STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING COMPLETED 06/28/202			D	
NAME OF I	PROVIDER OR SUPPLIE	R	1306	EET ADDRESS, CITY, STATE, ZIP COD 6 S BLOOMINGTON STREET EENCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	D BE CC	(X5) OMPLETION DATE
E 0000						
Bldg	conducted by the I accordance with 42 Survey Date: 06/2 Facility Number: Provider Number: AIM Number: 202 At this Emergency Inc. was found not Preparedness Required Medicaid Participator CFR 483.475 The facility has 20 certified for Medicaid the census was 20.	8/22 013405 15G811 1267570 Preparedness survey, Res-Care in compliance with Emergency sirements for Medicare and string Providers and Suppliers, 42 certified beds. All 20 beds are said. At the time of the survey,	E 0000			
E 0039 Bldg	403.748(d)(2), 41 441.184(d)(2), 48 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requ §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § (2), §491.12(d)(2 *[For ASCs at §4 OPO, "Organizati	6.54(d)(2), 418.113(d)(2), 6.54(d)(2), 483.475(d)(2), 6.102(d)(2), 485.625(d)(2), 6.727(d)(2), 485.920(d)(2), 6.112(d)(2), 494.62(d)(2) irements 6.18.113(d)(2), §441.184(d)(2), 6.82.15(d)(2), §483.73(d)(2), 6.484.102(d)(2), §485.68(d)(2), 6.485.727(d)(2), §485.920(d)				

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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZUL121 Facility ID: 013405 If continuation sheet Page 1 of 14

PRINTED: 07/20/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC					OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	<u></u>	COMPI	LETED
		15G811	B. W	'ING		06/28	/2022
NAME OF	PROVIDER OR SUPPLIEI	R		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI	E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	JATE	DATE
	§491.12, and ESF	RD Facilities at §494.62]:					
	exercises to test t	facility] must conduct the emergency plan cility] must do all of the					
	(i) Participate in a	full-scale exercise that is					
		l every 2 years; or					
	1	munity-based exercise is					
	1 ' '	onduct a facility-based					
		e every 2 years; or					
		ility] experiences an actual					
	` '	ade emergency that requires					
		emergency plan, the [facility]					
		ngaging in its next required					
	1	or individual, facility-based					
	1	e following the onset of the					
	actual event.	3					
		lditional exercise at least					
	` '	posite the year the full-scale					
		cise under paragraph (d)(2)					
		is conducted, that may					
		limited to the following:					
		scale exercise that is					
		l or individual, facility-based					
	functional exercis						
	(B) A mock disast	·					
	, ,	ercise or workshop that is					
		and includes a group					
	discussion using	- ·					
	_	emergency scenario, and a					
	1	atements, directed					
		pared questions designed					
	to challenge an e	•					
	_	acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
		ergency plan as needed					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet Page 2 of 14

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	JILDING	NSTRUCTION	(X3) DATE COMPL	ETED
		15G811	B. Wl	NG		06/28/	'2022
NAME OF P	PROVIDER OR SUPPLIER		•	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NEARLOS CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
TAG	*[For Hospices at (2) Testing for hose the patient's home conduct exercises plan at least annuthe following: (i) Participate in a community based (A) When a commaccessible, condubased functional et (B) If the hospice man-made emergof the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disassing (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an erecises to test the conduction of the community of the	418.113(d):] spices that provide care in e. The hospice must s to test the emergency sally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. dditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed		TAG			DATE
		an annual full-scale exercise					1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZULI21

Facility ID: 013405

If continuation sheet Page 3 of 14

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 06/28/2022	
NAME OF	PROVIDER OR SUPPLIE	R		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	that is community (A) When a commaccessible, conducted facility-based functional exercise emergency event (ii) Conduct an atthat may include, following: (A) A second full community-based functional exercise (B) A mock disast (C) A tabletop extendilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the maintain docume exercises, and enthe hospice's emergency semantal for the property of the pr	nunity-based exercise is not uct an annual individual ctional exercise; or experiences a natural or gency that requires activation plan, the hospice is aging in its next required nity based or facility-based se following the onset of the ct. dditional annual exercise but is not limited to the desercise that is dor a facility based se; or ster drill; or sercise or workshop led by a ludes a group discussion clinically-relevant ario, and a set of problem sted messages, or prepared to challenge an enospice's response to and intation of all drills, tabletop mergency events and revise ergency plan, as needed.		TAG	DEFICIENCY)		DATE
	conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community	s to test the emergency ar. The [PRTF, Hospital, e following: an annual full-scale exercise					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet Page 4 of 14

