| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G255 | A. BUILDING -- B. WING | 02/19/2019 |

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

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475.<br><br>Survey Date: 02/19/19<br><br>Facility Number: 000775<br>Provider Number: 15G255<br>AIM Number: 100248960<br><br>At this Emergency Preparedness survey, Res Care Community Alternatives Se In was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475.<br><br>The facility has 8 certified beds. At the time of the survey, the census was 8.<br><br>Quality Review completed on 02/22/19<br><br>The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by: | E 0000 | | |
| E 0007<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.4753(a)(3). This deficient practice | E 0007 | **E007: EP Program Patient Population**<br><br>**Corrective action:**<br>·Patient Population that would be at risk is identified at the bottom of the “Operation Description” form **(Attachment A)**. | 03/21/2019 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., the emergency preparedness plan (EPP) failed to address the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. Based on interview at the time of record review, the Site Supervisor stated he could not find the aforementioned requirements after looking throughout the EPP. | | ·Staff training **(Attachment B)** on the "Operation Description" form and all it entails.<br>·The EPP will address what services the facility would be able to provide in the Continuity of Operations Plan **(Attachment C).**<br>·The Continuity of Operations Plan **(Attachment C)** will be in place in the EPP to specify the continuity of operations.<br>·Staff Training **(Attachment B)** on the Continuity of Operations form.<br>**Monitoring of Corrective Action**:<br>·The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form.<br>·Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues.<br>·AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members.<br><br>**Completion Date: 3/21/19** | |

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| E 0009<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., no documentation was available to show the group home included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Based on interview at the time of record review, the Site Supervisor confirmed no contact has been made and no cooperation and collaboration has been documented. | E 0009 | **E009: Local, State, Tribal Collaboration Process**<br><br>**Corrective action:**<br>·Program Manager updated a contact form that will be used to contact local, tribal, regional, State and Federal emergency preparedness officials. **(Attachment D)**<br>·Staff training **(Attachment B)** on the updated contact form.<br>·In the event of an emergency or during the mock drill the staff will notify the Area Supervisor who will contact the Management Team who will ensure calls are made to the local, regional, federal and state officials regarding the emergency and also during the mock drill annually and will document on the updated contact form.<br>·This location is not part of a tribal community.<br>**Monitoring of Corrective Action**:<br>·Area Supervisor will train all staff on the updated contact form.<br>·Updated contact/drill form will be placed in the EPP binder and will also be available with the Area Supervisor, QIDP and all Management.<br>·All mock drills/contact forms once completed will be kept in the EPP binder at the facility. | 03/21/2019 |

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| | | | **Completion Date: 3/21/19** | |
| E 0015<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observation with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., the facility was unable to provide documentation for the policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place for the following:<br>a) medical needs<br>b) pharmaceutical needs<br>c) emergency lighting<br>d) sewage<br>e) waste disposal<br>Based on interview at the time of record review, the Site Supervisor was unable to find documentation for the provision of all aforementioned subsistence needs while reviewing the facility's plan on substance needs. | E 0015 | **E015: Subsistence Needs for Staff and Patients**<br><br>**Corrective action:**<br>·Sheltering-in-place Policy **(Attachment E)** details the alternate sources of energy to maintain other than seeking alternate shelter in an emergency.<br>·The Emergency Food Supply Form **(Attachment F)** details the items needed, including emergency lighting, for an emergency and should be in the emergency food supply containers.<br>·The Fire Watch Plan **(Attachment G)** details how to handle fire detection, extinguishing, and alarm during an emergency disaster.<br>·Sheltering-in-place Policy **(Attachment E)** informs of the proper disposal of sewage and waste.<br>·All staff will be trained **(Attachment B)** in the following plans and how to implement: Sheltering-in-place, Emergency Food Supply Form and The Fire Watch Plan.<br>**Monitoring of Corrective Action**:<br>·All trainings are sent to the | 03/21/2019 |

