STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G193	A. BUILDING -- B. WING	02/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13711 BENNETTSVILLE RD MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/19/19 Facility Number: 000723 Provider Number: 15G193 AIM Number: 100234760 At this Emergency Preparedness survey, Res Care Community Alternatives Se In was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 7 certified beds. At the time of the survey, the census was 7. Quality Review completed on 02/22/19 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0007 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.4753(a)(3). This deficient practice	E 0007	1.The facility maintains an The Emergency Plan that includes continuity of operations, delegation of authority and secession plans that deal with the client population. 1.All staff will be trained on the Emergency Plan delegation of	03/21/2019

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

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	could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., the emergency preparedness plan failed to address the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. Based on interview at the time of record review, the Residential Manager stated he could not find the aforementioned requirements after looking throughout the EPP.		authority, continuity of operations and secession plan. 1.Area Supervisor will ensure the EPP includes a copy of the continuity of operations, delegation of authority and secession plans that deal with the client population. 1.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 1.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues.	

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E 0009 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., no documentation was available to show the group home included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Based on interview at the time of record review, the Residential Manager confirmed no contact has been made and no cooperation and collaboration has been documented.	E 0009	The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager 1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses notification of the Indiana State Department of Health during a disaster or emergency. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses notification of the Indiana State Department of Health during a disaster or emergency. 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and	03/21/2019

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			document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0015 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance	E 0015	1.The administrator will ensure the emergency plan policies and procedures addresses the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, including but not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain – (A) Temperatures to protect resident health and safety and for the safe and sanitary	03/21/2019

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	with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on observation with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., the facility was unable to provide documentation for the policies and procedures for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place for the following: a) medical needs b) pharmaceutical needs c) emergency lighting d) sewage e) waste disposal Based on interview at the time of record review, the Residential Manager was unable to find documentation for the provision of all aforementioned subsistence needs while reviewing the facility's plan on substance needs.		storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will	

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			be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0018 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., no policies and procedures which include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency was available to review. Based on interview at the time of record review, the Residential Manager stated their tracking procedures and confirmed, after reviewing the facility's emergency preparedness plan, the stated tracking procedures are not documented in the emergency preparedness plan.	E 0018	1.The administrator will ensure the emergency plan policies and procedures addresses the tracking of staff and clients, whether they evacuate or shelter in place. Including the consideration of care and treatment needs of evacuees, staff responsibilities; transportation; identification of evacuation locations; and primary and means of communication with external assistance. 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained	03/21/2019

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			on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0022 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect	E 0022	1.The administrator will ensure the emergency plan policies and procedures addresses a means to shelter in place for staff, volunteers and clients who remain in the facility. Including but not limited to	03/21/2019

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	all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., the policy and procedure plan did not include a means to shelter in place for clients, staff, and volunteers who remain in the facility. Based on interview at the time of record review, the Residential Manager searched the facility's emergency preparedness plan and confirmed he was unable to find a policy and procedure plan for a means of shelter in place in the emergency preparedness plan.		the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain – (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program	

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			Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0023 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., no policies and procedures which include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records was available to review. Based on interview at the time of record review, the Residential Manager searched the facility's	E 0023	1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses a system of medical documentation of from the ICF/IID facility and includes consideration of maintaining protection of confidentiality of patient information and secures and maintains availability of records. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be	03/21/2019

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	emergency preparedness plan but confirmed that none of the policies and procedures indicate a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records.		monitored and reviewed for effectiveness at a minimum bi-annual 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0024 Bldg. --				

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	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., no policies and procedures which include the use of volunteers in an emergency or other emergency staffing strategies was available for review. Based on interview at the time of record review, the Residential Manager stated, after reviewing the emergency preparedness binder, the facility's emergency preparedness plan did not have a policy and procedure for the use of volunteers.	E 0024	1.The emergency plan policies and procedures will be updated to include use of volunteers in an emergency or other emergency staffing strategies including the integration of State and Federal designated healthcare professionals to address surge needs during an emergency. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area	03/21/2019

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			Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0025 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., no policies and procedures which include the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients was available for review. Based on interview at the time of record review, the Residential Manager stated he was	E 0025	1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses arrangements with other ICF/IID facilities and/or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services. 2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annually.	03/21/2019

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	unaware of any arrangements with other ICF/IID facilities to receive clients.		4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0026 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID	E 0026	1.The administrator will ensure the table of contents for the emergency disaster preparedness	03/21/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., no policies and procedures which include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was available for review. Based on interview at the time of record review, the Residential Manager was unaware of what the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act.		manual is updated to include the location of the policy on the Roles of the facility Under a Waiver declared by Secretary is in the emergency preparedness manual. 2.The area supervisor and program manager will train all staff on the table of contents, the policy and procedure, where to locate the policy, and the policy will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annually. 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will	

