PRINTED: 10/07/2021 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		15G194	B. WING		09/08/2021		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
		-		ONEGATE			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	BEDFC	PRD, IN 47421			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
E 0000	REGULATORI ON	Lese identification	IAU		DATE		
L 0000							
Bldg							
Bidg	An Emanagement Duar	andrage Summer mag	E 0000				
		baredness Survey was	E 0000				
	-	diana Department of Health in					
	accordance with 42	CFR 483.475.					
	Survey Date: 09/08	3/21					
	Facility Number: 0						
	Provider Number:						
	AIM Number: 100	243320					
		Preparedness survey, Res Care					
	-	tives SE IN was found not in					
	-	nergency Preparedness					
	Requirements for M	ledicare and Medicaid					
	Participating Provid	lers and Suppliers, 42 CFR					
	483.475.						
	The facility has 8 co	ertified beds. At the time of the					
	survey, the census v	vas 7.					
	-						
	Quality Review con	npleted on 09/13/21					
		-					
	The requirement at	42 CFR, Subpart 483.475 is					
	NOT MET as evide	nced by:					
		2					
E 0039	403.748(d)(2), 416	6.54(d)(2), 418.113(d)(2),					
		2.15(d)(2), 483.475(d)(2),					
Bldg		102(d)(2), 485.625(d)(2),					
Diag.		727(d)(2), 485.920(d)(2),					
		1.12(d)(2), 494.62(d)(2)					
	EP Testing Requi						
		18.113(d)(2), §441.184(d)(2),					
		32.15(d)(2), §483.73(d)(2),					
	• • • • •	484.102(d)(2), §485.68(d)(2),					
		485.727(d)(2), §485.920(d)					
	(2), §491.12(d)(2)	, §494.62(d)(2).					

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: YVIV21

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 09/08/2021 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop YVIV21 Event ID: Facility ID: 000724 Page 2 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 09/08/2021 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct YVIV21 Event ID: Facility ID: 000724 Page 3 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G194	(X2) MULTIPLE CC A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2021	
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP C	OD	
RES CA	RE COMMUNITY	ALTERNATIVES SE IN		ONEGATE PRD, IN 47421		
(X4) ID	1	Y STATEMENT OF DEFICIENCIE	ID	,		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH	IOULD BE	COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
		an annual full-scale exercise				
	that is communit					
		munity-based exercise is not				
		luct an annual individual,				
		nctional exercise; or				
		Hospital, CAH] experiences				
		or man-made emergency	1			
		ivation of the emergency				
		is exempt from engaging in				
		full-scale community based				
		ility-based functional exercise				
		set of the emergency event.				
	-	an [additional] annual				
		hat may include, but is not				
	limited to the foll					
		I-scale exercise that is				
	community-base					
		nctional exercise; or				
		ock disaster drill; or				
	. ,	op exercise or workshop that				
	• •	ator and includes a group				
	discussion, using	C 1				
		t emergency scenario, and a				
		atements, directed				
	· ·	epared questions designed				
	to challenge an e					
	-	the [facility's] response to	1			
	and maintain do	cumentation of all drills,				
	tabletop exercise	es, and emergency events				
		acility's] emergency plan, as				
	needed.					
	*[For PACE at §4	460.84(d):1				
		PACE organization must				
		es to test the emergency				
	plan at least ann					
		st do the following:				
	-	an annual full-scale exercise				
	that is communit					
		munity-based exercise is not				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED 09/08/2021		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			115 ST	ADDRESS, CITY, STATE, ZIP C ONEGATE DRD, IN 47421	COD		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETIO	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	activation of the e is exempt from e full-scale commu- facility-based fun- onset of the eme (ii) Conduct an a that may include following: (A) A second full community-base facility-based fun- (B) A mock disas (C) A tabletop ex- led by a facilitato discussion, using clinically-relevan set of problem st messages, or pre- to challenge an e (iii) Analyze the I maintain docume exercises, and ei the ICF/IID's eme *[For HHAs at §4 (d)(2) Testing. Th exercises to test least annually. Th following: (i) Participate in a	emergency plan, the ICF/IID ngaging in its next required nity-based or individual, ctional exercise following the rgency event. dditional annual exercise , but is not limited to the -scale exercise that is d or an individual, ctional exercise; or ster drill; or ercise or workshop that is r and includes a group g a narrated, t emergency scenario, and a atements, directed epared questions designed emergency plan. CF/IID's response to and entation of all drills, tabletop mergency plan, as needed. -84.102] he HHA must conduct the emergency plan at he HHA must do the a full-scale exercise that is					
	is not accessible	community-based exercise , conduct an annual -based functional exercise					
	(B) If the HI natural or man-m activation of the exempt from eng	HA experiences an actual nade emergency that requires emergency plan, the HHA is aging in its next required nity-based or individual,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 09/08/2021 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. YVIV21 Event ID: Facility ID: 000724 Page 9 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 15G194 B. WING 09/08/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 115 STONEGATE **RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility E 0039 10/08/2021 Residential Manager and staff will failed to conduct at least two exercises to test the be trained on tabletop drills per emergency plan at least annually. The ICF/IID emergency preparedness plans. facility must do the following: A tabletop drill will be conducted. Area Supervisor will review drill (i) Participate in an annual full-scale exercise that is community-based; or schedule monthly to ensure that a. When a community-based exercise is not tabletop drill is completed per accessible, conduct an annual individual, schedule facility-based functional exercise. b. If the ICF/IID facility experiences an actual Persons responsible: Residential natural or man-made emergency that requires Manager, Area Supervisor, activation of the emergency plan, the ICF/IID **Program Manager** facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Or conduct an exercise that may include, but is not limited to the following: a. A full-scale exercise that is community-based or YVIV21 Facility ID: 000724 Event ID: Page 10 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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10/07/2021

