PRINTED:	06/25/2021
FORM AP	PROVED
OMB NO. ()938-0391

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

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING		COMP	LETED	
		15G255	B. WI	NG		06/01	/2021	
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF 1	PROVIDER OR SUPPLIE	R						
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		154 CH VERSA	ILLES, IN 47042			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION	
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	TRIATE	DATE	
E 0000								
Bldg		1 2						
		eparedness Survey was	E 00	000				
		ndiana Department of Health						
	in accordance with	42 CFR 483.475.						
	Survey Date: 06/0	1/2021						
	Facility Number:	000775						
	Provider Number:							
	AIM Number: 100							
	Anvi Number. 100	J248900						
	At this Emergency	Preparedness survey, Res						
	υ.	Alternatives SE IN was found						
		with Emergency Preparedness						
	-	Medicare and Medicaid						
	-	ders and Suppliers, 42 CFR						
	483.475.							
	The facility has 8 c	certified beds. All 8 beds are						
	-	aid. At the time of the survey,						
	the census was 8.							
	Quality Review co	mpleted on 06/07/21						
E 0004	403.748(a), 416.	54(a), 418.113(a),						
	441.184(a), 482.1	15(a), 483.475(a),						
Bldg		02(a), 485.625(a),						
	485.68(a), 485.72	27(a), 485.920(a),						
	486.360(a), 491.1	12(a), 494.62(a)						
	Develop EP Plan	, Review and Update						
	Annually							
	§403.748(a), §41	6.54(a), §418.113(a),						
		0.84(a), §482.15(a),					1	
		.475(a), §484.102(a),						
	- , -	.625(a), §485.727(a),					1	
		6.360(a), §491.12(a),					1	
	§494.62(a).							
L					1		1	

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

TITLE

(X6) DATE

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

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CC A. BUILDING B. WING	<u></u>	(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIEF		154 CH	ADDRESS, CITY, STATE, ZIP CODE		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN	VERSA	ILLES, IN 47042		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLET DATE	
	Federal, State and preparedness req must develop esta comprehensive en program that mee section. The emen program must incl the following elem (a) Emergency PL develop and main preparedness pla and updated at lea must do all of the * [For hospitals at §485.625(a):] Em- or CAH] must con Federal, State, an preparedness req CAH] must develor comprehensive en program that mee section, utilizing a * [For LTC Facilitie Emergency Plan. develop and main preparedness pla and updated at lea * [For ESRD Facili Emergency Plan. develop and main	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital nply with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts the requirements of this n all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated],				
	Based on record rev	view and interview, the	E 0004	E004: Develop EP Plan, Revi	iew 07/01/20	

	R MEDICARE & MEDIC					_	1B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMP	COMPLETED	
		15G255	B. WING			06/01	/2021	
NUME OF			ST	REET .	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIE	ĸ	1	54 C⊦	IAD DR			
RES CA	RE COMMUNITY A	LTERNATIVES SE IN	V	ERSA	AILLES, IN 47042			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	EFICIENCY MUST BE PRECEDED BY FULL		FIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	4G	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	facility failed to ma	aintain an emergency			and Update Annually			
	preparedness plan							
	years. The plan mu			Corrective action:				
	1) Be based on and			·Program Manager updates	s the			
	-	community-based risk			Emergency Plan annually an	d as		
		ng an all-hazards approach,			needed.			
	including missing				·All staff are trained and te	sted		
	2) Include strategie			annually and as needed.				
		y the risk assessment.			(Attachment A)			
		cial needs of its client			·New hire staff are trained	•		
	population, including, but not limited to, persons				the Emergency Plan during t	heir		
		risk; the type of services the ICF/IID has the			OJT (on the job training).			
		n an emergency; and continuity			(Attachment B)			
	-	iding delegations of authority			Program Director updates			
	and succession pla				Risk Assessment for our faci	lities.		
		s for cooperation and			(Attachment C)	-1 41		
		local, tribal, regional, State,			·Program Manager update	a the		
	-	ency preparedness officials'			Shelter in Place Policy.			
		an integrated response during			(Attachment D) ·Program Manager update	d tha		
	-	ency situation in accordance 75(a). This deficient practice			Continuity of Operations Plan			
	could affect all occ				(Attachment E)	1.		
		upants.			·Program Manager created	2		
	Findings include:				signature sheet for all staff to			
	T manigs menuae.				when trained on the EPP.	Sign		
	Based on record re	view of the facility's			(Attachment F)			
		edness Plan entitled "EPP-			·Program Manager created	а		
	e	er Manual" on 06/01/2021			form to track when emergend			
		. and 1:00 p.m. with the			plans are reviewed and or			
		r (RM), the document was			updated. (Attachment F)			
	-	vith a reviewed on date of			Monitoring of Corrective			
		dual components of the			Action:			
		oublished and updated prior to			·Area Supervisor will train a	all		
	-	on an interview at the time of			staff annually and as needed			
		RM explained that the manual			send to the Program Manage			
	was "reviewed" at	the time of each employee EPP			review and file in the EPP bir			
		t training was documented on			·Risk Assessment will be			
	-	M acknowledged that			updated as needed by the			
		he plan/manual did not reflect			Program Director.			
	La . v. ·	1 . 01/10/2010				" ~	1	

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

that it was reviewed since 01/10/2019.

Event ID:

U4PF21 Fac

Facility ID: 000775

If continuation sheet

·Rescare trainer monitors all On

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PRINTED:

