PRINTED: 01/02/2024 FORM APPROVED

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	FORM AT 1 KOVED
	OMB NO. 0938-039
ONSTRUCTION	(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G159		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/06/2023		
	VIDER OR SUPPLIE	R LTERNATIVES SE IN		1337 E	ADDRESS, CITY, STATE, ZIP ( SOUTHVIEW LN IN 47454	COD	
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A c. a			E 0	000			
F P	Tacility Number: ( Provider Number: 100 AIM Number: 100	000695 15G159					
C c R P	Community Altern ompliance with E Requirements for M	Preparedness survey, Res Care atives SE IN was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR					
	The facility has 7 c ensus of 7.	ertified beds, with a current					
Ç	Quality Review co	mpleted on 12/08/23					
4 Bldg 4 4 4 E § § (2	41.184(d)(2), 48 83.73(d)(2), 484 85.68(d)(2), 485 86.360(d)(2), 49 P Testing Requi 416.54(d)(2), §4 460.84(d)(2), §4 483.475(d)(2), § 485.625(d)(2), § 2), §491.12(d)(2)	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) ), §494.62(d)(2).					
C	PO, "Organizati	16.54, CORFs at §485.68, ons" under §485.727, 920, RHCs/FQHCs at					
LABORATORY E	DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATUR	E	TITLE		(X6) DATE

Mark Slaughter

AED

12/21/2023

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.

Event ID:

UIVN21 Facility ID: 000695

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### 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 12/06/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN** PAOLI. IN 47454 (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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise: or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. Event ID: UIVN21 Facility ID: 000695 Page 2 of 12 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 12/06/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN** PAOLI. IN 47454 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE \*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill: or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise Event ID: UIVN21 Facility ID: 000695 Page 3 of 12 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159	A.	BUILDING WING	DNSTRUCTION	co 12	ate survey mpleted <b>/06/2023</b>
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	accessible, cond facility-based fun (B) If the hospice man-made emer of the emergency exempt from eng full-scale commu functional exercis emergency even (ii) Conduct an a that may include following: (A) A second ful community-base functional exercis (B) A mock disa (C) A tabletop et facilitator that inclusing a narrated emergency scen statements, direc questions design emergency plan. (iii) Analyze the maintain docume exercises, and et the hospice's emergency for the hospice's emergency for the hospice's emergency for the hospice's emergency for (2) Testing. The conduct exercise plan twice per yea CAH] must do th (i) Participate in that is community	munity-based exercise is not uct an annual individual actional exercise; or e experiences a natural or gency that requires activation y plan, the hospice is laging in its next required unity based or facility-based se following the onset of the t. additional annual exercise , but is not limited to the I-scale exercise that is d or a facility based se; or ster drill; or xercise or workshop led by a cludes a group discussion , clinically-relevant ario, and a set of problem cted messages, or prepared ted to challenge an hospice's response to and entation of all drills, tabletop mergency events and revise lergency plan, as needed. 441.184(d), Hospitals at ts at §485.625(d):] [PRTF, Hospital, CAH] must as to test the emergency ear. The [PRTF, Hospital, e following: an annual full-scale exercise					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 12/06/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN** PAOLI. IN 47454 (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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to 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 Event ID: UIVN21 Facility ID: 000695 Page 5 of 12 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 12/06/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN** PAOLI. IN 47454 (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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. \*[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that Event ID: UIVN21 Facility ID: 000695 Page 6 of 12 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 12/06/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN** PAOLI. IN 47454 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of 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, Event ID: UIVN21 Facility ID: 000695 Page 7 of 12 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERV	CES
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AND PLAN	STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         IND PLAN OF CORRECTION       IDENTIFICATION NUMBER         15G159		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/06/2023	
	PROVIDER OR SUPPLI RE COMMUNITY	<sup>ER</sup> ALTERNATIVES SE IN		1337 E	ADDRESS, CITY, STATE, ZIP SOUTHVIEW LN IN 47454	COD	
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	onset of the eme (ii) Conduct an a that may include following: (A) A second ful community-based facility-based fur (B) A mock disa (C) A tabletop e: led by a facilitate discussion, usin clinically-relevar set of problem s messages, or pr to challenge an (iii) Analyze the maintain docum exercises, and e the ICF/IID's em *[For HHAs at §- (d)(2) Testing. T exercises to test least annually. T following: (i) Participate in community-base (A) When a is not accessible individual, facility every 2 years; o (B) If the H natural or man-r activation of the exempt from eng full-scale commu	additional annual exercise a, but is not limited to the I-scale exercise that is ad or an individual, nctional exercise; or ster drill; or xercise or workshop that is or and includes a group g a narrated, at emergency scenario, and a tatements, directed epared questions designed emergency plan. ICF/IID's response to and entation of all drills, tabletop emergency events, and revise ergency plan, as needed. 484.102] he HHA must conduct t the emergency plan at he HHA must do the a full-scale exercise that is ed; or community-based exercise a, conduct an annual y-based functional exercise					
	onset of the eme (ii) Conduct an a	ergency event. additional exercise every 2					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 12/06/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN** PAOLI. IN 47454 (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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. \*[For OPOs at §486.360] (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 Event ID: UIVN21 Facility ID: 000695 Page 9 of 12 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G159		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/06/2023		
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	1337 E	address, city, state, zip cod 5 SOUTHVIEW LN , IN 47454		
(X4) ID PREFIX TAG	(EACH DEFICIE	7 STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETIO DATE
	needed. *[ RNCHIs at §40 (d)(2) Testing. The exercises to test RNHCI must do finite in the exercises to test RNHCI must do finite in the exercises in the exercises in the exercises in the exercises in the exercises, and each is the RNHCI's emerging the RNHCI's emerging the follow (i) Participate in an is community-base a. When a community-base a. When a community-base a. When a community-base function of the exercise in the RNHCI's emerging the interval or man-the exercise in the follow (i) Participate in an is community-base function of the each is community-base function of the each is exercise in the follow (i) Participate in an is community-base function of the each is community-base function of the each is the follow is not the following th	he RNHCI must conduct the emergency plan. The the following: ber-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a y-relevant emergency set of problem statements, es, or prepared questions enge an emergency plan. RNHCI's response to and entation of all tabletop mergency events, and revise ergency plan, as needed. wiew and interview, the facility exercises to test the emergency per year. The ICF/IID facility ving: n annual full-scale exercise that ed; or nity-based exercise is not t an annual individual, stional exercise. acility experiences an actual de emergency plan, the ICF/IID from engaging its next required munity-based or individual, scale functional exercise for 1 onset of the actual event. ditional exercise that may limited to the following: cale exercise that is or an individual, facility-based ex.	E 0039	<ol> <li>The administrator will the participation in a full-sca community based exercise a table top exercise is present EPP manual.</li> <li>The area supervisor a program manager will ensure documentation of the table to exercise and the community based exercise are present Emergency Disaster Preparedness Manual for reference as needed. The associate executive director review the training documer to ensure it has been compliand is present. The safety committee will review and u annually as needed.</li> <li>This information is loca section 22 of the Emergence Disaster Preparedness Man</li> </ol>	le and a t in the nd re op , in the will atation eted pdate ated in	12/21/202