PRINTED: 07/20/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15G811	B. WING		06/28	/2022	
NAME OF	PROVIDER OR SUPPLIEI	8		ADDRESS, CITY, STATE, ZIP COD	•		
RES-CA				BLOOMINGTON STREET NCASTLE, IN 46135			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	<u> </u>		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE	
1110		uct an annual individual,	1.1.0			Bille	
		ctional exercise; or					
	1	Hospital, CAH] experiences					
		or man-made emergency					
		vation of the emergency					
	1	is exempt from engaging in					
		ull-scale community based					
	or individual, facil	ity-based functional exercise					
	following the onse	et of the emergency event.					
	(ii) Conduct	an [additional] annual					
	exercise or and the	nat may include, but is not					
	limited to the follo	•					
	(A) A second full-scale exercise that is						
	community-based						
	-	ctional exercise; or					
	1 ' '	ock disaster drill; or					
	` '	p exercise or workshop that					
	1	tor and includes a group					
	discussion, using						
		emergency scenario, and a					
		atements, directed					
		pared questions designed					
	to challenge an e						
	1 ' ' '	he [facility's] response to					
		umentation of all drills,					
	1	s, and emergency events					
	needed.	cility's] emergency plan, as					
	needed.						
	*[For PACE at §4	60 84(d)·1					
	-	PACE organization must					
	1 ' '	s to test the emergency					
	plan at least annu						
	organization must	•					
	_	an annual full-scale exercise					
	that is community						
	,	nunity-based exercise is not					
		ict an annual individual,					

FORM CMS-2567(02-99) Previous Versions Obsolete

facility-based functional exercise; or

(B) If the PACE experiences an actual natural

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet

Page 5 of 14

PRINTED: 07/20/2022

						I KINTED.	01/20/2022	
DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FORM A	PPROVED	
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED)	
		15G811	B. WI	NG		06/28/202	2	
NAME OF PROVIDER OR SUPPLIER RES-CARE INC				1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	

X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	or man-made emergency that requires			
	activation of the emergency plan, the PACE			
	is exempt from engaging in its next required			
	full-scale community based 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 individual, 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.			
	(iii) Analyze the PACE's response to and			
	maintain documentation of all drills, tabletop			
	exercises, and emergency events and revise			
	the PACE's emergency plan, as needed.			
	*[For LTC Facilities at §483.73(d):]			
	(2) The [LTC facility] must conduct exercises			
	to test the emergency plan at least twice per			
	year, including unannounced staff drills using			
	the emergency procedures. The [LTC facility,			
	ICF/IID] must do the following:			
	(i) Participate in an annual full-scale exercise			
	that is community-based; or			
	(A) When a community-based exercise is not			
	accessible, conduct an annual individual,			
	facility-based functional exercise.			
	(B) If the [LTC facility] facility experiences an			
	actual natural or man-made emergency that			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet Page 6 of 14

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

PRINTED: 07/20/2022 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	1 '	ILDING	NSTRUCTION	(X3) DATE COMPI 06/28	LETED
	OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
	LTC facility is exerequired a full-scalindividual, facility following the onset (ii) Conduct an athat may include, following: (A) A second full community-based based functional (B) A mock disast (C) A tabletop extended by a facilitation discussion, using clinically-relevant set of problem staressages, or preto challenge an et (iii) Analyze the [response to and all drills, tabletop events, and revise emergency plan, *[For ICF/IIDs at (2) Testing. The Itexercises to test to twice per year. The following: (i) Participate in a that is community (A) When a community (A) When a community (B) If the ICF/IID on a control of the exercise is exempt from er is exempt from er	ster drill; or sercise or workshop that is r includes a group a narrated, emergency scenario, and a atements, directed epared questions designed mergency plan. [LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. §483.475(d)]: CF/IID must conduct the emergency plan at least ne ICF/IID must do the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet Page 7 of 14

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/28/2022	
NAME OF P	PROVIDER OR SUPPLIEF	R		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility-based fund	tional exercise following the					
	onset of the emer						
	1 ' '	ditional annual exercise					
	I	but is not limited to the					
	following:						
	1 ' '	scale exercise that is					
	community-based						
	1	etional exercise; or					
	(B) A mock disast	er drill, or ercise or workshop that is					
		and includes a group					
	discussion, using	• .					
	_	emergency scenario, and a					
	set of problem sta	•					
	•	pared questions designed					
	to challenge an er	·					
	_	CF/IID's response to and					
		ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	=					
	1 ' ' ' '	e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:	full cools avenues that is					
		full-scale exercise that is					
	community-based	; or ommunity-based exercise					
	1 ' '	conduct an annual					
		based functional exercise					
	every 2 years; or.						
	1	A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
		tional exercise following the					
	onset of the emer						
	(ii) Conduct an ad	ditional exercise every 2					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet Page 8 of 14

