available for review, the Communications portion of the manual was dated 12/17/2018 with a reviewed on date of	E 0029	**E029:** The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be updated at least annually. **Corrective Action:** ·Program Manager updated the emergency contact list to include Federal, State, tribal, Regional and local emergency preparedness staff. (**Attachment J**) ·Program Manager updates Emergency plans are updated monthly to ensure the most accurate contact information is included.	07/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING -- B. WING	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	01/10/2019. Based on an interview at the time of record review the RM explained that the manual was "reviewed" at the time of each employee EPP training and the last training was documented on 01/07/2021. The RM acknowledged that documentation of the plan/manual did not reflect that it was reviewed since 01/10/2019. This issue was reviewed with the RM at the Exit Conference on 06/01/2021 at 2:30 p.m.		·QIDP will update all guardians and families as needed in the event of an emergency and will document the contact on the IDT Team Meeting Note**. (Attachment K)** **Monitoring of Corrective Action:** ·Program Manager updated the emergency contact list to include Federal, State, tribal, Regional and local emergency preparedness staff. ·Program Manager updates emergency preparedness manual monthly and as needed. ·All IDT Team Meeting forms are sent to the Program Manager for review. ·Area Supervisor trains all staff on the Emergency Preparedness plan and submits training to the Program Manager and HR. **Completion Date: 7/1/21**	
E 0033 Bldg. --	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6),			

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	§483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.			

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	*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants. Findings include: During review of the emergency preparedness documentation entitled "EPP Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manager (RM), the emergency preparedness plan did not include a method for sharing information and medical documentation in an emergency. Based on interview at the time of record review, the RM could not explain the policy and or procedures. The RM acknowledged that the manual did not include emergency preparedness policies and procedures for sharing information and medical documentation in an emergency. This issue was reviewed with the RM at the Exit Conference on 06/01/2021 at 2:30 p.m.	E 0033	**E033: Methods for Sharing Information** **Corrective action:** ·The Continuity of Operations Plan **(Attachment E)** provides information on how all information will be shared and the protection of client information will be secured. ·Maintenance Technician purchased a locking tote to transport consumer documentation in the event of an emergency. **(Attachment L)** **Monitoring of Corrective Action**: ·The Continuity of Operations Plan will be updated as needed to include additional information by the Program Manager. **Completion Date: 7/1/21**	07/01/2021

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E 0034 Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.			

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	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction (AHJ) or the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. Findings include: During review of the emergency preparedness documentation entitled "EPP Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manager (RM), the emergency preparedness plan did not include a means for providing information about the needs and abilities of the clients to the AHJ in an emergency. Based on interview at the time of record review, the RM could not explain the policy and or procedures. The RM acknowledged that the manual did not include emergency preparedness policies and procedures for providing information about the needs and abilities to the AHJ in an emergency. This issue was reviewed with the RM at the Exit Conference on 06/01/2021 at 2:30 p.m.	E 0034	**E034: Information on Occupancy/Needs** **Corrective action:** ·The Continuity of Operations Plan **(Attachment E)** provides a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction or IC and will be placed in the EPP. ·All staff will be trained on the Continuity of Operations Plan. **Monitoring of Corrective Action**: ·The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form. ·AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. **Completion Date: 7/1/21**	07/01/2021
E 0035 Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):]			

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	[(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: During review of the emergency preparedness documentation entitled "EPP Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manager (RM), the emergency preparedness plan did not include a method for sharing information from the emergency plan with clients and their families in an emergency. Based on interview at	E 0035	**E035: LTC and ICF/IID Sharing Plan with Patients** **Corrective action:** ·The EPP plan will be discussed by the QIDP and shared with family members, the consumer, guardians and representatives of the consumers at their quarterly IDT meetings. **(Attachment K)** ·QIDP-D will provide any updates to family members, the consumer, guardians and representatives of the consumers as the EPP is updated. **Monitoring of Corrective Action**: ·The QIDP-D sends all IDT meeting forms to the QIDP and Program Manager for review and	07/01/2021

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	15G255	A. BUILDING -- B. WING	06/01/2021

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	the time of record review, the RM explained that he had all the telephone numbers to contact the families if an emergency occurred. The RM acknowledged that the manual did not include emergency preparedness policies and procedures for providing information about the emergency plan with clients and their families. This issue was reviewed with the RM at the Exit Conference on 06/01/2021 at 2:30 p.m.		to ensure completion. **Completion Date: 7/1/21**	
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 §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[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 training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training.			

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	(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 new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.			