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255		A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		154 CH	ADDRESS, CITY, STATE, ZIP CODE HAD DR AILLES, IN 47042		
					AILLES, IN 47042		
(X4) ID		ATEMENT OF DEFICIENCIES ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETIO
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	This issue was revie Conference on 06/0	ewed with the RM at the Exit 1/2021 at 2:30 p.m.			the Job training packets to ens all training was complete on th new hires including training on Emergency Plan.	е	
					Completion Date: 7/1/21		
0013	403.748(b), 416.5 441.184(b), 482.1						
Bldg	 483.73(b), 484.10 485.68(b), 485.72 486.360(b), 491.1 Development of E §403.748(b), §416 §441.184(b), §460 §443.73(b), §483. §485.68(b), §485. §485.920(b), §486. §494.62(b). (b) Policies and pridevelop and implering preparedness politions based on the emerging paragraph (a) of the assessment at para section, and the criparagraph (c) of the section of the	2(b), 485.625(b), 7(b), 485.920(b), 2(b), 494.62(b) P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b), cocedures. [Facilities] must ement emergency cies and procedures, rgency plan set forth in his section, risk ragraph (a)(1) of this formmunication plan at his section. The policies ust be reviewed and					
	and procedures. T develop and imple	at §483.73(b):] Policies The LTC facility must ement emergency cies and procedures,					
	paragraph (a) of the assessment at paragraph (a) of the assessment at paragraph (a) of the constraint	rgency plan set forth in nis section, risk ragraph (a)(1) of this ommunication plan at nis section. The policies					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	/ULTIPLE CO	NSTRUCTION	(X3) DA'	TE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING		COMPLETED		
		15G255	B. V	VING		06/	01/2021	
JAME OF	PROVIDER OR SUPPLIEI	3		STREET A	ADDRESS, CITY, STATE, ZIP C	Y, STATE, ZIP CODE		
				154 CH				
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		VERSA	ILLES, IN 47042			
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A		COMPLET	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		nust be reviewed and						
	updated at least a	innually.						
	*Additional Requi	rements for PACE and						
	ESRD Facilities:							
		60.84(b):] Policies and						
		PACE organization must						
	develop and imple							
		icies and procedures,						
		ergency plan set forth in						
	paragraph (a) of t							
		ragraph (a)(1) of this						
		ommunication plan at						
		his section. The policies						
		nust address management						
		nmedical emergencies,						
	-	limited to: Fire; equipment,						
		ailure; care-related						
	-	I natural disasters likely to						
	threaten the healt							
		or the public. The policies						
		nust be reviewed and						
	updated at least e	every 2 years.						
	*[For ESRD Facili	ties at §494.62(b):]						
	-	edures. The dialysis						
		op and implement						
	-	redness policies and						
		d on the emergency plan						
		aph (a) of this section, risk						
		ragraph (a)(1) of this						
		ommunication plan at						
		-						
		his section. The policies						
	-	nust be reviewed and						
		every 2 years. These						
	-	ude, but are not limited to,						
	fire, equipment or	-						
		gencies, water supply						
	i interruption, and r	natural disasters likely to	1					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MU. PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUI 15G255 B. WIN				(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIEI	LTERNATIVES SE IN		154 CH	address, city, state, zip code IAD DR AILLES, IN 47042	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL 2 LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETIC DATE
	Based on record rec facility failed to rev two years in accord 483.475(b). This de all occupants. Findings include: Based on review of Preparedness Plan Disaster Manual" of a.m. and 1:00 p.m. (RM), documentati program reviewed 1 recent 2-year period the Policies and Pro- manual was dated 1 date of 01/10/2019. time of record review employee EPP train documented on 01/ acknowledged that plan/manual did no since 01/10/2019.	The facility's Emergency entitled "EPP- Emergency n 06/01/2021 between 10:35 with the Residential Manger on for a complete emergency by the facility within the most d was not available for review, becedures portion of the 2/17/2018 with a reviewed on Based on an interview at the ew the RM explained that the ved" at the time of each hing and the last training was	EO)13	E013: Development of EP policies and Procedures Corrective Action: •The Emergency Plan is updated annually and as nee •Area Supervisor trains all annually. •All new hires are trained a part of their On the Job Train and then annually. •Program Manager created form to track when emergence plans are reviewed and upda (Attachment F) •Program Manager will ensithe facility has the most curred plans, policies and procedured •Area Supervisor will review plans in the book when emergency preparedness is reviewed during facility staff meetings.	staff s ing l a cy ited. sure ent es.
	Conference on 06/01/2021 at 2:30 p.m.				Action: •Program Manager will upor the emergency preparedness at least every 2 years and as needed and ensure the updation information is in the facility at sign on the updated tracking •On the job training is sent the Rescare Trainer and Hur Resources for review and monitoring for completion.	s plan ted nd form. to

ENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		BUILDING		-		
		15G255	В.	WING		- 06/0)1/2021	
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CO	DDE		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN			HAD DR AILLES, IN 47042			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	DULD BE	COMPLETIO	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	FROFRIATE	DATE	
					Completion Date: 7/1/	21		
0018	403.748(b)(2), 41	8(b)(2), 416.54(b)(1), 418.113(b)(6)						
	(ii) and (v), 441.184(b)(2), 482.15(b)(2),							
Bldg		3.73(b)(2), 485.625(b)(2),						
		6.360(b)(1), 494.62(b)(1)						
		acking of Staff and						
	Patients	110 FA/L)(1) S110 110(L)						
		416.54(b)(1), §418.113(b) I1.184(b)(2), §460.84(b)						
	(2), §482.15(b)(2)							
		485.625(b)(2), §485.920(b)						
	(1), §486.360(b)(
		procedures. The [facilities]						
		l implement emergency						
		icies and procedures,						
		ergency plan set forth in						
	paragraph (a) of t	ragraph (a)(1) of this						
		communication plan at						
		his section. The policies						
		nust be reviewed and						
	updated at least e	every 2 years [annually for						
		a minimum, the policies						
	and procedures n	nust address the following:]						
	[(2) or (1)] A syste	em to track the location of						
		sheltered patients in the						
		ring an emergency. If						
		sheltered patients are						
	•	he emergency, the [facility]						
		ne specific name and						
	location.	ceiving facility or other						
	*[For PRTFs at §4	441.184(b), LTC at						
		IDs at §483.475(b), PACE						
	L at \$460.04/b).1 D	plicies and procedures. (2)	1		1		1	

NTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-03		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	A.	MULTIPLE CC BUILDING WING		COM	(X3) DATE SURVEY COMPLETED 06/01/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP (CODE		
NAME OF	PROVIDER OR SUPPLIEF	l l		154 CH	AD DR			
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		VERSA	ILLES, IN 47042			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWINEDIC DI AN OF COL	DECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S	HOULD BE	COMPLETI	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
TAG	A system to track and sheltered resi ICF/IID or PACE] emergency. If on- residents are reloc emergency, the [F PACE] must docu and location of the location. *[For Inpatient Ho Policies and proce (ii) Safe evacuation includes considerance needs of evacuee transportation; ide location(s) and prior of communication assistance. (v) A system to tra- employees' on-du the hospice's care the on-duty emplo are relocated duri hospice must doc and location of the location. *[For CMHCs at § procedures. (2) Sa CMHC, which incl and treatment nee responsibilities; tra- of evacuation location location location.	the location of on-duty staff dents in the [PRTF's, LTC, care during and after an -duty staff and sheltered cated during the PRTF's, LTC, ICF/IID or ment the specific name e receiving facility or other spice at §418.113(b)(6):] edures. In from the hospice, which ation of care and treatment s; staff responsibilities; entification of evacuation mary and alternate means with external sources of ack the location of hospice ty and sheltered patients in e during an emergency. If pyees or sheltered patients ing the emergency, the ument the specific name e receiving facility or other 485.920(b):] Policies and afe evacuation from the udes consideration of care eds of evacuees; staff ansportation; identification ation(s); and primary and if communication with		TAG	DEFICIENCY)		DATE	
	procedures. (2) A	86.360(b):] Policies and system of medical at preserves potential and						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G255		A. BUILDING B. WING		COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIE	R R ALTERNATIVES SE IN		154 CH	ADDRESS, CITY, STATE, ZIP CODE HAD DR AILLES, IN 47042		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	e (X5) COMPLETIC DATE	
	 information, and availability of recomposition of the record research of the location of on-in the ICF/IID facility must docume location of the recomposition of the rec	potential and actual donor secures and maintains the	EO	D18	E018: Procedures for Trackin 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 st and consumers will be complet by the Area Supervisor and related the information to the Administrative Management Tee for continuous monitoring of all staff and consumers. Site Revis 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	aff ied ay eam ew	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		STREET A 154 CH VERSA	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 0024 Bldg	441.184(b)(6), 484 483.73(b)(6), 484 485.68(b)(4), 485 491.12(b)(4), 494 Policies/Procedur §403.748(b)(6), §4 (4), §441.184(b)(6) §482.15(b)(6), §4 (6), §484.102(b)(5) §485.625(b)(6), §4 (5), §491.12(b)(4) [(b) Policies and p must develop and preparedness pol based on the eme paragraph (a) of t assessment at pa section, and the c paragraph (c) of tt and procedures m updated at least e LTC facilities]. At and procedures m (6) [or (4), (5), or use of volunteers emergency staffin process and role f Federally designa professionals to a an emergency. *[For RNHCIs at § procedures. (6) Th emergency and or	es-Volunteers and Staffing 416.54(b)(5), §418.113(b) 5), §460.84(b)(7), 83.73(b)(6), §483.475(b) 5), §485.68(b)(4), 485.727(b)(4), §485.920(b) , §494.62(b)(5). Frocedures. The [facilities] implement emergency cies and procedures, ergency plan set forth in his section, risk ragraph (a)(1) of this ommunication plan at his section. The policies fust be reviewed and very 2 years [annually for a minimum, the policies fust address the following:] (7) as noted above] The in an emergency or other g strategies, including the for integration of State and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	È É	ILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/01/2021
	PROVIDER OR SUPPLIEI RE COMMUNITY A	R LTERNATIVES SE IN		154 CH	ADDRESS, CITY, STATE, ZIP CODE IAD DR AILLES, IN 47042	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETI DATE
	procedures. (4) T employees in an e emergency staffin process and role of Federally designar professionals to a an emergency. Based on record rea facility failed to emploicies and proced volunteers in an em staffing strategies, i for integration of S health care professi during an emergend 483.475(b)(6). This affect all occupants Findings include: During review of th documentation enti Disaster Manual" o a.m. and 1:00 p.m. (RM), the emergen include the use of v other emergency st the process and rold Federally designate address surge needs on interview at the RM said the emergy documentation incl volunteers. The RM manual did not incl policies and proced in an emergency.	Address surge needs during view and interview, the sure emergency preparedness hures include the use of hergency or other emergency including the process and role tate or Federally designated toonals to address surge needs cy in accordance with 42 CFR s deficient practice could s. the emergency preparedness tled "EPP Emergency on 06/01/2021 between 10:35 with the Residential Manager cy preparedness plan did not volunteers in an emergency or affing strategies, including e for integration of State or the health care professionals to as during an emergency. Based time of record review, the	E 00)24	E024: Policies/Procedures-Volunt and Staffing Corrective action: •The ROC program is used volunteers needed in an emergency situation, the atta packet/policy reflects the directions for all ROC volunts (Attachment H) •All staff will be tested (Attachment I) on the ROC Handbook Overview packet/ Monitoring of Corrective Action: •"Rescare On Call" staff ar identified and tested annually the ROC tests. •ROC staff would be trained the EPP by the Administrative Management Team in the evan emergency. Completion Date: 7/1/21	d for ached eers policy. e y on d on re

CENTERS FO STATEME	T OF HEALTH AND HU R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION X	FORM APPROVED OMB NO. 0938-0391 3) DATE SURVEY COMPLETED 06/01/2021
	PROVIDER OR SUPPLIE	R R LTERNATIVES SE IN	154 C	T ADDRESS, CITY, STATE, ZIP CODE HAD DR AILLES, IN 47042	
(X4) ID PREFIX TAG E 0029	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION) 01/2021 at 2:30 p.m. 04(c), 418.113(c).	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg	 441.184(c), 482.1 483.73(c), 484.10 485.68(c), 485.72 486.360(c), 491.1 Development of C §403.748(c), §410 §441.184(c), §460 §483.73(c), §483. §485.68(c), §485. §485.920(c), §485. §485.920(c), §486. §494.62(c). (c) The [facility] rr an emergency properties of the component of the Communication 	5(c), 483.475(c), (2(c), 485.625(c), (7(c), 485.920(c),	E 0029	E029: The facility must develop and maintain an emergency preparedness communication pl that complies with Federal, State and local laws and must be updated at least annually. Corrective Action: Program Manager updated th emergency contact list to include Federal, State, tribal, Regional and local emergency preparedness staff. (Attachmen J) Program Manager updates Emergency plans are updated monthly to ensure the most accurate contact information is included.	e e

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 01/10/2019. Based on an interview at the time of ·QIDP will update all guardians record review the RM explained that the manual and families as needed in the event of an emergency and will was "reviewed" at the time of each employee EPP document the contact on the IDT training and the last training was documented on 01/07/2021. The RM acknowledged that Team Meeting Note. (Attachment documentation of the plan/manual did not reflect K) that it was reviewed since 01/10/2019. **Monitoring of Corrective** This issue was reviewed with the RM at the Exit Action: Conference on 06/01/2021 at 2:30 p.m. ·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 403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), Bldg. --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), FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U4PF21 Facility ID: 000775 If continuation sheet Page 13 of 44

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AND PLAN	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	A. BUILDINGB. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIEF			154 CH			
RES CA		LTERNATIVES SE IN	VERSAILLES, IN 47042				
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	 §484.102(c)(4)-(5 §485.625(c)(4)-(6 §485.920(c)(4)-(6) §494.62(c)(4)-(6). [(c) The [facility] n an emergency pre plan that complies local laws and mu at least every 2 ye facilities]. The co include all of the f (4) A method for s medical documen [facility's] care, as health providers te care. (5) A means, in th to release patient under 45 CFR 16- provision is not re §484.102(c), COF (6) [(4) or (5)]A m- information about location of patient as permitted under *[For RNHCIs at § for sharing inform documentation for RNHCI's care, as providers to main 	 b), §485.727(c)(4), b), §491.12(c)(4), b), §491.12(c)(4), Invest develop and maintain eparedness communication is with Federal, State and st be reviewed and updated ears [annually for LTC mmunication plan must ollowing: Investigation of the evaluation of the evaluation of the parents under the necessary, with other on maintain the continuity of Investigation of the evaluation of evaluation of evaluation of the evaluation of the evaluation of the evaluation of eva					