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| | | | Program Manager and Human Resource Department for tracking and monitoring of completion.<br>·The EPP is updated annually and as needed by the Program Manager.<br>·AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members.<br><br>**Completion Date: 3/21/19** | |
| E 0018<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., no policies and procedures which include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency was available to review. Based on interview at the time of record review, the Site | E 0018 | **E018: Procedures for Tracking of Staff and Patients**<br><br>**Corrective action:**<br>·Program Manager created a form for tracking of all staff and consumers. This form will be completed each shift and documented**. (Attachment H)**<br>**Monitoring of Corrective Action**:<br>·The tracking form to track staff and consumers will be completed by the Area Supervisor and relay the information to the Administrative Management Team for continuous monitoring of all staff and consumers. Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and | 03/21/2019 |

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| | Supervisor stated their tracking procedures and confirmed, after reviewing the facility's emergency preparedness plan, the stated tracking procedures are not documented in the emergency preparedness plan. | | follow-up as necessary to correct all issues.<br><br>**Completion Date: 3/21/19** | |
| E 0022<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., the policy and procedure plan did not include a means to shelter in place for clients, staff, and volunteers who remain in the facility. Based on interview at the time of record review, the Site Supervisor searched the facility's emergency preparedness plan and confirmed he was unable to find a policy and procedure plan for a means of shelter in place in the emergency preparedness plan. | E 0022 | **E022: Policies/Procedures for Sheltering in Place**<br><br>**Corrective action:**<br>·Sheltering-in-place Policy **(Attachment E)** will be placed in the EPP to acknowledge a shelter in place for clients, staff and volunteers who remain in the facility.<br>·Staff will be trained **(Attachment B)** on the Sheltering-in-Place Policy.<br>**Monitoring of Corrective Action**:<br>·The Shelter in Place Policy will be updated as needed by the Program Manager.<br>**Completion Date: 3/21/19** | 03/21/2019 |
| E 0023<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This | E 0023 | **E023: Policies/Procedures- for Medical Documentation**<br><br>**Corrective action:**<br>·The Maintenance Technician will purchase locking totes for all homes to ensure all consumer | 03/21/2019 |

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| | deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., no policies and procedures which include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records was available to review. Based on interview at the time of record review, the Site Supervisor searched the facility's emergency preparedness plan but confirmed that none of the policies and procedures indicate a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records. | | documentation is secured at all times during an emergency situation. **(Attachment I)**<br>·All staff will be trained **(Attachment B)**. The documentation is kept locked in the homes for security and will be secured at all times in the locked totes during an emergency situation.<br>**Monitoring of Corrective Action**:<br>·Staff trained on securing documentation will be secured in the locking tote and transported to the designated location in the event of an emergency evacuation of the facility.<br>·All trainings are sent to the Program Manager and Human Resources.<br>**Completion Date: 3/21/19** | |
| E 0024<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants.<br><br>Findings include: | E 0024 | **E024: Policies/Procedures-Volunteers and Staffing**<br><br>**Corrective action:**<br>·The ROC Handbook Overview **(Attachment J)** details the use of volunteers in an emergency.<br>·All staff will be trained **(Attachment B)** on the ROC Handbook Overview.<br>**Monitoring of Corrective Action**: | 03/21/2019 |

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| | Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., no policies and procedures which include the use of volunteers in an emergency or other emergency staffing strategies was available for review. Based on interview at the time of record review, the Site Supervisor stated, after reviewing the emergency preparedness binder, the facility's emergency preparedness plan did not have a policy and procedure for the use of volunteers. | | ·"Rescare On Call" staff are identified and tested annually on the ROC tests.<br>·ROC staff would be trained on the EPP by the Administrative Management Team in the event of an emergency.<br><br>**Completion Date: 3/21/19** | |
| E 0025<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities and other providers to receive clients in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., no policies and procedures which include the development of arrangements with other ICF/IID facilities and other providers to receive clients in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients was available for review. Based on interview at the time of record review, the Site Supervisor stated he was unaware of any arrangements with other ICF/IID facilities to receive clients. | E 0025 | **E025: Arrangement with Other Facilities**<br><br>**Corrective action:**<br>·The Continuity of Operations Plan **(Attachment C)** addresses the arrangement with other facilities to receive clients in the event of clients from another facility needed to evacuate.<br>·Primary hotel if needed for each location has been identified. **(Attachment K)**<br>·In the event we would need to locate to one of our other facilities the Program Manager would notify the ISDH through the Gateway Link.<br>**Monitoring of Corrective Action**:<br>·The Continuity of Operations Plan will be updated as needed to include any additional information.<br>·Mock Drills will be held and the primary hotel identified will be used as the destination in the | 03/21/2019 |