	R MEDICARE & MEDIC						OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION		TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			CON	COMPLETED	
		15G194	B. WING			09/08/2021		
NAME OF				STREET A	ADDRESS, CITY, STATE, ZIP C	COD		
NAME OF 1	PROVIDER OR SUPPLIEF	x			ONEGATE			
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		BEDFO	RD, IN 47421			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COF	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETIC	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	an individual, facili	ity-based functional exercise.						
	b. A mock disaster	drill; or						
	c. A tabletop exerci	ise or workshop that is led by a						
	facilitator that inclu	ides a group discussion led by						
	a facilitator, using a	a narrated, clinically relevant						
	emergency scenario	o, and a set of problem						
	statements, directed							
	questions designed							
	plan.							
	(iii) Analyze the IC							
	maintain document							
	exercises, and emer							
	ICF/IID facility's en							
	accordance with 42	2 CFR 483.475(d)(2). This						
	deficient practice co	ould affect all occupants.						
	Findings include:							
	Based on review of	the facility's Emergency						
	Preparedness Plan	on 09/08/21 between 12:40 p.m.						
	and 1:50 p.m. with	the House Manager present,						
	the facility provide	d emergency preparedness						
	documentation, how	wever it was incomplete. There						
		provided of the facility's						
	response to the CO	VID-19 Public Health						
		er, the facility was unable to						
	-	tion of an additional exercise						
		e emergency preparedness						
	-	erview at the time of record						
		Manager acknowledged she						
	-	ide documentation of an						
		of choice and stated one had						
	not been conducted	not been conducted.						
	This finding was re	wiewed with the House						
	Manager at the exit							
0000								
3ldg. 02								

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

X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 09/08/2021 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE A Life Safety Code Recertification Survey was K 0000 conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/08/2021 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 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 was sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, sleeping rooms, common living areas & heat detection in the attic. The facility has a capacity of eight and had a census of seven 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 0.96. Quality Review completed on 09/13/21 K S345 **NFPA 101** Fire Alarm System - Testing and Bldg. 02 Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained

X2) MULTIPLE CONSTRUCTION

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Event ID: YVIV21

21 Facility ID: 000724

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PRINTED: 10/07/2021 FORM APPROVED OMB NO. 0938-039

X3) DATE SURVEY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/07/2021 FORM APPROVED