	T OF HEALTH AND HU R MEDICARE & MEDIO				FORM APPROVE OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		15G255	B. WING		06/01/2021
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NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE	
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN	VERS	GAILLES, IN 47042	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	(X5)
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TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	*[For RHCs/FQH	Cs at §491.12(c):] (4) A			
	means of providin	ng information about the			
	general condition	and location of patients			
	under the facility	s care as permitted under			
	45 CFR 164.510				
	Based on record re	view and interview, the	E 0033	E033: Methods for Shari	ng 07/01/202
		sure the emergency		Information	
	· ·	nunication plan includes (4) A			
	-	g information and medical		Corrective action:	
		clients under the ICF/IID		•The Continuity of Opera	
		ecessary, with other health		Plan (Attachment E) prov	
	-	naintain the continuity of care;		information on how all info	
		e event of an evacuation, to		will be shared and the pro-	
		mation as permitted under 45		of client information will be	;
)(ii); (6) A means of providing		secured.	
		the general condition and		Maintenance Technicia	
	location of clients under the facility's care as $parmitted under 45 CEP 164 510(b)(4)$ in			purchased a locking tote to	0
	-	nitted under 45 CFR 164.510(b)(4) in rdance with 42 CFR 483.475(c)(4). This		transport consumer documentation in the ever	tofon
		could affect all occupants.			
	deficient practice c	could affect all occupants.		emergency. (Attachment	L)
	Findings include:			Monitoring of Corrective	
	8			Action:	
	During review of t	he emergency preparedness		The Continuity of Operation	ations
		itled "EPP Emergency		Plan will be updated as ne	
		on 06/01/2021 between 10:35		include additional informat	
	a.m. and 1:00 p.m.	with the Residential Manager		the Program Manager.	, ,
	-	ncy preparedness plan did not			
	include a method f	or sharing information and			
	medical document	ation in an emergency. Based		Completion Date: 7/1/21	
	on interview at the	time of record review, the			
	RM could not expl	ain the policy and or			
	-	M acknowledged that the			
		lude emergency preparedness			
		dures for sharing information			
	and medical docum	nentation in an emergency.			
	This issue was rev Conference on 06/	iewed with the RM at the Exit			
	I I 'amtanamaa am ()6/				

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

Event ID:

U4PF21 Facility ID:

Facility ID: 000775

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES. IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) E 0034 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), Bldg. --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. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U4PF21 Facility ID: 000775 If continuation sheet Page 16 of 44

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G255	A. BU B. WI	ILDING		COMPLETED 06/01/2021
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		154 C⊦	address, city, state, zip code IAD DR NILLES, IN 47042	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETI DATE
	facility failed to enar preparedness comm means of providing ICF/IID facility's of ability to provide as having jurisdiction Command Center, of with 42 CFR 483.4 practice could affect Findings include: During review of the documentation entiti Disaster Manual" of a.m. and 1:00 p.m. (RM), the emergence include a means for the needs and abiliti in an emergency. B of record review, the policy and or proceet that the manual did preparedness policities providing informatica abilities to the AHJ	aunication plan includes a information about the ecupancy, needs, and its sisistance, to the authority (AHJ) or the Incident or designee in accordance 75(c)(7). This deficient t all occupants. e emergency preparedness ted "EPP Emergency n 06/01/2021 between 10:35 with the Residential Manager cy preparedness plan did not providing information about ies of the clients to the AHJ ased on interview at the time e RM could not explain the dures. The RM acknowledged not include emergency es and procedures for on about the needs and in an emergency.	E 00)34	E034: Information on Occupancy/Needs Corrective action: •The Continuity of Operation Plan (Attachment E) provides method to share occupancy needs and ability to provide assistance to the Authority Hay 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 departme Program Managers, QIDP-D's, Nurse Manager, AED, and ED complete monthly site reviews each location and document at issues/findings on the site revie form. •AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursin Manager will perform Best In Class reviews at all locations within the year. The results will shared with all team members.	a ving e nt, of ny ew
: 0035 Bldg	483.475(c)(8), 483 LTC and ICF/IID 5 §483.73(c)(8); §44	Sharing Plan with Patients				
	*[For LTC Facilitie	s at §483.73(c):]				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) [(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. E035: LTC and ICF/IID Sharing Based on record review and interview, the E 0035 07/01/2021 facility failed to ensure the emergency Plan with Patients preparedness communication plan includes a method for sharing information from the Corrective action: The EPP plan will be discussed emergency plan that the facility has determined by the QIDP and shared with is appropriate with clients and their families or representatives in accordance with 42 CFR family members, the consumer, 483.475(c)(8). This deficient practice could guardians and representatives of the consumers at their quarterly affect all occupants. IDT meetings. (Attachment K) Findings include: ·QIDP-D will provide any updates to family members, the During review of the emergency preparedness consumer, guardians and documentation entitled "EPP Emergency representatives of the consumers Disaster Manual" on 06/01/2021 between 10:35 as the EPP is updated. a.m. and 1:00 p.m. with the Residential Manager **Monitoring of Corrective** (RM), the emergency preparedness plan did not Action: include a method for sharing information from ·The QIDP-D sends all IDT the emergency plan with clients and their meeting forms to the QIDP and families in an emergency. Based on interview at Program Manager for review and FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U4PF21 Facility ID: 000775 If continuation sheet Page 18 of 44

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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 15G255	ì í	UILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED 06/01/2021	
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	RECOMMUNITYA	LTERNATIVES SE IN		VERSA	ILLES, IN 47042		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
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		eview, the RM explained that			to ensure completion.		
	-	hone numbers to contact the			Opennelskiew Dates 7/4/04		
		gency occurred. The RM			Completion Date: 7/1/21		
	-	the manual did not include dness policies and procedures					
		nation about the emergency					
	plan with clients an						
	This issue was revi	ewed with the RM at the Exit					
	Conference on 06/0	01/2021 at 2:30 p.m.					
0037	403.748(d)(1), 41	6.54(d)(1), 418.113(d)(1),					
	441.184(d)(1), 48	2.15(d)(1), 483.475(d)(1),					
3ldg	483.73(d)(1), 484	.102(d)(1), 485.625(d)(1),					
		.727(d)(1), 485.920(d)(1),					
	486.360(d)(1), 49						
	EP Training Progr						
		416.54(d)(1), §418.113(d)					
	(1), §441.184(d)(1	1), §460.84(d)(1), 83.73(d)(1), §483.475(d)					
	(1), §484.102(d)(1						
		485.727(d)(1), §485.920(d)					
	(1), §486.360(d)(1)						
	*[For RNCHIs at §	403.748, ASCs at					
		s at §482.15, ICF/IIDs at					
	§483.475, HHAs a						
		nder §485.727, OPOs at					
	-	QHCs at §491.12:]					
		ram. The [facility] must do					
	all of the following	י: ה emergency preparedness					
	.,	edures to all new and					
	1	viduals providing services					
		nt, and volunteers,					
	-	eir expected roles.					
		ency preparedness					
	training at least ev	• • •					
	(iii) Maintain docu	mentation of all emergency					
	preparedness trai	ning					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/01/2021	
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TAG	 (iv) Demonstrate semergency procession (v) If the emergency and procedures a the [facility] must of updated policies at the hospice must (i) Initial training in policies and procession providing services consistent with the (ii) Demonstrate semergency procession (iv) Periodically references (include with special emphoyees (include with special emphoyees (include with special emphoyees train dothers. (v) Maintain documpreparedness trais (vi) If the emergency and procedures a the hospice must updated policies a procedures. *[For PRTFs at §4 program. The PR following: (i) Initial training in policies and procedures. 	cy preparedness policies re significantly updated, conduct training on the and procedures. §418.113(d):] (1) Training. do all of the following: emergency preparedness edures to all new and mployees, and individuals under arrangement, eir expected roles. taff knowledge of dures. gency preparedness very 2 years. view and rehearse its redness plan with hospice ling nonemployee staff), asis placed on carrying out ecessary to protect patients mentation of all emergency hing. hey preparedness policies re significantly updated, conduct training on the and 41.184(d):] (1) Training IF must do all of the memergency preparedness edures to all new and viduals providing services nt, and volunteers,		TAG	DEFICIENCY)		DATE

