

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

PRINTED: 09/13/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G449		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 08/30/2021	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260			
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E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 08/30/21</p> <p>Facility Number: 000963 Provider Number: 15G449 AIM Number: 100244740</p> <p>At this Emergency Preparedness survey, Community Alternatives-Adept was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475.</p> <p>The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 6.</p> <p>Quality Review completed on 09/02/21</p> <p>The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:</p>		E 0000				
E 0006  Bldg. --	<p>403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2)</p> <p>Plan Based on All Hazards Risk Assessment</p> <p>§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2),</p>						

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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	<p>§460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>*[For LTC facilities at §483.73(a):]</p>						

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	<p>Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan which was based on a facility-based and community-based risk assessment, utilizing and all-hazards approach that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(a). In the Survey &amp; Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards</p>		E 0006	<p><b>CORRECTION:</b></p> <p><i>The emergency preparedness plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. Specifically, the facility will update its emergency preparedness plan to include the risks of emerging infectious diseases in its community-based risk assessment.</i></p>		09/29/2021	

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E 0026  Bldg. --	<p>approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual Delbrook" documentation dated 11/15/20 and "Emergency, Disaster, Evacuation Plans &amp; Response" documentation dated 12/09/19 with the Maintenance Aide during record review from 1:10 p.m. to 2:45 p.m. on 08/30/21, the facility-based and community-based risk assessment documentation did not include emerging infectious diseases. Based on interview at the time of record review, the Maintenance Aide agreed the facility-based and community-based risk assessment documentation did not include emerging infectious diseases.</p> <p>This finding was reviewed with the Maintenance Aide during the exit conference.</p> <p>403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7)</p> <p>Roles Under a Waiver Declared by Secretary</p> <p>§403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7).</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency</p>			<p><b>PREVENTION:</b></p> <p>Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p>			

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	<p>preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]</p> <p>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.</p> <p>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual Delbrook" documentation</p>			E 0026	<p><b>CORRECTION:</b> <i>[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan. Specifically, the facility will incorporate the following policies into its emergency preparedness plan: The role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency</i></p>		09/29/2021

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E 0037  Bldg. --	<p>dated 11/15/20 and "Emergency, Disaster, Evacuation Plans &amp; Response" documentation dated 12/09/19 with the Maintenance Aide during record review from 1:10 p.m. to 2:45 p.m. on 08/30/21, the emergency preparedness plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview at the time of record review, the Maintenance Aide agreed the plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act.</p> <p>This finding was reviewed with the Maintenance Aide during the exit conference.</p> <p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at</p>			<p>management officials.</p> <p><b>PREVENTION:</b></p> <p>Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p>			

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	<p>§416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency</p>						

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	<p>preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p>						



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	<p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p>						

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	<p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p>						

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	<p>Based on record review and interview, the facility failed to ensure staff received training in regards to emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual Delbrook" documentation dated 11/15/20 and "Emergency, Disaster, Evacuation Plans &amp; Response" documentation dated 12/09/19 with the Maintenance Aide during record review from 1:10 p.m. to 2:45 p.m. on 08/30/21, the facility lacked documentation of staff training on the emergency preparedness plan within the most recent two year period. Based on interview at the time of record review, the Maintenance Aide stated staff training documentation on emergency preparedness policies and procedures within the most recent two year period was not available for review at the time of the survey.</p> <p>This finding was reviewed with the Maintenance Aide during the exit conference.</p>		E 0037	<p><b>CORRECTION:</b></p> <p><i>The facility must have a training program on place with (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.</i></p> <p>Specifically, the facility will provide an emergency preparedness training program that includes the following. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; and provide emergency preparedness training at least annually; and maintain documentation of the training; and demonstrate staff knowledge of emergency procedures.</p> <p>The QIDP Manager will work with the agency Training Coordinator to develop a specific emergency preparedness curriculum, including competency testing, that will be presented during new-hire orientation as will be included in</p>		09/29/2021	