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### 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 12/06/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN** PAOLI. IN 47454 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE c. A tabletop exercise or workshop that is led by a 4 Dated Documentation will be facilitator that includes a group discussion led by provided showing the completion a facilitator, using a narrated, clinically-relevant of a tabletop exercise emergency scenario, and a set of problem The AED will in service the 5 statements, directed messages, or prepared Program Manager, Area questions designed to challenge an emergency Supervisor and Residential plan. Manager on the requirement of (iii) Analyze the ICF/IID facility's response to and conducting an annual community maintain documentation of all drills, tabletop based exercise and maintaining exercises, and emergency events, and revise the documentation. ICF/IID facility's emergency plan, as needed in 6 A community based drill accordance with 42 CFR 483.475(d)(2). This was completed on October 19, deficient practice could affect all occupants. 2023 and a second will be conducted in January 2024. Findings include: 7 All supervisory staff responsible for maintaining drills Based on review of the Emergency/Disaster will be retrained to ensure each Preparedness Manual (EDPM) on 12/06/23 group home is completing the between 11:35 a.m. and 12:55 p.m. with the Area drills per LSC. Ongoing monitoring Supervisor, Home Manager, and Maintenance will be achieved by the Quality Tech present, the facility was able to provide a Assurance Department table top exercise performed during the past 12 maintaining a tracking month period, however, the facility was unable to spreadsheet to ensure all drills are provide emergency preparedness documentation completed per the calendar. for a community based exercise to test the emergency preparedness plan during the past 12 Persons Responsible: AED, month period. Based on interview at the time of Program Manager, Area record review, the Area Supervisor said the Supervisor, and Residential facility did experience the actual event of a Manager, DSP Quality Assurance. tornado in August of 2023 where the facility was without power for at least four or five days and DATE OF COMPLETION: had to relocate during that time, however, there January 22, 2024 was no documentation of the event available for review. This finding was reviewed with the Area Supervisor, Home Manager, and Maintenance Tech during the exit conference.

UIVN21

Facility ID: 000695

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If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         IDENTIFICATION NUMBER         1550			(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION 02	(X3) DAT COM	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 12/06/2023	
	15G159			B. WING			
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	1337 E	address, city, state, zip co SOUTHVIEW LN IN 47454	DD		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE PPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
< 0000							
Bldg. 02		e Recertification Survey was ndiana Department of Health in 2 CFR 483.470(j).	K 0000				
	Survey Date: 12/0	6/23					
	Facility Number: ( Provider Number: AIM Number: 100	15G159					
	Community Altern compliance with R Medicaid, 42 CFR from Fire and the N Association) 101, I	Code survey, Res Care atives SE IN was found in equirements for Participation in Subpart 483.470(j), Life Safety NFPA (National Fire Protection LSC (Life Safety Code) 2012 3, Existing Residential Board cies.					
	facility has a fire a smoke detectors in living areas. The f	lity was sprinklered. The larm system with hard wired the corridor and common acility has a capacity of 7 and t the time of this survey.					
	(E-Score) using NH Approaches to Life	Evacuation Difficulty Score FPA 101A, Alternative Safety, Chapter 6, rated the h an E-Score of 1.2.					
	Quality Review co	mulated on $12/08/23$					

UIVN21 Facility ID: 000695