STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G175	A. BUILDING -- B. WING	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3607 MIDDLE RD JEFFERSONVILLE, IN 47130

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/19/19 Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190 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. The facility has 7 certified beds. At the time of the survey, the census was 6. Quality Review completed on 02/22/19 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0009 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	E 0009	1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses notification of the Indiana State Department of Health during a disaster or emergency. 2.The area supervisor and program manager will train all staff	03/21/2019

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

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	participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional and the Program Manager on 02/19/19 between 2:40 p.m. and 3:20 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 Direct Support Professional and the Program Manager stated the plan is in the works but confirmed no cooperation and collaboration has been documented.		on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses notification of the Indiana State Department of Health during a disaster or emergency. 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues.	

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	15G175	A. BUILDING -- B. WING	02/19/2019

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RES CARE COMMUNITY ALTERNATIVES SE IN	3607 MIDDLE RD JEFFERSONVILLE, IN 47130

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E 0018 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. Findings include: Based on record review with the Direct Support Professional and the Program Manager on 02/19/19 between 2:40 p.m. and 3:20 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 Direct Support Professional and the Program Manager stated their tracking procedures and confirmed, after reviewing the facility's emergency preparedness plan, the stated tracking procedures are not documented in the emergency	E 0018	The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager **Completion Date: March 21, 2019** 1.The administrator will ensure the emergency plan policies and procedures addresses the tracking of staff and clients, whether they evacuate or shelter in place. Including the consideration of care and treatment needs of evacuees, staff responsibilities; transportation; identification of evacuation locations; and primary and means of communication with external assistance. 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness	03/21/2019

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	preparedness plan.		Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0024 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	E 0024	1.The emergency plan policies and procedures will be updated to include use of volunteers in an emergency or other emergency staffing strategies including the	03/21/2019

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	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. Findings include: Based on record review with the Direct Support Professional and the Program Manager on 02/19/19 between 2:40 p.m. and 3:20 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 Direct Support Professional and the Program Manager 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.		integration of State and Federal designated healthcare professionals to address surge needs during an emergency. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annually. 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area	

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			Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0034 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. Findings include: Based on record review with the Direct Support Professional and the Program Manager on 02/19/19 between 2:40 p.m. and 3:20 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 Direct Support Professional and the Program Manager were unaware of the regulation but confirmed nothing in the communication plan stated what means of information about the	E 0034	1.The administrator will ensure the emergency plan policies and procedures will be updated to include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction. 2.The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annually. 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of	03/21/2019

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	ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee the facility would employ.		where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
K 0000 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). Survey Date: 02/19/19 Facility Number: 000709 Provider Number: 15G175	K 0000		

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	AIM Number: 100243190 At this Life Safety Code survey, Res Care Community Alternatives Se In was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story 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 6 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-score of 1.3. Quality Review completed on 02/22/19			
K S345 Bldg. 02	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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility	K S345	1.The administrator will ensure	03/21/2019

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	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. 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. Findings include: Based on record review with the Direct Support Professional and the Program Manager on 02/19/19 at 2:45 p.m., no documentation for a smoke detector semi-annual, annual and sensitivity test was available for review. Based on interview at the time of record review, the Direct Support Professional and the Program Manager stated all the paperwork should be in the binder provided.		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. 2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate 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. 1.The Program Manager met with Koorsen Fire and Security on February 4, 2019 to ensure completion of required annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes was performed by Koorsen Fire and Security. 1.Eric Gray with Koorsen Fire and Security will email reports of the tests/inspections to the Program manager by upon completion by email.	
K S353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt)			

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	NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (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			

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	(NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	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. Findings include:	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 Program Manager for monitoring. The administrator will ensure monthly sprinkler gauge	03/21/2019

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	Based on record review with the Direct Support Professional and the Program Manager on 02/19/19 at 2:46 p.m., no documentation was available for the quarterly inspections for second, third, and fourth quarter of 2018. Based on interview at the time of record review, the Direct Support Professional and the Program Manager stated all the paperwork should be in the binder provided.		inspections and monthly control valve inspections are conducted by the ResCare maintenance coordinator, documentation will be maintained on site and a copy kept with ResCare Maintenance Manager. The program manager will conduct random monthly inspections to ensure monthly and quarterly inspections are being preformed as required. The Program Manager met with Koorsen Fire and Security on February 4, 2019 to ensure completion of required quarterly and annual sprinkler inspections are being completed as required. Eric Gray with Koorsen Fire and Security will email reports of the tests/inspections to the Program manager upon completion.	
K S511 Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric 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. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 power 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	K S511	1.The administrator will ensure all GFCI outlets in the facility interrupt power in the event of a ground fault as required in accordance with NFPA 70 Article	03/21/2019

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RES CARE COMMUNITY ALTERNATIVES SE IN	3607 MIDDLE RD JEFFERSONVILLE, IN 47130

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	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. Findings include: Based on observation with the Direct Support Professional and the Program Manager on 02/19/19 at 3:44 p.m., a surge protector was powering a microwave and toaster in the Kitchen. Based on interview at the time of observation, the Direct Support Professional and the Program Manager confirmed and removed the surge protector. 2. Based on observation and interview, the facility failed to ensure 1 of 2 bathroom sink was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and at least 3 clients. Findings include: Based on observation with the Direct Support Professional and the Program Manager on 02/19/19 at 3:42 p.m., bathroom #1 had one GFCI		210.8. 2.The maintenance coordinator will test and replace the GFCI receptacles that fail to interrupt power as required. 3.The maintenance coordinator has purchased Replacement GFCI outlets needed to repair non-working GFCI outlets identified during testing on March 7, 2019, and will be install retest and verify good operation before March 21, 2019. 4.The facility will ensure grounding of all electrical equipment the freezer in the garage was move to another wall outlet in order to provide power without bypassing ground by the program manager on February 19, 2019. Staff has been trained on this standard. 5.The facility will ensure multiplug adapters/surge protectors are not used in the facility. The Direct Support Professional on duty removed the surge protector on February 19, 2019 and train staff on this standard. 6.The Residential Manager will inspect house weekly to ensure GFCI outlets preform as required, no surge protectors or electrical equipment is bypassing ground. Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure no multiplug adapters/surge protectors are in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G175	A. BUILDING 02 B. WING	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	receptacle within three feet of the hand sink. When the GFCI tester button was pressed, power was not interrupted on the GFCI receptacle. Based on interview at the time of observation, the Direct Support Professional and the Program Manager confirmed the GFCI failed to trip. 3. Based on observation and interview, the facility failed to ensure grounding of 1 of 1 garage 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 250 Grounding and Bonding. This deficient practice could affect staff only. Findings include: Based on observation with the Direct Support Professional and the Program Manager on 02/19/19 at 3:40 p.m., a three prong to two prong adapter was used to power a freezer in the garage. Based on interview at the time of observation, the Direct Support Professional and the Program Manager confirmed and removed the adapter.		use and GFCI outlets are operating as required. The persons responsible will be the, Program Manager, Maintenance Manager, Area Supervisor, and Residential Manager	