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260			
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E 0039  Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d) (2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d) (2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d) (2), §494.62(d)(2).			the operation's annual retraining requirements. Development of the curriculum is in progress and will be completed by 9/29/21. <b>PREVENTION:</b> Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety Committee will review and revise the plan as needed but no less than annually. <b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Safety Committee, Human Resources Department, Operations Team, Regional Director			

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	<p>*[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]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(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.</p> <p>(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.</p>						

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	<p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[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.</p>						

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	<p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that 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.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan</p>						

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	<p>twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] 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 full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p>						



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	<p>(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; or (B) If the PACE experiences an actual natural 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.</p> <p>(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.</p> <p>(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.</p> <p>*[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</p>						

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	<p>exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator 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.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is</p>						

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	<p>not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID 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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual</p>						

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	<p>natural or man-made emergency that requires activation of the emergency plan, the HHA 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.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(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</p>						

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	<p>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.</p> <p>(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.</p> <p>*[ RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(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.</p> <p>(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.</p> <p>Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event;</p>	E 0039	<p><b>CORRECTION:</b></p> <p><i>The [facility] must conduct exercises to test the emergency plan at least annually.</i></p> <p>Specifically, the agency's Quality Assurance Department has submitted a formal request to the Indianapolis Metropolitan Police Department/Department of Homeland Security Community Emergency Response Team (CERT) to conduct an initial "table talk" disaster exercise, with bi-annual exercises thereafter. Additionally the ResCare Quality</p>			09/29/2021	

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	<p>(ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual Delbrook" documentation dated 11/15/20 and "Emergency, Disaster, Evacuation Plans &amp; Response" documentation dated 12/09/19 with the Maintenance Aide during record review from 1:10 p.m. to 2:45 p.m. on 08/30/21, documentation of a community based disaster drill within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Aide agreed the facility is currently experiencing an actual natural emergency due to Covid-19 and Covid-19 policy and procedures currently in effect for the pandemic are stated in the emergency preparedness documentation but agreed the facility has not conducted a second community based disaster drill or conducted a tabletop exercise within the most recent twelve month period and agreed additional testing documentation was not available for review at the</p>		<p>Assurance Department has requested assistance from the IMPD District Commander to coordinate with CERT to facilitate this process. ResCare Facility supervisors, the QIDP and administrative level management (Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will participate in the exercises to assure facility emergency preparedness protocols are consistent with community emergency management practices. The facility will develop documentation of the activation of the Emergency Preparedness Plan during the 2020-2021 COVID-19 epidemic, by 9/29/21 using the current state of emergency as a platform. At the time of this exercise, a "table talk exercise will be scheduled with local emergency management officials within 6 months of the full-scale event.</p> <p><b>PREVENTION:</b> Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate</p>				

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K 0000  Bldg. 01	<p>time of the survey.</p> <p>This finding was reviewed with the Maintenance Aide during the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 08/30/21</p> <p>Facility Number: 000963 Provider Number: 15G449 AIM Number: 100244740</p> <p>At this Life Safety Code survey, Community Alternatives - Adept 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.</p>		K 0000	<p>reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components, including but not limited to bi-annual community-based disaster exercises, are present. Additionally, the agency Safety Committee will review and revise the plan as needed but no less than annually.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G449		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 08/30/2021	
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K S100  Bldg. 01	<p>This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has heat detectors installed in the attic. The facility has a capacity of 6 and had a census of 6 at the time of this survey.</p> <p>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 0.2.</p> <p>Quality Review completed on 09/02/21</p> <p>NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING</p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier doors which were arranged to self close or automatic close with fire alarm system activation would resist the passage of smoke. LSC Section 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC Section 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. This deficient</p>		K S100	<p><b>CORRECTION:</b> <i>The facility will ensure that portable appliances are used in a safe condition to limit fire development. Specifically, the facility will repair the self-closing dining room smoke barrier door to assure that it latches properly.</i></p> <p><b>PREVENTION:</b> The Residential Manager or designee will incorporate checks for unapproved appliances and other devices into the facility's monthly Home Environment Safety</p>		09/29/2021	