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| | | | Mock Drill.<br>·The Program Manager will notify ISDH through the gateway link annually and during the mock exercise.<br>**Completion Date: 3/21/19** | |
| E 0026<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., no policies and procedures which include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was available for review. Based on interview at the time of record review, the Site Supervisor was unaware of what the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. | E 0026 | **E026: Roles Under a Waiver Declared by Secretary**<br><br>**Corrective action:**<br>·"Requesting an 1135 Waiver" **(Attachment L)** defines the role of the ICF/IID facility under a waiver declared by the secretary, in accordance with section 1135 of the Act.<br>·All staff will receive training **(Attachment B)** on the "Requesting an 1135 Waiver" **(Attachment L).**<br>**Monitoring of Corrective Action**:<br>·The EPP will be updated annually and as needed by the Program Manager.<br><br>**Completion Date: 3/21/19** | 03/21/2019 |
| E 0032<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and | E 0032 | **E032: Primary/Alternate Means for Communication** | 03/21/2019 |

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| | alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.475(c)(3). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., no documentation about the communication plan which included (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies was available for review. Based on interview at the time of record review, the Site Supervisor stated the facility's policy but later confirmed that the emergency preparedness plan does not include the aforementioned regulation. | | **Corrective action:**<br>·The Continuity of Operations Plan **(Attachment C)** provides a method to communicate with federal, state, regional and local emergency officials.<br>·All staff will be trained **(Attachment B)** on the Continuity of Operations Plan.<br>·Program Manager updated mock drill form to use also as a contact sheet for when federal, state, regional and local emergency officials are notified. **(Attachment M)**<br>**Monitoring of Corrective Action**:<br>·The Continuity of Operations Plan will be updated as needed to include additional information by the Program Manager.<br>·Mock Drill/Contact Sheet will be kept in the EPP binder.<br><br>**Completion Date: 3/21/19** | |
| E 0033<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under | E 0033 | **E033: Methods for Sharing Information**<br><br>**Corrective action:**<br>·The Continuity of Operations Plan **(Attachment C)** provides information on how all information will be shared and the protection of client information will be secured.<br>·Maintenance Technician | 03/21/2019 |

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| | the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., no documentation was available for a communication plan which includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care. Based on interview at the time of record review, the Site Supervisor searched the facility's emergency preparedness plan but confirmed the communication plan did not indicate a method for sharing information and medical documentation for clients under the ICF/IID facility's care. | | purchased a locking tote to transport consumer documentation in the event of an emergency. **(Attachment I)**<br>·All staff will be trained **(Attachment B)** on the Continuity of Operations Plan.<br>**Monitoring of Corrective Action**:<br>·The Continuity of Operations Plan will be updated as needed to include additional information by the Program Manager.<br>·Locking tote delivered to the home by Maintenance Technician.<br><br>**Completion Date: 3/21/19** | |
| E 0034<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. | E 0034 | **E034: Information on Occupancy/Needs**<br><br>**Corrective action:**<br>·The Continuity of Operations Plan **(Attachment C)** provides a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction or IC and will be placed in the EPP. | 03/21/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G255 | A. BUILDING -- B. WING | 02/19/2019 |