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	<u>02</u>	(X3) DATE SURVEY COMPLETED 09/08/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.7.5, 9.7.7, 9.7.8, 1) Based on record a facility failed to ens system was maintain Section 9.6. Section system shall be insta accordance with the NFPA 72, National 2010 Edition, Section inspections, testing, provided that includ information requests include information or location and test a could affect all clier Findings include: Based on record rev p.m. to 1:50 p.m. wi documentation of th annual initiating dev within the most rece not available for review results of visual and fire alarm boxes and most recent twelve a	an approved program e requirements of NFPA 70, code, and NFPA 72, n and Signaling Code. acceptance, maintenance adily available. and NFPA 25 review and interview, the ure 1 of 1 manual fire alarm and in accordance with n 9.6.1.3 states a fire alarm alled, tested and maintained in applicable requirements of Fire Alarm Code. NFPA 72, on 14.6.2.4 states a record of all and maintenance shall be es all the applicable ed. Device test results shall such as device type, address result. This deficient practice atts, staff and visitors.	K \$345	Residential manager will be inserviced on obtaining routine reports from service provider to keep in emergency preparedne book for review, update inspect forms will be obtained from ser provider. Area Supervisor will review emergency preparedne book monthly to ensure reports are updated as needed Addendum information: To con the deficient practice superviso staff have been trained on ensu- the service providers complete inspections needed in a timely manner. ResCare will obtain a schedule from the service prov as to when all inspections are scheduled to be completed, an track via inspection tracking for The area supervisor will review update the tracking form for all inspections due and ensure all inspections have been complet and documentation is obtained least monthly. Ongoing monitoring will be achieved by monthly maintenance inspectio list to include the dates of all inspections. The supervisory s will review monthly for accurac	10/08/202 b c c c c c c c c c c c c c c c c c c c	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 09/08/2021 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 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 09/08/21 from 12:40 p.m. to 1:50 p.m. with the House Manager present, no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months. Based on interview at the time of record review, the House Manager acknowledged there was no documentation for a semi-annual visual fire alarm system test/inspection during the past 12 months available for review. These findings were reviewed with the House Manage at the exit conference. K S353 **NFPA 101** Sprinkler System - Maintenance and Testing Bldg. 02 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of YVIV21 Facility ID: 000724 Event ID: Page 14 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 09/08/2021 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, YVIV21 Facility ID: 000724 Page 15 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE A. BUILDING B. WING	COMI	(X3) DATE SURVEY COMPLETED 09/08/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREE 115 S BEDF	D		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	(NFPA 25, section 13. Control valit their full range are annually (NFPA 2 14. Operating se lubricated annual 13.3.4). 15. Dry pipe sy unheated portion inspected, tested section 13.4.4). A. Date sprinkler necessary mainter B. Show who pro- C. Note the source automatic sprinkler (Provide in REM. coverage for any automatic sprinkler 33.2.3.5.3, 33.2.3 and NFPA 25 1. Based on record facility failed to pro- other evidence the had been inspected LSC 4.6.12.1 requires system required for maintained in accord for the Inspection, Water-Based Fire 4.3.1 requires record inspections, tests,	solutions are tested annually on 5.3.4). ves are operated through and returned to normal 25, section 13.3.3.1). stems of OS&Y valves are lly (NFPA 25, section estems extending into s of the building are and maintained (NFPA 25, system last checked and enance provided. vided the service. ce of the water supply for the er system. ARKS information on non-required or partial	K \$353	Residential manager wil inserviced on obtaining reports from service pro- keep in emergency prep book for review, update forms will be obtained fr provider. Area Supervis review emergency prep- book monthly to ensure are updated as needed Addendum information: the deficient practice su staff have been trained	routine vider to paredness inspection om service sor will aredness reports To correct pervisory	10/08/202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING		(X3) DATE SURVEY COMPLETED 09/08/2021		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDEORD IN 47421				