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	ì í	JILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIEF			154 CHA		DDE	
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		VERSAI	LLES, IN 47042		
(X4) ID					PROVIDER'S PLAN OF CORR		(X5)
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ning, provide emergency					
		ning every 2 years.					
		staff knowledge of					
	emergency proce						
		mentation of all emergency					
	preparedness trai	-					
		cy preparedness policies					
		re significantly updated,					
		onduct training on the					
	updated policies a	and procedures.					
		60.84(d):] (1) The PACE					
	organization must	do all of the following:					
	(i) Initial training ir	emergency preparedness					
		dures to all new and					
	-	/iduals providing on-site					
	services under an	angement, contractors,					
	participants, and v	olunteers, consistent with					
	their expected role						
		ency preparedness					
	training at least ev						
		staff knowledge of					
		dures, including informing					
		at to do, where to go, and					
	whom to contact i	n case of an emergency.					
	· · /	mentation of all training.					
		ncy preparedness policies					
		re significantly updated,					
		onduct training on the					
	updated policies a	and procedures.					
		es at §483.73(d):] (1)					
		The LTC facility must do					
	all of the following						
		emergency preparedness					
		dures to all new and					
	-	viduals providing services					
	-	nt, and volunteers,					
	consistent with the	-					
	(ii) Provide emerg	ency preparedness					

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RES CA	RE COMMUNITY /	ALTERNATIVES SE IN		VERSA	ILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
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	training at least a	-					
	· · /	umentation of all emergency					
	preparedness tra						
		staff knowledge of					
	emergency proce	edures.					
	*[For CORFs at §485.68(d):](1) Training.						
	-	do all of the following:					
		training in emergency					
		licies and procedures to all					
		staff, individuals providing					
	-	rrangement, and volunteers,					
		neir expected roles.					
		gency preparedness					
	training at least e						
	-	umentation of the training.					
	· ,	staff knowledge of					
		edures. All new personnel					
		and assigned specific					
		egarding the CORF's					
		within 2 weeks of their first					
	• • •	ining program must include					
		location and use of alarm					
		nals and firefighting					
	equipment.	0 0					
	(v) If the emerg	ency preparedness policies					
	and procedures	are significantly updated,					
	the CORF must	conduct training on the					
	updated policies	and procedures.					
		l85.625(d):] (1) Training					
		AH must do all of the					
	following:						
		in emergency preparedness					
		edures, including prompt	1				
		tinguishing of fires,					
		where necessary, evacuation					
		onnel, and guests, fire					
		cooperation with firefighting					
	I and disaster auth	norities, to all new and	1				1

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	OMB NO. 0938-039 [X3] DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIE	R R LTERNATIVES SE IN	154 C	T ADDRESS, CITY, STATE, ZIP CODE CHAD DR SAILLES, IN 47042		
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF existing staff, indi- under arrangement consistent with th (ii) Provide emerger training at least e (iii) Maintain docu (iv) Demonstrate emergency process (v) If the emerger and procedures at the CAH must co updated policies at *[For CMHCs at §	imentation of the training. staff knowledge of dures. ency preparedness policies ire significantly updated, nduct training on the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E (X5) COMPLETI DATE	
	procedures to all individuals provid arrangement, and their expected rol documentation of must demonstrate emergency proce CMHC must prov preparedness tra Based on record re facility failed to em preparedness progr program includes a facility must do all training in emergen procedures to all m individuals providi and volunteers, con roles; (ii) Provide of training at least eve documentation of a training; (iv) Demo	the training. The CMHC e staff knowledge of dures. Thereafter, the	E 0037	E037: EP Training Program` Corrective action: •All staff are trained and tester annually on the Emergency Preparedness Plan. (Attachmer A) •The Mock Drill form will be used for all drills and or true emergency disaster situations (Attachment M) •The Mock Drill contact form to be used following an emergence drill. (Attachment O)	ent	

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

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G255	A. BUILDING B. WING	<u></u>	completed 06/01/2021
	PROVIDER OR SUPPLIE	R R LTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP CODE HAD DR AILLES, IN 47042	
RES CA (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF significantly update training on the upd in accordance with deficient practice of Findings include: During review of th documentation entri Disaster Manual" of a.m. and 1:00 p.m. (RM), the emergen include a policy an in the Emergency If interview at the tim indicated that all st and new employee training. The RM a did not include pol initial training in th policies and proceo	STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ed, the facility must conduct ated policies and procedures 42 CFR 483.475(d) (1). This ould affect all occupants. The emergency preparedness tled "EPP Emergency on 06/01/2021 between 10:35 with the Residential Manager cy preparedness plan did not d procedure for initial training Preparedness Plan. Based on the of record review, the RM aff attended annual training s participated in the annual icknowledged that the manual icies and procedures for the emergency preparedness			e
				Completion Date: 7/1/21	

PRINTED: 06/25/2021 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES. IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) E 0039 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), Bldg. --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 followina: (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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U4PF21 Facility ID: 000775 If continuation sheet Page 25 of 44