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

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|---|---|---|---|---|
| | Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., the facility was unable to provide documentation for a communication plan including a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee. Based on interview at the time of record review, the Site Supervisor was unaware of the regulation and confirmed he was unable to find the aforementioned regulation in the communication plan. | | ·All staff will be trained **(Attachment B)** on the Continuity of Operations Plan.<br>**Monitoring of Corrective Action**:<br>·The Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and ED will complete monthly site reviews of each location and document any issues/findings on the site review form.<br>·Site Review forms will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues.<br>·AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members.<br><br>**Completion Date: 3/21/19** | |
| E 0035<br><br>Bldg. -- | Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. | E 0035 | **E035: LTC and ICF/IID Sharing Plan with Patients**<br><br>**Corrective action:**<br>·The EPP plan will be discussed and shared with family members, the consumer, guardians and representatives of the consumers | 03/21/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| | Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., the facility was unable to provide documentation for a communication plan which includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives. Based on interview at the time of record review, the Site Supervisor stated the communication plan talks about contacting the families during an emergency but nothing in the plan talks about sharing information from the emergency plan with clients and their families or representatives. | | at their quarterly IDT meetings.<br>·QIDP-D will provide any updates to family members, the consumer, guardians and representatives of the consumers as the EPP is updated.<br>**Monitoring of Corrective Action**:<br>·The QIDP-D sends all IDT meeting forms to the QIDP and Program Manager for review and to ensure completion.<br><br>**Completion Date: 3/21/19** | |
| E 0039<br><br>Bldg. -- | 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/IID 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/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC 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 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, | E 0039 | **E039: EP Testing Requirements**<br><br>**Corrective action:**<br>·The facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually and will use the Mock Drill Form **(Attachment M)** for completion and proof of the exercise.<br>·Staff training to ensure the facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually and will use the Mock Drill Form **(Attachment M)** for completion and proof of the | 03/21/2019 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| | clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., documentation was for either a community-based or tabletop exercise drill was incomplete. Based on interview at the time of record review, the Site Supervisor provided documentation for an exercise but agreed the documentation failed to include what hazard the exercise practiced. | | exercise.<br>·Staff will be tested annual on the EPP. **(Attachment U)**<br><br>**Monitoring of Corrective Action**:<br>·Copies of the completed drills will be sent to the Program Manager and will also remain in the EPP binder in the facility.<br>·Completed staff tests will be kept in the EPP binder and will be sent to Human Resource to remain in staff file.<br><br>**Completion Date: 3/21/19** | |
| K 0000<br><br>Bldg. 02 | A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).<br><br>Survey Date: 02/19/19<br><br>Facility Number: 000775<br>Provider Number: 15G255<br>AIM Number: 100248960<br><br>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 | K 0000 | | |

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|---|---|---|---|
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|---|---|
| RES CARE COMMUNITY ALTERNATIVES SE IN | 154 CHAD DR<br>VERSAILLES, IN 47042 |

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|---|---|---|---|---|
| | Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.<br><br>This one story facility with a crawl space was fully sprinkled. This facility has a fire alarm system with smoke detection in the corridors, common living areas, and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey.<br><br>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.3.<br><br>Quality Review completed on 02/22/19 | | | |
| K S200<br><br>Bldg. 02 | NFPA 101<br>Means of Egress Requirements - Other<br>Means of Escape Requirements - Other<br>2012 EXISTING<br>List in the REMARKS section any LSC Section 33.2.2 Means of Escape 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.<br>Based on record review and interview, the facility failed to maintain at least 1 of 1 battery operated emergency light in accordance with 33.1.1.3. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows: | K S200 | **K0200: General Requirements - Other**<br><br>**Corrective action:**<br>·Maintenance Technician will complete monthly 30 second tests on emergency lights and document on the Emergency Light form.<br>·Program Manager created a | 03/21/2019 |

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|---|---|---|---|
| | 15G255 | A. BUILDING 02<br>B. WING | 02/19/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RES CARE COMMUNITY ALTERNATIVES SE IN | 154 CHAD DR<br>VERSAILLES, IN 47042 |

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|---|---|---|---|---|
| | (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds.<br>(2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction.<br>(3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered.<br>(4) The emergency lighting equipment shall be fully operational for the duration of the test.<br>(5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction.<br>This deficient practice could affect all occupants if the facility were required to evacuate in an emergency during a loss of normal power. 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 occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 at 11:23 a.m., no testing documentation for the annual battery operated emergency lights was available for review. Based on interview at the time of observation, the Site Supervisor stated he had no knowledge of when the annual battery emergency light test was performed and agree the documentation failed to | | form for the Maintenance Technician from Rescare to test the emergency lights monthly for 30 seconds and yearly for 90 minutes. **(Attachment O)**<br>·Program Manager informed the Maintenance Technician of the need for him to test the emergency lights for 30 seconds every month as well as a 90 minute test annually.<br><br>**Monitoring of Corrective Action**:<br>·Program Manager to review the Emergency Light form for completion of the monthly 30 second emergency light test for a at least 3 consecutive months.<br>·Management team will complete monthly site review checklist at each home. Team member completing the checklist will check to see the monthly 30 second emergency light test has been completed as well as the annual 90 minute test.<br>·Program Director, Program Manager, Executive Director, Nursing Manager and Quality Assurance Manager will perform Best in Class reviews at all locations within the year. The results will be shared with all team members.<br>·Program Manager will ensure the Area Supervisor has completed the weekly check to inspect the emergency lights.<br>·Maintenance technician will | |