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

PRINTED: 07/20/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 	COM	TE SURVEY PLETED 28/2022	
NAME OF I	PROVIDER OR SUPPLIEI		1306 S	ADDRESS, CITY, STATE, ZIP C BLOOMINGTON STREI NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	functional exercis of this section is conclude, but is not (A) A second community-based facility-based function (B) A mock discontinuous (C) A tabletor is led by a facilitated discussion, using clinically-relevant set of problem statemessages, or preto challenge an election (iii) Analyze the Hemaintain document exercises, and enthe HHA's emergent (ii) Conduct a papor workshop at lease exercise is led by group discussion, relevant emergency plantactual natural or requires activation OPO is exempt for required testing enthe of the emergency (ii) Analyze the Omaintain document in the conduct of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction is not the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iii) Analyze the Omaintain document in the conduction of the emergency (iiii) Analyze the Omaintain document in the conduction of the emergency (iiii) Analyze the Omaintain document in the conduction of the emergency (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	limited to the following: full-scale exercise that is lor an individual, ctional exercise; or isaster drill; or p exercise or workshop that tor and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. HA's response to and ntation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct he emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ints, directed messages, or ins designed to challenge an lif the OPO experiences an man-made emergency plan, the om engaging in its next xercise following the onset				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet

Page 9 of 14

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	l í	ILDING		COMPL	
		15G811	B. WI	NG		06/28	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	2			BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	OPO's] emergency plan, as					
	needed.						
	*[DNOUL at \$40'	7.401.					
	*[RNCHIs at §403						
		e RNHCI must conduct					
	RNHCI must do the	he emergency plan. The					
		er-based, tabletop exercise					1
		A tabletop exercise is a					
	-	led by a facilitator, using a					
		r-relevant emergency					
	-	et of problem statements,					
		s, or prepared questions					
		enge an emergency plan.					
	_	NHCI's response to and					
		ntation of all tabletop					
	exercises, and em	nergency events, and revise					
		rgency plan, as needed.					
	Based on record rev	view and interview, the facility	E 00)39	Managers and Maintenance s	taff	07/18/2022
	failed to conduct ex	tercises to test the emergency			were retrained on the following	g:	
	plan at least twice p	per year. The ICF/IID facility			Testing. The [facility] must		
	must do the followi	_			conduct exercises to test the		
		annual full-scale exercise that			emergency plan annually. The		
	is community-based				[facility] must do all the followi	ng:	
		ity-based exercise is not			(i) Participate in a full-scale		
	·	an annual individual,			exercise that is community-ba	sed	
	facility-based funct				every 2 years; or		
		cility experiences an actual			(A) When a community-based		
		le emergency that requires			exercise is not accessible,	'	
		nergency plan, the ICF/IID			conduct a facility-based functi	onal	
		om engaging its next required ty-based or individual,			exercise every 2 years; or	on	
		cale functional exercise for 1			(B) If the [facility] experiences	dII	1
	-	onset of the actual event.			actual natural or man-made emergency that requires activ	ation	1
		itional exercise that may			of the emergency plan, the	auun	
		imited to the following:			[facility] is exempt from engag	ina	
	a. A second full-sca	9			in its next required	ıı ıy	
		or an individual, facility-based			community-based or individua	ıl	
	functional exercise.				facility-based	,	
	b. A mock disaster				functional exercise following the	he	
ı	1 311 41545001	, ·-	1		i		Î.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet

Page 10 of 14

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

PRINTED: 07/20/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/28/2022	
NAME OF P	ROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	c. A tabletop exercifacilitator that inclusing a facilitator that inclusing a emergency scenarior statements, directed questions designed plan. (iii) Analyze the IC maintain documentate exercises, and emer ICF/IID facility's eraccordance with 42 deficient practice conficient practice conficient practice conficient practice of Technician on 06/28 11:38 a.m. the facility documentation of it Public Health Emerdocumentation of a test the emergency interview at the times	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION se or workshop that is led by a des a group discussion led by narrated, clinically-relevant , and a set of problem messages, or prepared to challenge an emergency F/IID facility's response to and ation of all drills, tabletop gency events, and revise the nergency plan, as needed in CFR 483.475(d)(2). This ould affect all occupants. w with the Maintenance 8/22 between 10:05 a.m. and tty was able to provide s response to the COVID-19 gency, however, there was no second exercise of choice to preparedness plan. Based on the of record review, the	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) onset of the actual event. (ii) Conduct an additional exe at least every 2 years, opposi the year the full-scale or funct exercise under paragraph (d) of this section is conducted, the may include, but is not limited the following: (A) A second full-scale exerci that is community-based or individual, facility-based funct exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a grou discussion using a narrated, clinically relevant emergency scenario, and a set of probler statements, directed message or prepared questions design challenge an emergency plan (iii) Analyze the [facility's] response to and maintain	p DATE DATE Troise te te tional (2)(i) nat I to se ional p n es, ed to
K 0000 Bldg. 01	who stated no exerc test the Emergency This finding was re Technician at the tin	viewed with the Maintenance	K 0000	documentation of all drills, tabletop exercises, and emergency events, and revise [facility's] emergency plan, as needed.	
	accordance with 42 Survey Date: 06/28	CFR 483.470(j).			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet Page 11 of 14