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIEI		1	54 CHA			
RES CA	RE COMMUNITY A	LTERNATIVES SE IN	V	'ERSAIL	LES, IN 47042		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PRE	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		N BE PRIATE	(X5) COMPLETIC DATE
	community-based functional exercis (B) A mock disast (C) A tabletop exe led by a facilitator discussion using a clinically-relevant a set of problem s messages, or pre to challenge an el (iii) Analyze the [fi maintain document exercises, and en the [facility's] eme *[For Hospices at (2) Testing for ho the patient's home conduct exercises at least annually. following: (i) Participate in a community based (A) When a comm accessible, condu based functional e (B) If the hospice man-made emerge activation of the el is exempt from er full scale communi individual facility-l following the onset (ii) Conduct an ac years, opposite th functional exercise of this section is c	scale exercise that is or individual, facility-based e; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and statements, directed pared questions designed mergency plan. acility's] response to and ntation of all drills, tabletop nergency events, and revise ergency plan, as needed.					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	LIA (X2) MU A. BUI B. WIN		NSTRUCTION	(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIEF	R LTERNATIVES SE IN		154 CH	.ddress, city, state, zip co AD DR ILLES, IN 47042	DDE	
(X4) ID	SUMMARY S	MARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETIC
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	. ,	scale exercise that is or a facility based					
	functional exercise	e; or					
	(B) A mock disas	ter drill; or					
		ercise or workshop that is					
		and includes a group					
	discussion using a						
		emergency scenario, and					
		tatements, directed					
		pared questions designed					
	to challenge an er	nergency plan.					
	(3) Testing for hos	spices that provide inpatient					
	care directly. The	hospice must conduct					
		he emergency plan twice					
		spice must do the following:					
		an annual full-scale					
		ommunity-based; or					
	• •	nunity-based exercise is					
		nduct an annual individual					
	-	tional exercise; or					
		experiences a natural or ency that requires					
	•	mergency plan, the					
		t from engaging in its next					
		community based or					
		ctional exercise following					
	the onset of the e						
		dditional annual exercise					
	that may include,	but is not limited to the					
	following:						
	• •	scale exercise that is					
		or a facility based					
	functional exercis						
	(B) A mock disas						
	. ,	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,	-					
		rio, and a set of problem					
	I statements, direct	ed messages, or prepared					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				IULTIPLE CO	DNSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING		CON	MPLETED
		15G255	В. W	ING		- 06/	01/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CO	DDE	
NAME OF	PROVIDER OR SUPPLIE	R		154 CH	AD DR		
RES CA	RE COMMUNITY /	ALTERNATIVES SE IN		VERSA	ILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	questions design	ed to challenge an					
	emergency plan.						
	(iii) Analyze the	hospice's response to and					
	maintain docume	entation of all drills, tabletop					
		mergency events and revise					
		ergency plan, as needed.					
	*IFor PRFTs at 8	441.184(d), Hospitals at					
	-	s at §485.625(d):]					
		[PRTF, Hospital, CAH] must					
		is to test the emergency plan					
		The [PRTF, Hospital, CAH]					
	must do the follo						
		an annual full-scale					
		ommunity-based; or					
		•					
		munity-based exercise is					
		onduct an annual individual,					
		ctional exercise; or					
	(B) If the [PRTF,						
		actual natural or man-made					
		requires activation of the					
		the [facility] is exempt from					
		ext required full-scale					
		d or individual, facility-based					
	functional exercis	se following the onset of the					
	emergency even						
		an [additional] annual					
		hat may include, but is not					
	limited to the follo	owing:					
	(A) A second ful	I-scale exercise that is					
	community-base	d or individual, a					
	facility-based fur	ctional exercise; or					
	(B) A m	ock disaster drill; or					
	(C) A tableto	op exercise or workshop that					
	. ,	ator and includes a group					
	discussion, using	÷ .					
		t emergency scenario, and					
	-	statements, directed					
		epared questions designed					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) 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.

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

Event ID:

U4PF21 Facility ID: 000775

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ENTERS FO	R MEDICARE & MED	ICAID SERVICES			OMB NO. 0938-0391
	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED
		15G255	B. WING		06/01/2021
			ST	REET ADDRESS, CITY, STATE, 2	ZIP CODE
NAME OF	PROVIDER OR SUPPLI	ER		4 CHAD DR	
	RE COMMUNITY	ALTERNATIVES SE IN		ERSAILLES, IN 47042	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O	
PREFIX		ENCY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO	THE APPROPRIATE
TAG		OR LSC IDENTIFYING INFORMATION)	TA	.G DEFICIENC	CY) DATE
		PACE's response to and			
		entation of all drills, tabletop			
		emergency events and revise			
	the PACE's eme	ergency plan, as needed.			
	*[For TC Facili	ties at §483.73(d):]			
	-	cility] must conduct exercises			
		gency plan at least twice per			
		unannounced staff drills			
		ency procedures. The [LTC			
		must do the following:			
		n an annual full-scale			
	.,	community-based; or			
		nmunity-based exercise is			
		conduct an annual individual,			
		nctional exercise.			
	-	acility] facility experiences			
		al or man-made emergency			
	that requires act	tivation of the emergency			
	plan, the LTC fa	cility is exempt from			
	engaging its nex	kt required a full-scale			
	community-base	ed or individual, facility-based			
	functional exerc	ise following the onset of the			
	emergency ever				
	(ii) Conduct an	additional annual exercise			
	,	e, but is not limited to the			
	following:				
		Ill-scale exercise that is			
	-	ed or an individual, facility			
	based functiona				
	(B) A mock disa				
		exercise or workshop that is			
		or includes a group			
	discussion, usin	-			
	-	nt emergency scenario, and			
		statements, directed			
		repared questions designed			
	-	emergency plan.			
		e [LTC facility] facility's			
	response to and	I maintain documentation of			

Event ID: U4PF21 Facility ID: 000775

PRINTED: 06/25/2021 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U4PF21 Facility ID: 000775 If continuation sheet Page 31 of 44

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AND PLAN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G255		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		154 CH	address, city, state, zip c IAD DR ILLES, IN 47042	CODE		
		TATEMENT OF DEFICIENCIES					(75)	
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S		(X5) COMPLETIO	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
	exercises to test t least annually. Th following: (i) Participate in a community-based (A) When a c is not accessible, individual, facility- every 2 years; or. (B) If the HH natural or man-ma requires activation the HHA is exemp required full-scale individual, facility following the onse (ii) Conduct an ad years, opposite th functional exercise of this section is c include, but is not (A) A second community-based facility-based func (B) A mock d (C) A tabletop is led by a facilitat discussion, using clinically-relevant a set of problem s messages, or pre to challenge an en (iii) Analyze the H maintain documen	e HHA must conduct he emergency plan at e HHA must do the full-scale exercise that is ; or ommunity-based exercise conduct an annual based functional exercise A experiences an actual ade emergency that of the emergency plan, of the emergency plan, of the emergency plan, of the emergency vent. ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, tional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and tatements, directed pared questions designed mergency plan. HA's response to and nation of all drills, tabletop hergency events, and revise ency plan, as needed.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES. IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (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. E039: EP Testing Based on record review and interview, the 07/01/2021 E 0039 facility failed to conduct exercises to test the Requirements emergency plan at least once per year. The FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U4PF21 Facility ID: 000775 If continuation sheet Page 33 of 44

