

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2018
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	<p>A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 12/21/17 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 02/14/18</p> <p>Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190</p> <p>At this PSR survey, Res Care Community Alternatives Se In was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475.</p> <p>The facility has 7 certified beds. At the time of the survey, the census was 7.</p> <p>Quality Review completed on 02/19/18 - DA</p> <p>The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:</p>	E 0000		
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IDD facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent	E 0037	The agency has developed an Emergency Disaster Preparedness Plan that meets all Federal, State, and local emergency preparedness requirements and the plan will be reviewed	03/16/2018

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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E 0039 Bldg. --	<p>with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on review of the Res Care Emergency Disaster Preparedness Manual dated 07/21/17 with direct support associate #1 on 02/14/18 at 9:10 a.m., there was no documentation of initial training or annual training for staff over the past year. This was confirmed by direct support associate #1 at the time of record review.</p> <p>This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IDD facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IDD facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IDD facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional</p>	E 0039	<p>and updated annually by the Safety Committee. All staff will be trained on the plan policies and procedures and participate in a community based disaster drill.</p> <p>The Program Manager will train the area supervisor on the policies and procedures and the area supervisor will train all facility employees. The Safety Committee will monitor to ensure all training has been completed.</p> <p>The agency has developed an Emergency Disaster Preparedness Plan that meets all Federal, State, and local emergency preparedness requirements and the plan will be reviewed and updated annually by the Safety Committee. The administrator will ensure all staff participate in two annual training exercises each year.</p> <p>The Program Manager will train the area supervisor on the policies and procedures and the area</p>	03/16/2018

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K 0000 Bldg. 02	<p>exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IDD facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IDD facility's emergency plan, as needed in accordance with 42 CFR 483.475(d) (2). This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on review of the Res Care Emergency Disaster Preparedness Manual dated 07/21/17 with direct support associate #1 on 02/14/18 at 9:15 a.m., there was no documentation of two annual training exercises conducted over the past year. This was confirmed by direct support associate #1 at the time of record review.</p> <p>This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 12/21/17 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 02/14/18</p>		K 0000	<p>supervisor will train all facility employees. The Safety Committee will monitor to ensure all training has been completed.</p>	

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K S100 Bldg. 02	<p>Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190</p> <p>At this PSR 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.</p> <p>This one story facility with a basement was fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the corridors and common living areas. The facility has a capacity of 7 and had a census of 7 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-score of 1.85.</p> <p>Quality Review completed on 02/19/18 - DA</p> <p>NFPA 101 General Requirements - Other General Requirements – Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on observation and interview, the facility</p>	K S100	The administrator will ensure	03/16/2018

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	<p>failed to ensure 2 of 2 battery operated emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 02/14/18 with direct support associate #1 during a tour of the facility from 9:10 a.m. to 10:00 a.m., the facility had a battery operated emergency light fixture located on the wall in the kitchen and on the wall in the basement with a sticker on each light from Koorsen Fire & Security indicating an annual ninety minute test was conducted on February 2017. Furthermore, when asked if the facility had documentation of monthly testing conducted over the past year, direct support associate #1 stated the facility does not have documentation of monthly testing over the past year for the two battery backup lights. This was confirmed by direct support associate #1 at the time of observations.</p> <p>This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.</p>		<p>a functional test of emergency lighting equipment will be conducted for 30 seconds at 30 day intervals and an annual test will be conducted on every required battery-operated emergency lighting system for not less than a 1 ½ hour duration. Koorsen Fire and Security will conduct the 1 ½ hour annual testing and the maintenance coordinator will conduct the monthly 30 seconds testing. Both parties conducting the testing will then provide proper documentation to the QA Manager upon completion. The QA Manager will monitor to ensure the facility remains in compliance with regulatory requirements. The Program Director will train the maintenance coordinators on conducting the testing and maintaining documentation.</p> <p>The executive director and QA manager will meet with Koorsen Fire and Security on March 14, 2018 to ensure</p>	

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K S345 Bldg. 02	<p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System – Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system including the components was inspected annually to protect 4 of 4 clients. LSC 9.6.1.3 requires fire alarm systems to be installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, Table 14.4.5 requires functional testing to be conducted annually for initiating devices such as smoke detectors, release devices, and fire alarm boxes. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>Based on record review on 02/14/18 at 9:30 a.m. with direct support associate #1, there was no record available for review to indicate an annual functional test was conducted on fire alarm system components. This was confirmed by direct support associate #1 at the time of record review.</p>	K S345	<p>they are conducting all system testing as required under LSC 7.9.3.</p> <p>1. The administrator will ensure annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review.</p> <p>2. The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate</p>	03/16/2018

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K S353 Bldg. 02	<p>This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on record review with direct support associate #1 on 02/14/18 at 9:30 a.m., there was no records available for review to indicate a two year sensitivity test was conducted on eight photoelectric smoke detectors located in the facility. This was confirmed by direct support associate #1 at the time of record review.</p> <p>This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System – Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems</p>			<p>year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion.</p> <p>3. The executive director and the QA manager will meet with Koorsen Fire and Security on March 14, 2018 to ensure they are completing all system testing as required by LSC 9.6.1.3 and NFPA 14.4.5.3.2.</p>

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	<p>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.</p> <p>NFPA 13D Systems</p> <p>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:</p> <ol style="list-style-type: none"> 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 			(X5) COMPLETION DATE

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	<p>11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15).</p> <p>12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4).</p> <p>13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).</p> <p>14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4).</p> <p>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).</p> <p>A. Date sprinkler system last checked and necessary maintenance provided.</p> <hr/> <p>B. Show who provided the service.</p> <hr/> <p>C. Note the source of the water supply for the automatic sprinkler system.</p> <hr/> <p>(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.)</p> <p>33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems was tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A</p>		K S353	The administrator will ensure Koorsen Fire and Security conducts quarterly sprinkler inspections and that the reports of the inspections are available in the facility for review and forwarded to the QA Manager for monitoring. The administrator will ensure monthly sprinkler gauge

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	<p>test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on record review with direct support associate #1 on 02/14/18 at 9:20 a.m., there was no quarterly sprinkler system inspection conducted for the first quarter, second quarter, or third quarter of the year 2017. Furthermore, the only documentation provided for review by direct support associate #1 at the time of record review was a quarterly sprinkler inspection report from Simplex/Grinnell dated 11/13/17. This was confirmed by direct support associate #1 at the time of record review.</p> <p>This deficiency was cited on 12/21/17. The facility failed to implement a systematic plan of correction to prevent recurrence.</p>		<p>inspections and monthly control valve inspections are conducted by the ResCare maintenance coordinator, and that reports of the inspections are available in the facility for review and forwarded to the QA Manager for monitoring.</p> <p>The executive director and the QA manager will meet with Koorsen Fire and Security on March 14, 2018 to ensure they are completing all system testing as required by NFPA 25, Section 5.2.5 and Section 5.3.3.2.</p>	