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	15G193	A. BUILDING -- B. WING	02/19/2019

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RES CARE COMMUNITY ALTERNATIVES SE IN	13711 BENNETTSVILLE RD MEMPHIS, IN 47143

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			be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0032 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.475(c)(3). This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., no documentation about the communication plan which included (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies was available for review. Based on interview at the time of record review, the Residential Manager stated the facility's policy but later confirmed that the emergency preparedness plan does not include the aforementioned regulation.	E 0032	1.The method of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies will be place in the EPP by the Program Manager. 1.All staff will be trained on the method of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies. 1.Area Supervisor will ensure the EPP includes a copy the method of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies.	03/21/2019

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			1.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 1.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0033 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness	E 0033	1.The facility will maintain emergency plan policies and	03/21/2019

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	communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., no documentation was available for a communication plan which includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care. Based on interview at the time of record review, the Residential Manager searched the facility's emergency preparedness plan but confirmed the communication plan did not indicate a method for sharing information and medical documentation for clients under the ICF/IID facility's care.		procedures that complies with Federal, State and local laws that must be reviewed annually to include a method for sharing information and medical documentation for patients under the facility's care; a means of releasing patient information as permitted under 45 CFR 164.510(b)(1)(ii); a means of providing information general information and location of patients as permitted under 45 CFR 164.510(b)(1)(ii). 1.The Quality Assurance Department will ensure the EPP is reviewed and updated annually in accordance with Federal, State and local laws outlining a method for sharing information and medical documentation for patients under the facility's care; a means of releasing patient information as permitted under 45 CFR 164.510(b)(1)(ii); a means of providing information general information and location of patients as permitted under 45 CFR 164.510(b)(1)(ii). 1.The Program Manager, and Area Supervisor will ensure all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual	

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			and document the visit on the Home Visitor Sign In form located in each home. 1.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0034 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. Findings include:	E 0034	1.The administrator will ensure the emergency plan policies and procedures will be updated to include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction. 2.The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to	03/21/2019

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	Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., the facility was unable to provide documentation for a communication plan including a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee. Based on interview at the time of record review, the Residential Manager was unaware of the regulation and confirmed he was unable to find the aforementioned regulation in the communication plan.		provide assistance to the Authority Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annually. 4.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 5.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area	

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E 0035 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., the facility was unable to provide documentation for a communication plan which includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives. Based on interview at the time of record review, the Residential Manager stated the communication plan talks about contacting the families during an emergency but nothing in the plan talks about sharing information from the emergency plan with clients and their families or representatives.	E 0035	Supervisor, and Residential Manager 1.The administrator will ensure the emergency plan policies and procedures will be shared with patient's and guardians during annual meetings. The Emergency Plan will be made available for review at request of patients and guardians. 2.The administrator will ensure the emergency plan policies and procedures will be shared with patient's and guardians during annual meetings. The Emergency Plan will be made available for review at request of patients and guardians. 1.The QIDP, Area Supervisor and Program Manager will ensure the emergency plan policies and procedures is shared with patient's and guardians during annual meetings. 2.The Program Manager, and Area Supervisor will ensure a copy of the Emergency Preparedness Manual is available onsite and at ResCare Jeffersonville main office for patient and guardian review. The Area Supervisor will ensure staff have knowledge of where the Emergency Preparedness Manual is kept in the home and all its content updated. Upon visiting a	03/21/2019

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			home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. 3.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills 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	E 0039	1.The administrator will ensure the emergency plan policies and procedures includes the participation in a full-scale community based exercise and a table top exercise in accordance with CFR 483.475(d)(2) and present in the EPP manual. 2.To meet the requirements for the Emergency/Disaster Preparedness training, the facility	04/09/2019

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	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; (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. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., no documentation was available for either a community-based or tabletop exercise drill. One exercise was documented but failed to include the hazard for the exercise. Based on interview at the time of record review, the Residential Manager provided documentation for an exercise but agreed the documentation failed to include what hazard the exercise practiced.		must conduct mock drills twice a year. These should be conducted the same months other simulated drills are completed (January and July). **3.The Program Manager and Area Supervisor will ensure the facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually** **4.Area Supervisor will ensure Mock drill form is sent to the Program Manager for review and follow-up. Program Manager will forward Mock Drill to the QA department for review and filing.** **5.A community based full scale drill has been scheduled with local emergency responders and will be conducted on April 9, 2019.** 6.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be	