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	15G255	B. WING		06/01/2021
		100200			00/01/2021
NAME OF	PROVIDER OR SUPPLIEF	ξ		ADDRESS, CITY, STATE, ZIP CODE HAD DR	
		LTERNATIVES SE IN		AILLES, IN 47042	
				AILLES, IN 47042	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		imentation of counting the		Corrective action:	
		as an actual emergency that		•The facility will conduct at le	east
	-	of the existing EPP. The		two full scale or one full scale	ing
		ist do the following:		exercise and a table top exercise	
	that is community-l	annual full-scale exercise		to test the emergency plan at	
				annually and will use the Mocl Drill Form (Attachment M) for	
		ity-based exercise is not an annual individual,		completion and proof of the	
	facility-based funct			exercise.	
		cility experiences an actual		·Area Supervisor trained to	
		le emergency that requires		ensure the facility will conduct	at
		hergency plan, the ICF/IID		least two full scale or one full	
		om engaging its next		exercise and a table top exerci	
		in a community-based or		to test the emergency plan at	
	-	based full-scale functional		annually and will use the Mocl	
		following the onset of the		Drill Form (Attachment N) for	
	actual event.	C		completion and proof of the	
	(ii) Conduct an add	itional exercise that may		exercise.	
		imited to the following:		·Staff will be tested annual of	on
	a. A second full-sca	ale exercise that is		the EPP. (Attachment A)	
	community-based of	or an individual, facility-based			
	functional exercise.			Monitoring of Corrective	
	b. A mock disaster	drill; or		Action:	
		se or workshop that is led by		·Copies of the completed dr	ills
		ludes a group discussion led		will be sent to the Program	
	by a facilitator, usir			Manager and will also remain	in
		emergency scenario, and a set		the EPP binder in the facility.	
	-	nts, directed messages, or		·Completed staff tests will be	
	· · ·	designed to challenge an		kept in the EPP binder and wi	ll be
	emergency plan.			sent to Human Resource to	
	• •	F/IID facility's response to		remain in staff file.	
		nentation of all drills, tabletop			
		gency events, and revise the			
		mergency plan, as needed in $(EP, 482, 475(4)(2))$ This		Completion Date: 7/1/21	
		CFR 483.475(d)(2). This			
	deficient practice co	ould affect all occupants.			
	Findings include:				
	During review of th	e emergency preparedness			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG 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 K 0000 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U4PF21 Facility ID: 000775 If continuation sheet Page 35 of 44

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G255		(X2) MULTIPLE CC A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 06/01/2021	
	PROVIDER OR SUPPLIEF	R LTERNATIVES SE IN	154 CH	address, city, state, zip c AD DR ILLES, IN 47042	ODE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	(X5)	
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A	HOULD BE COMPLETIO	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	fire alarm system w corridors and all liv capacity of 8 and ha this survey. Calculation of the F (E-Score) using NF	htrol panel. The facility has a with smoke detection in ing areas. The facility has a ad a census of 8 at the time of Evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the m an E-Score of 3.6.				
	Quality Review cor	npleted on 06/07/21				
S351	NFPA 101					
	Sprinkler System					
3ldg. 02	installed, for eithe building coverage accordance with S shall initiate the fin accordance with S modified below. T supply shall be do In Prompt Evacua sprinkler system in with NFPA 13D, S of Sprinkler Syste and two Family D Homes, shall be p Automatic sprinkle closets not exceed feet and in bathro square feet, provi spaces are finished materials providin thermal barrier. In Prompt Evacua	tic sprinkler system is r total or partial , the system shall be in Section 9.7 and re alarm system in Section 9.6, as he adequacy of the water boumented. tion facilities, an automatic n accordance Standard for the Installation ms in One wellings and Manufactured bermitted. ers shall not be required in ding 24 square oms not exceeding 55 ded that such ed with lath and plaster or g a 15-minute				
	where an automa system is in accor	tic sprinkler dance with NFPA 13,				

	NT OF DEFICIENCIES	S X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
15G255			B. WING			06/01/2021	
NAME OF PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE	•		
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN			IAD DR NLLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE PRIATE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Standard for the						
		is, automatic sprinklers shall					
	not be required in						
		uare feet and in bathrooms					
	not exceeding 55	-					
		ch spaces are finished with					
	lath and plaster of						
		inute thermal barrier.					
	In Prompt Evacu						
	buildings four or						
	above grade plar						
	with NFPA 13R,						
		rinkler Systems in					
		ipancies up to and					
	including Four St	tories in Height, shall be					
	permitted.						
	Initiation of the fi	re alarm system shall not be					
	required for exist	0					
		ccordance with 33.2.3.5.6.					
		atic sprinkler is installed,					
	attics used for liv						
		ired equipment are sprinkler					
		5, 2019. Attics not used for					
	• • •	storage, or fuel-fired					
		one of the following:					
		eat detection system to					
	activate the fire a	-					
	according to 9.6.						
		utomatic sprinkler system					
	according to 9.7.						
		f noncombustible or					
		ble construction; or					
		f fire-retardant-treated wood					
	according to NFF						
		3.5.3.1, 33.2.3.5.3.3,					
		2.3.5.3.6, 33.2.3.5.7					
		vation and interview, the	K S	351	K0351: Sprinkler System	-	07/01/20
		nsure automatic sprinkler			Installation		
		ntire house when the storage					
	room was added to	o the house. There is no			Corrective action:		1

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 COMPLETED 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) sprinkler protection of the porch storage room. This deficient practice could affect all clients Program Manager reached out to Aramark to have the light in and staff in the facility. Office bedroom #1 changed to a low profile light to ensure the Findings include: spray of the sprinkler head would not be obstructed. (Attachment Based on observation with the Residential Manager (RM during a tour of the facility on P) 06/01/2021 between 1:00 p.m. and 2:00 p.m., Program Manager submitted a work order to have a sprinkler there are no sprinklers located in the storage room which has more combustible storage than head added to the storage area on the back porch. (Attachment an average sleeping room. The open roof framing appears to be separated from the attic of the Q) original house by a single sheet of plywood. **Monitoring of Corrective** Based on interview at the time of observation, the RM acknowledged the fact that the storage Action: room lacked automatic sprinkler protection. The Program Manager will follow up RM stated that the storage room addition was with Aramark to ensure work there prior to his arrival at the home, and he did orders have been completed. not know when it was constructed. This deficiency was reviewed at the Exit Conference on 06/01/2021 at 2:30 p.m. Completion Date: 7/1/21 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 02 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG 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 **NFPA 101** Sprinkler System - Maintenance and Testing Bldg. 02 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: U4PF21 Facility ID: 000775 If continuation sheet Page 39 of 44