RES CA (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C authority having ju requires that recor performed (e.g., in the organization th results, and the da waterflow alarm d quarterly to verify damage. NFPA 2: waterflow alarm d to, water motor go 5.3.3.2 requires va switch-type waterfl tested semiannuall affect all clients, s Findings include: Based on review of sprinkler system in 1:10 p.m. with the was no second qua quarterly sprinkler for review. During record review, the	ALTERNATIVES SE IN (STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>OR LSC IDENTIFYING INFORMATION</u> urisdiction upon request. 4.3.2 ds shall indicate the procedure aspection, test, or maintenance), nat performed the work, the te. NFPA 25, 5.2.5 requires that evices shall be inspected they are free of physical 5, 5.3.3.1 requires the mechanical evices including, but not limited mgs, shall be tested quarterly. me-type and pressure flow alarm devices shall be by. This deficient practice could taff, and visitors in the facility. If the facility's quarterly spection records on 09/08/21 at Home Manager present, there arter (April, May, June) of 2021 • system inspections available g an interview at the time of Home Manager said there were akler syssstem inspection			DRD, IN 47421 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) the service providers completions needed in a timeled manner. ResCare will obtain schedule from the service pro- as to when all inspections are scheduled to be completed, a track via inspection tracking for The area supervisor will revier update the tracking form for a inspections due and ensure a inspections have been compliand documentation is obtained least monthly. Ongoing monitoring will be achieved b monthly maintenance inspect list to include the dates of all inspections. The supervisory will review monthly for accuration	te all y a ovider and form. w and all eted ad at y a tion	(X5) COMPLETIC DATE
	reports available for 2. Based on record facility failed to pro- other evidence the had been inspected LSC 4.6.12.1 requires system required for maintained in accor- requirements. Spri- maintained in accor- for the Inspection, Water-Based Fire 4.3.1 requires record	· ·					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 09/08/2021 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all clients, staff, and visitors in the facility. Based on record review on 09/08/2021 from 12:40 p.m. to 1:50 p.m. with the House Manager present, there was no current annual backflow device inspection report available to review. There was an annual inspection dated 02/07/2018 that indicated the next inspection to be 02/2019. Based on interview at the time of record review, the House Manager stated she had no additional documentation available for review at the time of the survey. These findings were reviewed with the House Manager at the exit conference. K S511 **NFPA 101** Utilities - Gas and Electric Bldg. 02 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 Residential manager and staff will K S511 10/08/2021 YVIV21 Event ID: Facility ID: 000724 Page 18 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 09/08/2021 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 115 STONEGATE **RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure 2 of 2 flexible cords in the north be trained on reporting bedrooms were not used as a substitute for fixed maintenance issues and use of wiring according to 33.2.5.1. LSC 33.2.5.1 states surge protectors. Area Supervisor utilities shall comply with Section 9.1. LSC 9.1.2 will conduct monthly site survey to requires electrical wiring and equipment shall be in ensure maintenance requests accordance with NFPA 70. National Electrical have been followed up on and Code. NFPA 70, 2011 Edition, Article 400.8 reported requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute Persons responsbile: Residential for fixed wiring of a structure. This deficient manager, Area Supervisor and practice could affect four clients in the north **Program Manager** bedrooms. Findings include: Addendum information: **To** correct the deficient practice Based on observations during a tour of the home the light fixture has been with the House Manager on 09/08/21 from 1:55 repaired and all surge p.m. to 2:08 p.m. the bedroom of DH & TS had protectors have been removed. electrical equipment plugged into and powered by a powerstrip. Additionally, the bedroom of AS & MM had electrical equipment plugged into and powered by a powerstrip. Based on interview at the time of observation, the House Manage agreed electrical equipment was plugged into powerstrips at the aforementioned locations. 2. Based on observation and interview, the facility failed to ensure 1 of 1 junction boxes located in the pantry were protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect all clients at staff. Findings include: Based on observations on 09/08/21 between 1:55 p.m. and 2:08 p.m. during a tour of the facility with the House Manager, there was a ceiling light in the pantry hanging down by the electrical wires. YVIV21 Facility ID: 000724

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				ON	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>02</u>		COMPLETED	
		15G194	B. W.	ING		09/08	/2021
	NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				ADDRESS, CITY, STATE, ZIP COD ONEGATE IRD, IN 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIEN			DATE
	Based on interview	at the time of observation, the					
	House Manager stat	ted she was unaware that the					
	light was hanging fi	rom the ceiling and would have					
	it repaired as soon as possible. The findings were reviewed with the House						
	Manager during the	exit conference.					

YVIV21 Facility ID: 000724