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED		
		15G811	B. WING		_	06/28/2022		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				BLOOMINGTON STREET			
RES-CARE INC			1	GREENCASTLE, IN 46135				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRE				
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION Facility Number: 013405			TAG	DEFICIENCE		DATE	
	Provider Number: 0							
	AIM Number: 2012							
	Allvi Nuilloet. 2012	207370						
	At this Life Safety Code survey, Res-Care Inc.							
		mpliance with Requirements						
		Medicaid, 42 CFR Subpart						
	_	ety from Fire and the 2012						
	edition of the National Fire Protection Association							
		afety Code (LSC), Chapter 33,						
	Existing Residential Board and Care Occupancies and with 410 IAC 9, Community Residential							
	Facilities for Persons with Developmental							
	Disabilities.							
	This one story facility with a partial basement was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection on all							
	*	ent sleeping rooms, corridors						
		areas. The attic is protected						
	_	nkler system. The facility has						
	the capacity for 20 a	and had a census of 20 at the						
	time of this survey.							
	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 1.32.						
	Quality Review con	npleted on 06/29/22						
K S100	NFPA 101							
	General Requirem	nents - Other						
Bldg. 01	General Requirem							
	2012 EXISTING							
		RKS section any LSC						
		3.2 General Requirements						
		ssed by the provided						
		ficient. This information,						
along with the applicable Life Safety Code or								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet Page 12 of 14

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

PRINTED: 07/20/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811		iultiple construction uilding <u>01</u> ving		(X3) DATE SURVEY COMPLETED 06/28/2022	
NAME OF PROVIDER OR SUPPLIER RES-CARE INC			STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
IAU	NFPA standard con Form CMS-25 Based on observatifailed to document extinguishers locat to maintenance at it year. LSC 33. 1.1. Chapter 4, General requires any device condition, arranger fire-resistive constraction requiring periodic to ensure its maintenance at integration of the partial basement or label securely at and year the maintenance at integration or label securely at and year the maintenance at integration or label securely at and year the maintenance at integration or label securely at and year the maintenance at integration or label securely at and year the maintenance identifies the person identifies the name work. This deficient the partial basement Findings include: Based on observation Technician during a.m. to 10:05 a.m. extinguisher locate affixed maintenance on interview at the Maintenance Technical care at the maintenance on the partial basement on interview at the Maintenance Technical care at the maintenance on interview at the Maintenance Technical care at the maintenance on the partial basement on interview at the Maintenance Technical care at the maintenance on the partial basement on interview at the Maintenance Technical care at the maintenance on the partial basement of the partial basement of the partial basement on the partial basement of the partial	itation, should be included 67. on and interview, the facility 1 of 8 portable fire ed in the facility was subjected intervals of not more than one 3 states the provisions of , shall apply. LSC 4.6.12.4 e, equipment, system, ment, level of protection, ruction, or any other feature testing, inspection, or operation enance shall be tested, ted as specified in applicable NFPA 10, the Standard for guishers, 2010 Edition, Section extinguishers shall be subject to ervals of not more than one chydrostatic test, or when ed by an inspection. Section re extinguisher shall have a tag tached that indicates the month enance was performed, in performing the work, and of the agency performing the at practice could affect staff in int. on with the Maintenance a tour of the facility from 9:45 on 06/28/22, the portable fire d in the basement had an the tag or label documenting the was September 2019. Based time of observation, the incian confirmed the portable the basement had annual	KS	100	Maintenance Technician and Managers were retrained aborequirement for any device, equipment, system, condition, arrangement, level of protectic fire-resistive construction, or a other feature requiring perioditesting, inspection, or operated specified in applicable NFPA standards. NFPA 10, the Stanfor Portable Fire Extinguishers 2010 Edition, Section 7.3.1.1 states fire extinguishers shall subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indic by an inspection. Section 7.3. states each fire extinguishers have a tag or label securely attached that indicates the more and year the maintenance was performed, identifies the person performing the work, and identifie name of the agency performed the work. Maintenance Techn will assure all fire extinguisher are maintained as required. Program manager will verify maintenance has been complete.	on, iny c on to oe as dard s, be ated 3 hall onth s on tifies rming ician	07/18/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZULI21

Facility ID: 013405

If continuation sheet Page 13 of 14

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

PRINTED: 07/20/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		15G811	B. WING		06/28/2022		
NAME OF PROVIDER OR SUPPLIER RES-CARE INC			STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	This finding was re Technician at the ex	viewed with the Maintenance cit conference.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZULI21 Facility ID: 013405 If continuation sheet Page 14 of 14