STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING -- B. WING	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR 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: 03/11/20 Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510 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 8 certified beds. At the time of the survey, the census was 5. Quality Review completed on 03/18/20	E 0000		
E 0029 Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC). Based on record review and interview, the facility failed to maintain an emergency preparedness communication plan that complies with Federal, State, and local laws that was reviewed and	E 0029	1.The administrator will ensure the emergency preparedness plan is reviewed and updated annually. 2.Emergency Disaster	06/01/2020

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

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	updated at least every two years in accordance with 42 CFR 483.475(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency/Disaster Preparedness Manual on 03/11/20 between 10:30 a.m. and 12:00 p.m. with the Area Supervisor present, the emergency preparedness communication plan was last reviewed and updated on 02/10/18 which was more than 2 years since the last review and update. Based on interview at time of record review, the Area Supervisor confirmed the communication plan was review and updated over 2 years ago.		Preparedness Manual will be review Annually at a minimum by the Quality Assurance Manager to ensure all information remains up to date. **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP, Quality Assurance Department.	
E 0030 Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1) Names and Contact Information [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at			

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	§485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees.			

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	(ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants. Findings include:	E 0030	1.The administrator will ensure the emergency plan policies and procedures will be updated to include names and contact information for staff. 2.Due to screening and vetting of volunteers ResCare uses internal sources for assistance. ResCare's ResCare -On-Call Team (ROC) pulling from 54,000 current employees nationwide was developed to aid operations that	06/01/2020

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	Based on review of the Emergency/Disaster Preparedness Manual on 03/11/20 between 10:30 a.m. and 12:00 p.m. with the Area Supervisor present, there was no documentation to indicate the names and contact information for staff and volunteers. Based on an interview at the time of record review, the Area Supervisor agreed the Emergency/Disaster Preparedness Manual did not include a contact information list for staff and volunteers.		are in need of additional support and staffing that is activated by the Executive Director or subordinate Manager. All staff in the facility will be trained on the development of this program and its purpose. 3.The area supervisor and program manager will train all staff on the policies and procedures updates and the updates will be placed in the Emergency Disaster Preparedness Manual for reference as required. 4.Emergency Disaster Preparedness Manual will be review Annually at a minimum by the Quality Assurance Manager to ensure all information remains up to date. **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP, Quality Assurance Department.	
K 0000 Bldg. 03	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: 03/11/20 Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510 At this Life Safety Code survey, Res Care	K 0000		

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	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 not sprinkled. This facility has a fire alarm system with smoke detection on both levels including the corridors, common living areas, basement and all client sleeping rooms. The facility has a capacity of 8 and had a census of 5 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.44. Quality Review completed on 03/18/20			
K S100 Bldg. 03	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. Based on observation and interview, the facility failed to ensure 1 of 1 interior emergency light was tested, maintained, and the records of the testing maintained. 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	K S100	1.The facility will ensure emergency lighting will be tested monthly for a minimum of 30 seconds and an annual test of 90 minutes for all units in the facility. The program manager met with	06/01/2020

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	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: (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. (2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the test. (5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction. This deficient practice could affect all clients and staff. Findings include: Based on observations on 03/11/20 between 10:30 a.m. and 12:00 p.m. during a tour of the facility with the Area Supervisor, the facility had one battery powered emergency light unit. Based on record review between 10:30 a.m. and 12:00 p.m., there was no documentation to show the battery powered emergency light was tested for 30 seconds monthly during the past 12 months, plus, there was no documentation available for an annual 90 minute test during the past 12 months. Based on interview at the time of record review and observations, the Area Supervisor said she could not find any documentation to show a 30 second monthly test for the past 12 months, or an annual 90 minute test during the past 12 months.		Koorsen Fire and Security on May 15, 2020 to schedule annual 90 minute test of emergency lighting in the facility. Annual testing was completed in February 2020. **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP, Koorsen Fire and Security.	

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K S345 Bldg. 03	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 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system 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. This deficient practice could affect all clients and staff. Findings include: Based on record review on 03/11/20 between 10:30 a.m. and 12:00 p.m. with the Area Supervisor present, there was no documentation for an annual fire alarm system test/inspection during the past 12 months available for review. There was however a tag on the fire alarm control panel which indicated the fire alarm system had been inspected in February of 2020. Based on interview at the time of record review, the Program Manager acknowledged there was no documentation for an annual fire alarm system test/inspection during the past 12 months available for review other than the tag on the fire alarm control panel.	K S345	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. 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. 3.The Program Manager will meet with a representative from Koorsen Fire and Security, on May 15, 2020. The Facility will require schedule required testing and request copies of inspections	06/01/2020

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	2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients and staff. Findings include: Based on record review on 03/11/20 between 10:30 a.m. and 12:00 p.m. with the Area Supervisor present, no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months, furthermore, there was no documentation of an annual fire alarm system inspection during the past 12 months other than the tag on the fire alarm control panel dated February of 2020. Based on interview at the time of record review, the Program Manager acknowledged there was no documentation for a semi-annual visual fire alarm system test/inspection during the past 12 months available for review. 3. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems		and testing mailed to the program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany IN 47150. Persons Responsible: Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative.	