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	15G255	A. BUILDING -- B. WING	06/01/2021

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RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

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	(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 PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE 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			

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	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. (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			

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	15G255	A. BUILDING -- B. WING	06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

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	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 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 the emergency preparedness program (EPP) training and testing program includes a training program. The ICF/IID 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 training at least every two 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	E 0037	**E037: EP Training Program`** **Corrective action:** ·All staff are trained and tested annually on the Emergency Preparedness Plan. **(Attachment A)** ·The Mock Drill form will be used for all drills and or true emergency disaster situations **(Attachment M)** ·The Mock Drill contact form will be used following an emergency drill. **(Attachment O)**	07/01/2021

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	15G255	A. BUILDING -- B. WING	06/01/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: During review of the emergency preparedness documentation entitled "EPP Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manager (RM), the emergency preparedness plan did not include a policy and procedure for initial training in the Emergency Preparedness Plan. Based on interview at the time of record review, the RM indicated that all staff attended annual training and new employees participated in the annual training. The RM acknowledged that the manual did not include policies and procedures for initial training in the emergency preparedness policies and procedures. This issue was reviewed with the RM at the Exit Conference on 06/01/2021 at 2:30 p.m.		·Area Supervisor has been trained to complete a full scale mock drill annually and a tabletop emergency disaster situation at least annually using a full scenario. **(Attachment N)** ·New hires are trained as part of their on the job training once they are assigned to the facility. **(Attachment B**) **Monitoring of Corrective Action**: ·Copies of the completed drills will be sent to the Program Manager and will also remain in the EPP binder in the facility. ·Completed staff tests will be kept in the EPP binder and will be sent to Human Resource to remain in staff training file. ·Program Manager updates the Emergency Preparedness Plan annually and as needed. ·Area Supervisor trains all staff annually on the EPP and as needed. ·Area Supervisor ensures all new hires are trained upon placement as staff to the facility and annually thereafter. **Completion Date: 7/1/21**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING -- B. WING	06/01/2021

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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 §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and 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			

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	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 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:			

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	(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, 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			

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	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 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			

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	to challenge an emergency 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 PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization 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 PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE 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 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 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.			

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	(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE'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 plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of			

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	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 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.			

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	*[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a 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 every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA 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 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 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 plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360]			

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	15G255	A. BUILDING -- B. WING	06/01/2021

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	(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. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is 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. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least once per year. The	E 0039	**E039: EP Testing Requirements**	07/01/2021

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	facility had no documentation of counting the COVID pandemic as an actual emergency that required activation of the existing EPP. The ICF/IID facility 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 ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional 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 an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator 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: During review of the emergency preparedness		**Corrective action:** ·The facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually and will use the Mock Drill Form **(Attachment M)** for completion and proof of the exercise. ·Area Supervisor trained to ensure the facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually and will use the Mock Drill Form **(Attachment N)** for completion and proof of the exercise. ·Staff will be tested annual on the EPP. **(Attachment A)** **Monitoring of Corrective Action**: ·Copies of the completed drills will be sent to the Program Manager and will also remain in the EPP binder in the facility. ·Completed staff tests will be kept in the EPP binder and will be sent to Human Resource to remain in staff file. **Completion Date: 7/1/21**	

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	documentation entitled "EPP Emergency Disaster Manual" on 06/01/2021 between 10:35 a.m. and 1:00 p.m. with the Residential Manager (RM), no documentation of an additional exercise was provided for review. The RM indicated that no event had occurred in the last year that caused an activation of the EPP. The RM acknowledged that documentation of an additional exercise could not be provided. This issue was reviewed with the RM at the Exit Conference on 06/01/2021 at 2:30 p.m.			
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: 06/01/2021 Facility Number: 000775 Provider Number: 15G255 AIM Number: 100248960 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 attic which is not used for living purposes, storage, or fuel-fire equipment is protected by heat detection devices connected	K 0000		

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	to the fire alarm control panel. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 3.6. Quality Review completed on 06/07/21			
K S351 Bldg. 02	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with Section 9.6, as modified below. The adequacy of the water supply shall be documented. In Prompt Evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities where an automatic sprinkler system is in accordance with NFPA 13,			

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	Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.1, 33.2.3.5.3.3, 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7			
	1. Based on observation and interview, the facility failed to ensure automatic sprinkler protection of the entire house when the storage room was added to the house. There is no	K S351	**K0351: Sprinkler System – Installation** **Corrective action:**	07/01/2021

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	15G255	A. BUILDING 02 B. WING	06/01/2021

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	sprinkler protection of the porch storage room. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation with the Residential Manager (RM during a tour of the facility on 06/01/2021 between 1:00 p.m. and 2:00 p.m., there are no sprinklers located in the storage room which has more combustible storage than an average sleeping room. The open roof framing appears to be separated from the attic of the original house by a single sheet of plywood. Based on interview at the time of observation, the RM acknowledged the fact that the storage room lacked automatic sprinkler protection. The RM stated that the storage room addition was there prior to his arrival at the home, and he did not know when it was constructed. This deficiency was reviewed at the Exit Conference on 06/01/2021 at 2:30 p.m. 2. Based on observation and interview, the facility failed to ensure the sprinkler spray pattern from 1 of more than 10 sprinklers was not obstructed. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation with the Residential Manager (RM during a tour of the facility on 06/01/2021 between 1:00 p.m. and 2:00 p.m., the sprinkler water spray pattern is obstructed by the suspended ceiling light fixture in Office Bedroom #1. The light fixture is less than 12 inches from the sprinkler and the glass cover extends below the deflector of the sprinkler.		·Program Manager reached out to Aramark to have the light in Office bedroom #1 changed to a low profile light to ensure the spray of the sprinkler head would not be obstructed. **(Attachment P)** ·Program Manager submitted a work order to have a sprinkler head added to the storage area on the back porch. **(Attachment Q)** **Monitoring of Corrective Action**: ·Program Manager will follow up with Aramark to ensure work orders have been completed. **Completion Date: 7/1/21**	