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|---|---|---|---|
| | 15G255 | A. BUILDING 02<br>B. WING | 02/19/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RES CARE COMMUNITY ALTERNATIVES SE IN | 154 CHAD DR<br>VERSAILLES, IN 47042 |

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|---|---|---|---|---|
| | indicate an annual test. | | send monthly check of the emergency lights to the Program Director for monitoring and to ensure completion.<br>·Program Manager will contact Simplex Grinnell for all issues with the emergency lights at the facility.<br>·ResCare Administration will conduct monthly site reviews to ensure all emergency lights are inspected and operable.<br><br>**Completion Date:** 3/21/19 | |
| K S345<br><br>Bldg. 02 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Fire Alarm System - Testing and Maintenance<br>2012 EXISTING (Prompt)<br>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.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>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 | K S345 | **K0345:** Testing and Maintenance<br><br>**Corrective Action:**<br>·Program Manager contacted Simplex Grinnell to have documents of system inspections sent to Rescare to have them placed in the facility. | 03/21/2019 |

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|---|---|---|---|
| | 15G255 | A. BUILDING 02<br>B. WING | 02/19/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RES CARE COMMUNITY ALTERNATIVES SE IN | 154 CHAD DR<br>VERSAILLES, IN 47042 |

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|---|---|---|---|---|
| | 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NPFA 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 occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., no documentation for a smoke detector annual and sensitivity test was available for review. Based on interview at the time of record review, the Site Supervisor stated all the paperwork should be in the binder provided. | | ·Program Manager received documentation of the annual sensitivity testing that was completed on 9-4-18 **(Attachment P)**<br>·Program Manager will follow up with Simplex Grinnell to ensure all documents are received as completed and all inspections are completed as scheduled.<br><br>**Monitoring of Corrective Action:**<br>·Rescare Administration will complete monthly Site Reviews and send to the Program Director and Executive Director for monitoring of completion.<br>·Program Director will follow up on issues noted on the Site review and submit to the Program Manager for follow up on the issues.<br><br>**Completion Date: 3/21/19** | |
| K S353<br><br>Bldg. 02 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>2012 EXISTING (Prompt)<br>NFPA 13 and 13R Systems<br>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 | | | |

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|---|---|---|---|
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| RES CARE COMMUNITY ALTERNATIVES SE IN | 154 CHAD DR<br>VERSAILLES, IN 47042 |

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|---|---|---|---|---|
| | 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.<br>NFPA 13D Systems<br>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:<br>1. Control valves inspected monthly (NFPA 25, section 13.3.2).<br>2. Gauges inspected monthly (NFPA 25, section 13.2.71).<br>3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6).<br>4. Alarm devices tested semiannually (NFPA 25, section 5.3.3).<br>5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5).<br>6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1).<br>7. Visible pipe inspected annually (NFPA 25, section 5.2.2).<br>8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).<br>9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5).<br>10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2).<br>11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15).<br>12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). | | | |

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|---|---|---|---|
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|---|---|---|---|---|
| | 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).<br>14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4).<br>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).<br>A. Date sprinkler system last checked and necessary maintenance provided.<br>_____<br>B. Show who provided the service.<br>_____<br>C. Note the source of the water supply for the automatic sprinkler system.<br>_____<br>(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.)<br>33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 | | | |
| | 1. Based on observation and interview, the facility failed to replace sprinkler heads in 1 of 1 Front Entrance in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect all occupants.<br><br>Findings include: | K S353 | **K0353: Sprinkler System – Maintenance and Testing**<br><br>**Corrective action:**<br>·Program Manager contacted Simplex Grinnell to have one sprinkler head that is corroded in the front entrance.<br><br>**Monitoring of Corrective Action**:<br>·Program Manager to review Simplex Grinnell Reports for filing and follow-up if warranted.<br>·Program Manager will follow-up with Residential Manager to | 03/21/2019 |