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	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 and staff. Findings include: Based on record review on 03/11/20 between 10:30 a.m. and 12:00 p.m. with the Supervisor present, there was no documentation available for a smoke detector sensitivity test for the past 24 month period. Based on interview at the time of record review, the Residential Manager acknowledged the lack of a smoke detector sensitivity test during the past 24 month period.			
K S363 Bldg. 03	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or 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.			

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	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 Based on observation and interview, the facility failed to ensure 4 of 5 client sleeping room doors would close completely and latch into their door frames. This deficient practice could affect all clients. Findings include: Based on observations on 03/11/20 between 10:30 a.m. and 12:00 p.m. during a tour of the facility with the Area Supervisor, all four client sleeping room doors on the west side of the house did not close completely and latch when tested in this non sprinklered home, furthermore, client sleeping room #4 (last door on west side of house) had a robe draped over the top of the door further preventing the door from closing. Based on interview at the time of observations, the Area Supervisor acknowledged the client sleeping room doors not closing completely and latching when tested.	K S363	1.The Program Manager will ensure clients bedroom doors positively latch to the frame. 2.The maintenance coordinator will ensure all clients bedroom doors will positively latch as required. 3.4 Bedroom doors will be repaired by ResCare Maintenance on April 3, 2020. 4.The Residential Manager will inspect house weekly to ensure bedroom doors positively latch. Area Manager will perform random monthly inspections and Program Manager will provide quarterly inspections to ensure bedroom doors positively latch to frame as required. 5.Staff will notify ResCare Maintenance upon discovery of any damage that prevents Clients Bedroom Doors from positively latching to the frame as required by calling 844-ResCare. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance Manager.	04/03/2020
K S511 Bldg. 03	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

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	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 Based on observation and interview, the facility failed to ensure 1 of 1 living room using power strips were used correctly. 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. Findings include: Based on observation on 03/11/20 between 10:30 a.m. and 12:00 p.m. during a tour of the facility with the Area Supervisor, there was a power strip plugged into another power strip laying on the floor in the living room. Based on interview at the time of observation, the Area Supervisor acknowledged the two power strips plugged together in the living room.	K S511	1. The Program Manager will ensure the use of power strips are in accordance with NFPA 70, 2011 Article 400.8 2. Power strips may be used in limited applications where all of the following conditions are met: a. Must be installed for indoor use only. b. The mounting of the device must be such that it does not require the use of tools to remove it. c. Must be limited to the connection of electrical loads in areas that have a “high concentration of low-powered loads” d. Must be connected to a permanently installed receptacle. e. Cannot be connected in a series or daisy-chained together. f. Cords for power strips cannot be routed through walls, windows, ceilings, floors or similar openings. g. Must be installed in a location where they are not subject to physical damage. h. Must be UL listed in accordance with UL1363 for Relocatable Power Taps. 3. All staff at the home will be trained the acceptable use of	04/01/2020

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			power strips and instructed to remove any power strip in violation. Area Supervisor will perform random monthly inspection to insure no violations are found. **Persons Responsible:** Program Manager, ResCare Maintenance. Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance Manager.	
K S741 Bldg. 03	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of area where cigarettes were smoked. This deficient practice could affect all clients. Findings include: Based on observation on 03/11/20 between 10:30 a.m. and 12:00 p.m. during a tour of the facility with the Area Supervisor, there were at least 50 cigarette butts on the ground at the smoking area at the rear of the house, furthermore, many cigarette butts were mixed with bunches of leaves in the yard and against the house. This was acknowledged by the Area Supervisor at the time	K S741	1.All staff at the home will be re-trained the Facilities smoking policy, and use of the designated smoking area and disposal of cigarette butts in an approved container. 2.Aramark was notified and leaves and other debris was removed from the smoking area on March 27, 2020. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance	03/27/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 03 B. WING	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR 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
	of observation.		Manager. **DATE OF COMPLETION: June 1, 2020**	