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K S222  Bldg. 01	<p>practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Aide during a tour of the facility from 2:15 p.m. to 2:35 p.m. on 08/30/21, the smoke barrier door in the dining room, which was held open with a wall mounted magnetic holding device set to release with fire alarm system activation, failed to fully self close and latch into the door frame when tested to close multiple times and would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Aide agreed the smoke barrier door would not resist the passage of smoke when tested to close and latch into the door frame.</p> <p>This finding was reviewed with the Maintenance Aide during the exit conference.</p> <p>NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks</p>			<p>Inspection. Additionally, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manger, and Assistant Nurse Manager) will incorporate visual checks of the facility to assure smoke barrier doors close properly to resisit the passage of smoke.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Operations Team</p>			

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	<p>complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 bedroom doors were arranged such that staff can rescue clients in an emergency if the pantry room door was locked. This deficient practice could affect one client and staff.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Aide during a tour of the facility from 2:15 p.m. to 2:35 p.m. on 08/30/21, the corridor door to the southwest bedroom had a lock on the door handle which could be released from inside the room but required a key to release the door lock from outside the room. The lock was operable when tested to lock. Based on interview at the time of the observations, the Maintenance Aide tried to find a key to unlock the door but agreed a key was not available on the premises to release the lock. The Maintenance Aide stated a former client wanted a lock on his bedroom door but he passed away within the last couple years and the lock had then not been taken off the door.</p> <p>This finding was reviewed with the Maintenance Aide during the exit conference.</p>			K S222	<p><b>CORRECTION:</b> <i>No door in any means of escape shall be locked against egress when the building is occupied. Specifically, the facility will remove the door lock to the southwest bedroom door.</i></p> <p><b>PREVENTION:</b> Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emergency egresses into scheduled monthly audits to assure prompt evacuation can occur.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p>		09/29/2021

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K S353  Bldg. 01	<p>NFPA 101 Sprinkler System - Maintenance and Testing 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 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:</p> <ol style="list-style-type: none"> <li>1. Control valves inspected monthly (NFPA 25, section 13.3.2).</li> <li>2. Gauges inspected monthly (NFPA 25, section 13.2.71).</li> <li>3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6).</li> <li>4. Alarm devices tested semiannually (NFPA 25, section 5.3.3).</li> <li>5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5).</li> <li>6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1).</li> <li>7. Visible pipe inspected annually (NFPA 25, section 5.2.2).</li> <li>8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).</li> <li>9. Buildings inspected annually prior to</li> </ol>						

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	<p>freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5).</p> <p>10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2).</p> <p>11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15).</p> <p>12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4).</p> <p>13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).</p> <p>14. Operating stems of OS&amp;Y valves are lubricated annually (NFPA 25, section 13.3.4).</p> <p>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).</p> <p>A. Date sprinkler system last checked and necessary maintenance provided.</p> <p>_____</p> <p>B. Show who provided the service.</p> <p>_____</p> <p>C. Note the source of the water supply for the automatic sprinkler system.</p> <p>_____</p> <p>(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.)</p> <p>33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with the minimum number of spare sprinklers in a spare sprinkler cabinet on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section</p>	K S353	<p><b>CORRECTION:</b></p> <p><i>The facility shall maintain a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any</i></p>	09/29/2021			

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	<p>5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Aide during a tour of the facility from 2:15 p.m. to 2:35 p.m. on 08/30/21, the spare sprinkler cabinet in the sprinkler riser room contained a total of five spare sprinklers. Based on interview at the time of the observations, the Maintenance Aide agreed the spare sprinkler cabinet contained less than six spare sprinklers.</p> <p>This finding was reviewed with the Maintenance Aide during the exit conference.</p>				<p><i>way can be promptly replaced.</i> Specifically, the facility will purchase an additional spare sprinkler to assure there are no less than six on hand.</p> <p><b>PREVENTION:</b> Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's spare sprinklers, to assure the facility maintains an inventory of no fewer than six.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Environmental Services Staff, Operations Team</p>		