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	NT OF DEFICIENCIES OF CORRECTION	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G255		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/01/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET A 154 CHA VERSA	DE				
(X4) ID				ID			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	JLD BE	COMPLETIC	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APF DEFICIENCY)	ROPRIATE	DATE	
	(NFPA 25, sectior	n 5.2.6).						
	4. Alarm device	s tested semiannually						
	(NFPA 25, section	າ 5.3.3).						
	5. Valve supervi	sory switches tested						
	semiannually (NF	PA 25, section 13.3.3.5).						
		lers inspected annually						
	((NFPA 25, sectio	,						
		nspected annually (NFPA						
	25, section 5.2.2).							
		angers inspected annually						
	(NFPA 25, section	,						
	•	pected annually prior to						
	-	or adequate heat for water						
		A 25, section 5.2.5).						
		ative sample of fast						
	(NFPA 25, section	rs are tested at 20 years						
	•	ative sample of dry pendant						
		ed at 10 years (NFPA 25,						
	section 5.3.1.1.15							
		olutions are tested annually						
	(NFPA 25, section							
		es are operated through						
		d returned to normal						
	annually (NFPA 2	5, section 13.3.3.1).						
	14. Operating st	ems of OS&Y valves are						
	lubricated annuall	y (NFPA 25, section						
	13.3.4).							
	15. Dry pipe sys	tems extending into						
		of the building are						
		and maintained (NFPA 25,						
	section 13.4.4).							
	-	system last checked and						
	necessary mainte	nance provided.						
	B. Show who prov	vided the service.						
		o of the water averally for						
		e of the water supply for						
	the automatic spri	nkier system.						
	1						1	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 02 15G255 B. WING 06/01/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) (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 K S353 K0353: Sprinkler System -07/01/2021 Maintenance and Testing facility failed to ensure 2 of over 10 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Corrective action: Program Manager updated the Systems, 2010 Edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to forms to include monthly inspection of the control valves cover the annular space around a sprinkler shall be metallic or shall be listed for use around a was added to the current monthly sprinkler. This deficient practice could affect all pressure check on the sprinkler clients and staff in the facility. system gauges that is completed by the Aramark Maintenance Findings include: Technician. (Attachment R) ·Program Manager submitted a Based on observation with the Residential work order to Aramark to have the Manager (RM during a tour of the facility on escutcheon plate replaced on the 06/01/2021 between 1:00 p.m. and 2:00 p.m., sprinkler head in the North Bathroom. (Attachment S) the escutcheon plate on the sprinkler in North Program Manager submitted a Bathroom was missing and the escutcheon plate on the sprinkler in the Living Room was loose. work order to Aramark to have the Based on interview at the time of observation, escutcheon plate replaced on the the RM acknowledged the missing and loose sprinkler head in the Living Room. escutcheon plates on the sprinklers. (Attachment S) Program Manager submitted a work order to Aramark to have an This deficiency was reviewed at the Exit Conference on 06/01/2021 at 2:30 p.m. Internal Pipe Inspection completed at the facility and 2. Based on observation and interview, the provide the documentation of the facility failed to ensure the proper record inspection to Rescare. keeping of monthly valve inspections of the (Attachment T) sprinkler system. NFPA 25, Section 13.3.2 ·Site Reviews are completed requires that control valves be inspected monthly by Rescare Management monthly. This deficient practice could affect all and entered into the CRM database for tracking. clients and staff in the facility. (Attachment U) Findings include:

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AND PLAN	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	A. BUILDING B. WING	0NSTRUCTION (X3 02) date survey completed 06/01/2021		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 154 CHAD DR				
				AILLES, IN 47042			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE		
	Manager (RM durin 06/01/2021 betweet the "Monthly Sprin was not made to ind inspection of the co- interview at the tim indicated that the cl technician was in th gauge are located. T check list sheet did inspection and the of This deficiency was Conference on 06/0 3. Based on record facility failed to enso of a five-year obstrr inspection was avai interview during re constructed with th deficient practice of staff in the facility. Findings include: Based on record rev Manager (RM) on 0 a.m. and 1:00 p.m., a five-year Internal of the Sprinkler Pip licensed since 10/30 service provider wa 3/19/2021. Based on observation, the RM	on with the Residential ng a tour of the facility on n 1:00 p.m. and 2:00 p.m., kler Pressure Check" sheet clude the required monthly introl valves. Based on e of observation, the RM neck-mark indicated that the ne closet where the valves and The RM acknowledged the not document the monthly late of the inspection. as reviewed at the Exit 10/2021 at 2:30 p.m. review and interview, the sure that the documentation uction, internal pipe lable for review. Based on an cord review, the house was e sprinkler system. This build affect all clients and view with the Residential 10/01/2021 between 10:45 there is no documentation of Inspection for Obstructions sing. The facility has been D/2015. The sprinkler system is last in the facility on n interview at the time of <i>M</i> acknowledged the fact that of an internal pipe inspection		Monitoring of Corrective Action: Program Manager to review all Aramark reports for filing and follow-up if warranted. Program Manager will follow-u with Residential Manager to ensure Aramark has had the wor orders scheduled and completed The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED wi complete monthly site reviews of each location and document any issues/findings on the site review form including the pressure gaug and control valve log. Completion Date: 7/1/21	р к II		

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OMB NO. 0938-0391

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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G255		A. BUILDI B. WING	<u></u>	COMPLETED 06/01/2021	
	PROVIDER OR SUPPLI	^{BR} ALTERNATIVES SE IN	15	REET ADDRESS, CITY, STATE, ZIP CO 4 CHAD DR ERSAILLES, IN 47042	DE
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREF TA	PROVIDER'S PLAN OF CORRE TX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ECTION (X5) UULD BE COMPLETION PROPRIATE DATE
	-	as reviewed at the Exit /01/2021 at 2:30 p.m.			
K S511	NFPA 101 Utilities - Gas an	d Electric			
Bldg. 02	Utilities - Gas an Equipment using complies with NF Code, electrical complies with NF Code. 32.2.5.1, 33.2.5. Based on observat failed to ensure 1 ground fault circu protection against NEC 2011 Edition Circuit-Interrupter states, ground-faul personnel shall be 210.8(A) through circuit-interrupter accessible location NFPA 70, 517-20 receptacles and fix of the wet location interrupter (GFCI) can reduce the con and electrical insu failure. This defici client using North Findings include: Based on observat 06/04/2021 betwee with the Residenti	d Electric gas or related gas piping FPA 54, National Fuel Gas wiring and equipment PFA 70, National Electric 1, 9.1.1, 9.1.2 tion and interview, the facility of 4 wet locations maintained it interrupter (GFCI) electric shock. NFPA 70, a t 210.8 Ground-Fault Protection for Personnel, It circuit-interruption for provided as required in (C). The ground-fault shall be installed in a readily a. Wet Locations, requires all ed equipment within the area in to have ground-fault circuit protection. Note: Moisture intact resistance of the body, lation is more subject to cient practice could affect the Bathroom.	K \$511	K0511: Utilities- Gas a Electric Corrective Action: ·Program Manager su a work order to Araman replace the GFCI outlet North Bathroom. (Atta V) ·Rescare Administrat conducts Site reviews to ensure all systems a working properly. (Atta U) Monitoring of Corrective Action: · Program Manager w up with Aramark to ens work orders are comple ·Site reviews will be s the Program Director for monitoring of noted iss to ensure completion.	ubmitted rk t in the chment tion monthly are achment /e vill follow sure eted. sent to or
	to reset properly.	vanity in North Bathroom failed When tested with a GFCI cle registered no power. When		Completion Date: 7/1/2	21

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CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 15G255		A. BUILDING <u>02</u> B. WING		COMPLETED 06/01/2021		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			D. WI	STREET ADDRESS, CITY, STATE, ZIP CODE 154 CHAD DR VERSAILLES, IN 47042				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL LATORY 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	
	reset. Based on inte observation, the RM how long the device acknowledged that	I stated that he did not know has been broken and the device could not be reset. reviewed at the Exit						

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