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	Based on interview at the time of observation, the RM acknowledged the fact that the light fixture was within 12 inches of the sprinkler and the glass cover extended further from the ceiling than the sprinkler. The RM stated that the location of the sprinkler and the light fixture had not changed since his arrival at the home, and he did not know when the two items were installed. This deficiency was reviewed at the Exit Conference on 06/01/2021 at 2:30 p.m.			
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 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			

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	(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. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____			

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	(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 2 of over 10 sprinkler heads in the facility were 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 observation with the Residential Manager (RM during a tour of the facility on 06/01/2021 between 1:00 p.m. and 2:00 p.m., the escutcheon plate on the sprinkler in North Bathroom was missing and the escutcheon plate on the sprinkler in the Living Room was loose. Based on interview at the time of observation, the RM acknowledged the missing and loose escutcheon plates on the sprinklers. This deficiency was reviewed at the Exit Conference on 06/01/2021 at 2:30 p.m. 2. Based on observation and interview, the facility failed to ensure the proper record keeping of monthly valve inspections of the sprinkler system. NFPA 25, Section 13.3.2 requires that control valves be inspected monthly. This deficient practice could affect all clients and staff in the facility. Findings include:	K S353	**K0353: Sprinkler System – Maintenance and Testing** **Corrective action:** ·Program Manager updated the forms to include monthly inspection of the control valves was added to the current monthly pressure check on the sprinkler system gauges that is completed by the Aramark Maintenance Technician. **(Attachment R)** ·Program Manager submitted a work order to Aramark to have the escutcheon plate replaced on the sprinkler head in the North Bathroom. **(Attachment S)** ·Program Manager submitted a work order to Aramark to have the escutcheon plate replaced on the sprinkler head in the Living Room. **(Attachment S)** ·Program Manager submitted a work order to Aramark to have an Internal Pipe Inspection completed at the facility and provide the documentation of the inspection to Rescare. **(Attachment T)** ·Site Reviews are completed monthly by Rescare Management and entered into the CRM database for tracking. **(Attachment U)**	07/01/2021

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	Based on observation with the Residential Manager (RM during a tour of the facility on 06/01/2021 between 1:00 p.m. and 2:00 p.m., the "Monthly Sprinkler Pressure Check" sheet was not made to include the required monthly inspection of the control valves. Based on interview at the time of observation, the RM indicated that the check-mark indicated that the technician was in the closet where the valves and gauge are located. The RM acknowledged the check list sheet did not document the monthly inspection and the date of the inspection. This deficiency was reviewed at the Exit Conference on 06/01/2021 at 2:30 p.m. 3. Based on record review and interview, the facility failed to ensure that the documentation of a five-year obstruction, internal pipe inspection was available for review. Based on an interview during record review, the house was constructed with the sprinkler system. This deficient practice could affect all clients and staff in the facility. Findings include: Based on record review with the Residential Manager (RM) on 06/01/2021 between 10:45 a.m. and 1:00 p.m., there is no documentation of a five-year Internal Inspection for Obstructions of the Sprinkler Piping. The facility has been licensed since 10/30/2015. The sprinkler system service provider was last in the facility on 3/19/2021. Based on interview at the time of observation, the RM acknowledged the fact that no documentation of an internal pipe inspection was available.		**Monitoring of Corrective Action**: ·Program Manager to review all Aramark reports for filing and follow-up if warranted. ·Program Manager will follow-up with Residential Manager to ensure Aramark has had the work orders scheduled and completed. ·The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form including the pressure gauge and control valve log. . **Completion Date: 7/1/21**	

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	This deficiency was reviewed at the Exit Conference on 06/01/2021 at 2:30 p.m.			
K S511 Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 4 wet locations maintained ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect the client using North Bathroom. Findings include: Based on observation during the facility tour on 06/04/2021 between 1;00 p.m. and 2:00 p.m. with the Residential Manager (RM), the GFCI device above the vanity in North Bathroom failed to reset properly. When tested with a GFCI tester, the receptacle registered no power. When	K S511	**K0511: Utilities- Gas and Electric** **Corrective Action:** **·Program Manager submitted a work order to Aramark replace the GFCI outlet in the North Bathroom. (Attachment V)** **·Rescare Administration conducts Site reviews monthly to ensure all systems are working properly. (Attachment U)** **Monitoring of Corrective Action:** **· Program Manager will follow up with Aramark to ensure work orders are completed.** **·Site reviews will be sent to the Program Director for monitoring of noted issues and to ensure completion.** **Completion Date: 7/1/21**	07/01/2021

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	the reset button was pressed, the device did not reset. Based on interview at the time of observation, the RM stated that he did not know how long the device has been broken and acknowledged that the device could not be reset. This deficiency was reviewed at the Exit Conference on 06/01/2021 at 2:30 p.m.			