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| | Based on observation with the Site Supervisor on 02/19/19 at 12:12 p.m., one sprinkler head was corroded in the Front Entrance. Based on interview at the time of observation, the Site Supervisor acknowledged and confirmed the sprinkler head was corroded.<br><br>2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 33.2.3.5.8. LSC 33.2.3.5.8.1-15 indicates inspection and testing frequencies as referenced in NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Site Supervisor on 02/19/19 at 11:16 a.m., no documentation was available for the quarterly inspections for second, third, and fourth quarter of 2018. Additionally, no documentation was available for control valve and gauges inspections. Based on interview at the time of record review, the Site Supervisor stated all the paperwork should be in the binder provided. | | ensure Simplex Grinnell has completed the replacement of the corroded sprinkler head.<br>·Program Director, Program Manager, Executive Director, HR Manager, Nursing Manager will perform Best in Class reviews at all locations within the year. The results will be shared with all team members.<br><br>**Completion Date: 3/21/19** | |
| K S363<br><br>Bldg. 02 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors shall meet all of the following requirements:<br>1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed.<br>2. No doors shall be arranged to prevent the occupant from closing the door.<br>3. Doors shall be self-closing or | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G255 | A. BUILDING 02<br>B. WING | 02/19/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RES CARE COMMUNITY ALTERNATIVES SE IN | 154 CHAD DR<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7<br>Based on observation and interview, the facility failed to ensure 1 of 5 client rooms doors had no impediment to closing and positively latched into the frame. This deficient practice could affect staff and at least 1 client.<br><br>Findings include:<br><br>Based on observation with the Site Supervisor on 02/19/19 between 10:50 a.m. and 12:02 p.m., bedroom #2 failed to latch into the frame when tested. Based on interview at the time of observation, the Site Supervisor agreed the bedroom door was not latching into the frame. | K S363 | **K0363:** Corridor-Doors<br><br>**Corrective Action:**<br>·Program Manager reached out to Rescare Maintenance Technician for repair of the 1 self closing doors.<br>·Maintenance Technician went to the home and was able to adjust the hinges on the 1 self closing doors and they will now shut and latch properly when the alarm is activated**. (Attachment Q)**<br>·Rescare Administration conducts Site reviews 2 times monthly to ensure all systems are working properly. **(Attachment R)**<br>**Monitoring of Corrective Action:**<br>·Program Director receives all complete maintenance requests for review and monitoring of completion.<br>·Site reviews will be sent to the Program Director for monitoring of noted issues and to ensure completion.<br>**Completion Date: 3/21/19** | 03/21/2019 |
| K S511 | NFPA 101<br>Utilities - Gas and Electric | | | |

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| | 15G255 | A. BUILDING 02<br>B. WING | 02/19/2019 |

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| RES CARE COMMUNITY ALTERNATIVES SE IN | 154 CHAD DR<br>VERSAILLES, IN 47042 |

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| Bldg. 02 | Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code.<br>32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2<br>Based on observation and interview, the facility failed to ensure 1 of 1 extension cord was not used as a substitute for fixed wiring according to 33.2.5.1. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observation with the Site Supervisor on 02/19/19 at 12:10 p.m., an extension cord was powering a DVD player and television. Based on interview at the time of observation, the Site Supervisor confirmed each electronic device was powered by the extension cord in use. | K S511 | **K0511:** Utilities- Gas and Electric<br><br>**Corrective Action:**<br>·Area Supervisor trained all staff in the home that there is not to be extension cords used in the home at any time. **(Attachment S)**<br>·Area Supervisor completes weekly check and will ensure no extension cords are in use in the facility. **(Attachment T)**<br>·Rescare Administration conducts Site reviews 2 times monthly to ensure all systems are working properly. **(Attachment R)**<br><br>**Monitoring of Corrective Action:**<br>·Area Supervisor will train monthly at house meetings to ensure staff are not using extension cords in the facility.<br>·Area Supervisor will send completed weekly check to the Program Manager for review and monitoring of completion.<br>·Site reviews will be sent to the Program Director for monitoring of noted issues and to ensure completion.<br><br>**Completion Date: 3/21/19** | 03/21/2019 |

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| | 15G255 | A. BUILDING 02<br>B. WING | 02/19/2019 |

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