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			the, Program Manager, Area Supervisor, and Residential Manager	
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 02/19/19 Facility Number: 000723 Provider Number: 15G193 AIM Number: 100234760 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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 7 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, could not be determined at this time because no fire drills and F-1 forms were provided . LSC Chapter 32.2.1.2.2 states where such documentation is not furnished, the evacuation capability shall be	K 0000		

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	classified as Impractical. Quality Review completed on 02/22/19			
K S100 Bldg. 02	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to provide documentation to the authority having jurisdiction to be able to determine an evacuation assistance score in accordance with 33.2.1.2.2. LSC 33.2.1.2.2 states that facility management shall furnish to the authority having jurisdiction, upon request, an evacuation capability determination using a procedure acceptable to the authority having jurisdiction; where such documentation is not furnished, the evacuation capability shall be classified as impractical. This deficient practice could affect all occupants. Findings include: Based on observation with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., the facility was unable to provide the F1 worksheets used to rate the client and determine the client's overall need for assistance when requested. Based on interview at the time of observation, the Residential Manager stated he was new and said everything should be in the binder.	K S100	1.F1 Worksheets have been completed and will be uploaded for review. 2.The Program Manager, Area Supervisor and Residential Manager will ensure F1 Worksheets are available and updated as required. 3.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Area	03/08/2019

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			Supervisor, and Residential Manager	
K S345 Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NPFA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 at 1:51 p.m., no documentation for a smoke detector annual and sensitivity test was available for review. Based on interview at the time of observation, the	K S345	1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. 1.The Program Manager met with Koorsen Fire and Security on	03/21/2019

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	Residential Manager stated he was new and said everything should be in the binder.		February 4, 2019 to ensure completion of required annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes was performed by Koorsen Fire and Security. 1.Eric Gray with Koorsen Fire and Security will email reports of the tests/inspections to the Program manager by upon completion by email. 2.Uploaded smoke sensitivity test Koorsen will retest system on 3-25-2019	
K S353 Bldg. 02	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:			

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	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, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____			

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	B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 33.2.3.5.8. LSC 33.2.3.5.8.1-15 indicates inspection and testing frequencies as referenced in NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect all occupants. Findings include: Based on record review with the Residential Manager on 02/19/19 at 1:51 p.m., no documentation was available for the quarterly inspections for third, and fourth quarter of 2018. Additionally, no documentation was available for control valve and gauges inspections. Based on interview at the time of observation, the Residential Manager stated he was new and said everything should be in the binder.	K S353	The administrator will ensure Koorsen Fire and Security conducts quarterly sprinkler inspections and that the reports of the inspections are available in the facility for review and forwarded to the Program Manager for monitoring. The administrator will ensure monthly sprinkler gauge inspections and monthly control valve inspections are conducted by the ResCare maintenance coordinator, documentation will be maintained on site and a copy kept with ResCare Maintenance Manager. The program manager will conduct random monthly inspections to ensure monthly and quarterly inspections are being preformed as required. The Program Manager met with Koorsen Fire and Security on February 4, 2019 to ensure completion of required quarterly and annual sprinkler inspections	03/21/2019

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			are being completed as required. Eric Gray with Koorsen Fire and Security will email reports of the tests/inspections to the Program manager upon completion.	
K S359 Bldg. 02	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING (Impractical) All Impractical Evacuation Capability facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3. The system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 9.6, as modified below. The adequacy of the water supply shall be documented. In Impractical Evacuation Capability Facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in one-and-two-Family Dwellings and Manufactured Homes, with a 30 minute water supply, shall be permitted. All habitable areas and closets shall be sprinklered. Automatic Sprinklers shall not be required in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials provided a 15-minute thermal barrier. In Impractical Evacuation Capability Facilities up to and including four stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted.			

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	All habitable areas and closets shall be sprinklered. Automatic sprinklers shall not be required in bathrooms not exceeding 55 square feet provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected, by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6 by July 5, 2019. 2. Protected by automatic sprinkler system according to 9.7, by July 5, 2019. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.2, 33.2.3.5.3.5 through 33.2.3.5.3.7, 42 CFR 483.470(j)(1)(ii)			
	Based on record review and interview, the facility failed to install a 1 of 1 approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3. LSC 33.2.3.5.3 requires facilities with a impractical evacuation capability to be sprinklered in accordance with NFPA 13D. LSC 33.2.1.2.2 states that facility management shall furnish to the authority having jurisdiction, upon request, an evacuation capability determination using a procedure acceptable to the authority having jurisdiction; where such documentation is not furnished, the evacuation capability shall be classified as impractical. This deficient practice could affect all occupants.	K S359	The administrator will ensure Koorsen Fire and Security conducts quarterly sprinkler inspections and that the reports of the inspections are available in the facility for review and forwarded to the Program Manager for monitoring. The administrator will ensure monthly sprinkler gauge inspections and monthly control valve inspections are conducted by the ResCare maintenance coordinator, documentation will be	03/21/2019

