PRINTED: 09/21/2021 PPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			C	OMB NO. 0938-039		
	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE CC A. BUILDING B. WING	<u></u>	(X3) DATE SURVEY COMPLETED 08/30/2021			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042					
	1							
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)		
PREFIX	,	VCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	OPRIATE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
E 0000								
Bldg	Preparedness Surve	0/2021 000775 15G255	E 0000					
	Alternatives SE IN with Emergency Pr Medicare and Med and Suppliers, 42 C The facility has 8 c certified for Medica the census was 8. Quality Review con	ertified beds. All 8 beds are aid. At the time of the survey, mpleted on 09/01/21						
E 0033 Bldg	$\begin{array}{l} (4)-(6), 441.184(c)\\ 483.475(c)(4)-(6),\\ (4)-(5), 485.625(c)\\ 485.727(c)(4), 48\\ 494.62(c)(4)-(6)\\ Methods for Shar\\ \$403.748(c)(4)-(6)\\ \$418.113(c)(4)-(6)\\ \$460.84(c)(4)-(6),\\ \$460.84(c)(4)-(6),\\ \$483.73(c)(4)-(6),\\ \$484.102(c)(4)-(5),\\ \end{array}$	(416.54(c)(4)-(6), 418.113(c)) (4)(4)-(6), 482.15(c)(4)-(6), (483.73(c)(4)-(6), 484.102(c)) (4)-(6), 485.68(c)(4), (5.920(c)(4)-(6), 491.12(c)(4), ing Information), §416.54(c)(4)-(6),), §441.184(c)(4)-(6), §441.184(c)(4)-(6), §482.15(c)(4)-(6), §483.475(c)(4)-(6),), §485.68(c)(4), §485.625(c)) (c)(4), §485.920(c)(4)-(6),						

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

TITLE

(X6) DATE

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			COM	(X3) DATE SURVEY COMPLETED 08/30/2021	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN		154 CHA	ddress, city, state, zip AD DR LLES, IN 47042	P COD		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	I SHOULD BE	COMPLETIO	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	EAFFROFRIATE	DATE	
	§491.12(c)(4), §49	94.62(c)(4)-(6).						
	an emergency preplan that complies local laws and mu at least every 2 ye facilities]. The cor include all of the for (4) A method for s medical document [facility's] care, as	aust develop and maintain paredness communication with Federal, State and st be reviewed and updated pars [annually for LTC mmunication plan must ollowing: haring information and tation for patients under the necessary, with other o maintain the continuity of						
	release patient inf under 45 CFR 164 provision is not re	e event of an evacuation, to ormation as permitted I.510(b)(1)(ii). [This quired for HHAs under Fs under §485.68(c)]						
	about the general patients under the	eans of providing information condition and location of [facility's] care as 5 CFR 164.510(b)(4).						
	for sharing informa documentation for care, as necessar maintain the contin written election sta	403.748(c):] (4) A method ation and care patients under the RNHCI's y, with care providers to nuity of care, based on the atement made by the er legal representative.						
	means of providing	es at §491.12(c):] (4) A g information about the and location of patients care as permitted under 45).						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING		COMPLETED
		15G255	B. WING		08/30/2021
	PROVIDER OR SUPPLIE	R R ALTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP COD HAD DR AILLES, IN 47042	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
		view and interview, the facility e emergency preparedness	E 0033	E033: Methods for Sharing Information	09/15/202
		in includes (4) A method for		mormation	
	-	n and medical documentation		Corrective action:	
	for clients under th	e ICF/IID facility's care, as		· The Program Manager	
		her health care providers to		created a form to give to referra	ıls,
		uity of care; (5) A means, in		families and consumers regard	
	the event of an eva	cuation, to release client		our Emergency Preparedness	-
	information as per	mitted under 45 CFR 164.510(b)		Plan and its contents.	
	(1)(ii); (6) A mean	s of providing information about		(Attachment A) The form	
	the general condition	on and location of clients under		provides information on how all	
	the facility's care a	s permitted under 45 CFR		information will be shared and t	he
	164.510(b)(4) in ac	ccordance with 42 CFR 483.475(c)		protection of client information	vill
	(4). This deficient practice could affect all			be secured.	
	occupants.				
				Monitoring of Corrective	
	Findings include:			Action:	
				· Rescare as well as the	
	During review of the	he emergency preparedness		Program Manager will update the	ne
	documentation enti	itled "EPP Emergency Disaster		form as needed with any addition	onal
		21 between 1:45 p.m. and 2:45		information that will need to be	
	•	dential Manager (RM), the		shared.	
		dness plan did not include a			
		information and medical			
		in emergency. Based on		Completion Date: 9/15/21	
		ne of record review, the RM was			
	-	someone from the "main" office			
		lirect this surveyor to the			
		EPP Emergency Disaster			
		od for sharing information and			
	medical documenta	ation in an emergency.			
	This issue was revi	ewed with the RM at the Exit			
		30/2021 at 3:00 p.m.			
	This deficiency wa	s cited on 06/01/2021. The			
		plement a systemic plan of			
	correction to preve				
		ni recurrence.			

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

Event ID:

U4PF22 Facility ID: 000775

If continuation sheet

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09/21/2021 PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 08/30/2021 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES. IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE TAG 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), Bldg. --483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c) (6), §485.68(c)(5), §485.68(c)(5), §485.727(c) (5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Based on record review and interview, the facility E 0034 E034: Information on 09/15/2021 **U4PF22** Facility ID: 000775 Page 4 of 8 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

FORM APPROVED

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/30/2021			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR				
	1			VERSAILLES, IN 47042				
X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
mo	failed to ensure the	e emergency preparedness an includes a means of		mo	Occupancy/Needs			
	providing informat occupancy, needs, assistance, to the a (AHJ) or the Incide designee in accord. This deficient prac Findings include: During review of th documentation ent Manual" on 08/30/ p.m. with the Resid emergency prepare means for providin and abilities of the emergency. Based record review, the someone from the direct this surveyor Emergency Disaste procedures for provineeds and abilities This issue was revit Conference on 08/2	tion about the ICF/IID facility's and its ability to provide uthority having jurisdiction ent Command Center, or ance with 42 CFR 483.475(c)(7). tice could affect all occupants. he emergency preparedness itled "EPP Emergency Disaster 21 between 1:45 p.m. and 2:45 dential Manager (RM), the edness plan did not include a ag information about the needs clients to the AHJ in an on interview at the time of RM was on the phone with "main" office and neither could r to the location within the EPP er Manual for a policy and viding information about the to the AHJ in an emergency. iewed with the RM at the Exit 30/2021 at 3:00 p.m. as cited on 06/01/2021. The			Corrective action: The Continuity of Operations Plan (Attachmen provides a method to share occupancy needs and ability provide assistance to the Aut Having Jurisdiction or IC and be placed in the EPP. All staff will be trained the Continuity of Operations The Program Managel created a form to give to refe families and consumers rega our Emergency Preparedness Plan and its contents. (Attachment A) The form pro- information on how all inform will be shared and the protect of client information will be secured. Monitoring of Corrective Action: The Site Review Team consisting of the QA departm Program Managers, QIDP-D Nurse Manager, AED, and E	to thority will on Plan. rrals, rding s ovides ation tion		
	facility failed to implement a systemic plan of correction to prevent recurrence.				complete monthly site review each location and document issues/findings on the site re form. • Rescare as well as the Program Manager will update form as needed with any add	any view e e the litional		
					information that will need to b shared.	De		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/30/2021		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION		
				Completion Date: 9/15/21			
E 0035 Bldg	§483.73(c)(8); §4 *[For LTC Faciliti	Sharing Plan with Patients					
	maintain an eme communication p Federal, State ar reviewed and up	rgency preparedness lan that complies with Ind local laws and must be dated at least annually. The lan must include all of the					
	emergency prepa plan that complie local laws and m at least every 2 y	§483.475(c):] must develop and maintain an aredness communication as with Federal, State and ust be reviewed and updated rears. The communication a all of the following:]					
	emergency plan, determined is ap clients] and their Based on record re failed to ensure the	sharing information from the that the facility has propriate, with residents [or families or representatives. eview and interview, the facility e emergency preparedness an includes a method for sharing	E 0035	E035: LTC and ICF/IID Sha Plan with Patients	ring 09/15/202		
	information from t facility has determ and their families	the emergency plan that the ined is appropriate with clients or representatives in accordance 475(c)(8). This deficient practice		Corrective action: The EPP plan will be discussed by the QIDP and shared with family members, consumer, guardians and	, the		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMI	(X3) DATE SURVEY COMPLETED 08/30/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042				
RES CA (X4) ID PREFIX TAG				RSAILLES, IN 47042 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE APPROPRIATE consumers neetings. anager to referrals, rs regarding redness orm provides information protection II be vide any ubers, the and consumers ive nds all IDT QIDP and review and to as the update the ny additional	(X5) COMPLETION DATE	
K 0000 Bldg. 02	Code Recertificati	visit (PSR) to the Life Safety on Survey conducted on lucted by the Indiana	K 0000	Completion Date: 9/1	5/21		

PRINTED: 09/21/2021

	T OF HEALTH AND HU R MEDICARE & MEDIC					FO	TED: 09/21/20 RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING		(X3) DATE SURVEY COMPLETED 08/30/2021		
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		154 CH	ADDRESS, CITY, STATE, ZIP COD AD DR ILLES, IN 47042	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Department of Health in accordance with 42 CFR 483.470(j).						
	Survey Date: 08/3						
	Facility Number: Provider Number:						
	AIM Number: 100						
	At this PSR survey, Res Care Community Alternatives SE IN was found in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care						
	fully sprinklered. T living purposes, sto protected by heat of the fire alarm cont	lding was determined to be The attic which is not used for orage, or fuel-fire equipment is letection devices connected to rol panel. The facility has a fire smoke detection in corridors					

and all living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.

Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 3.6.

Quality Review completed on 09/01/21

U4PF22 Facility ID: 000775

If continuation sheet

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