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	Findings include: Based record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., the facility was unable to provide the F1 worksheets used to rate the client and determine the client's overall need for assistance when requested. Due to the lack of furnished F1 forms, the facility was classified as "Impractical" and was not provided with an approved, supervised automatic sprinkler system. Based on interview at the time of observation, the Residential Manager stated he was new and said everything should be in the binder.		maintained on site and a copy kept with ResCare Maintenance Manager. The program manager will conduct random monthly inspections to ensure monthly and quarterly inspections are being preformed as required. The Program Manager met with Koorsen Fire and Security on February 4, 2019 to ensure completion of required quarterly and annual sprinkler inspections are being completed as required. Eric Gray with Koorsen Fire and Security will email reports of the tests/inspections to the Program manager upon completion.	
K S363 Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15.			

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	33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure 1 of 6 client rooms doors positively latched into the frame. This deficient practice could affect staff and at least 1 client. Findings include: Based on observation with the Residential Manager on 02/19/19 at 1:56 p.m., bedroom #2 failed to latch into the frame when tested. Based on interview at the time of each observation, the Residential Manager agreed the bedroom door would not latch into the frame when tested.	K S363	1.The administrator will ensure clients bedroom doors positively latch to the frame. 2.The maintenance coordinator will ensure all clients bedroom doors will positively latch as required. 3.Bedroom #2 door will be repaired by ResCare Maintenance before March 21, 2019. 4.The Residential Manager will inspect house weekly to ensure bedroom Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure bedroom doors positively latch to frame as required. The persons responsible will be the, Program Manager, Maintenance Manager, Area Supervisor, and Residential Manager	03/21/2019
K S511 Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 Kitchen sink was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections	K S511	1.The administrator will ensure all GFCI outlets in the facility interrupt power in the event of a ground fault as required in	03/21/2019

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	9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect all occupants. Findings include: Based on observation with the Residential Manager on 02/19/19 at 2:00 p.m., the Kitchen had two receptacle within three feet of the hand sink. When the GFCI tester button was pressed, power was not interrupted on the receptacles. Based on interview at the time of observation, the Residential Manager agreed the the outlets were not tripping and stated he was unaware of the GFCI wiring situation. 2. Based on observation and interview, the facility failed to ensure 1 of 1 multiplug adapter was not used as a substitute for fixed wiring according to 33.2.5.1. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all occupants. Findings include:		accordance with NFPA 70 Article 210.8. 2.The maintenance coordinator will test and replace the GFCI receptacles that fail to interrupt power as required. 3.The maintenance coordinator has purchased Replacement GFCI outlets needed to repair non-working GFCI outlets identified during testing on March 7, 2019, and will be install retest and verify good operation before March 21, 2019. 4.The facility will ensure the removal of multiplug adapters in the facility and train staff on this standard. 5.The Residential Manager will inspect house weekly to ensure bedroom Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure no multiplug adapters are in use and GFCI outlets are operating as required. The persons responsible will be the, Program Manager, Maintenance Manager, Area Supervisor, and Residential Manager	

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	Based on observation with the Residential Manager on 02/19/19 at 2:02 p.m., a multiplug was powering computer components in Bedroom #5. Based on interview at the time of observation, the Residential Manager confirmed the multiplug adapter was being used and stated he was unaware of the issue.			
K S712 Bldg. 02	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct quarterly fire drills for 4 of 4	K S712	1.All staff at the home will be re-trained on conducting fire drills	03/21/2019

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	quarters in accordance with 42 CFR 483.470(i). 42 CFR 483.470(i) Standard: Evacuation drills. This deficient practice affects all staff and clients. Findings include: Based on record review with the Residential Manager on 02/19/19 between 1:45 p.m. and 1:53 p.m., there was no documentation fire drills available for review. Based on interview at the time of observation, the Residential Manager stated he was new and said everything should be in the binder.		quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date. 1.The Residential Manager will submit monthly drills to the QA Department upon completion. The QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required. 1.The Area supervisor will ensure drills are completed as required. 1.The program manager will conduct random monthly inspections to ensure drills are being completed as required. 1.The Program Manager conducted training at the Monthly Residential Managers Meeting on March 5, 2019 covering the standards and requirements of drills. 1.Monitoring of Corrective Action: A member of the Site	

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			Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. The persons responsible will be the, Program Manager, Maintenance Manager, Area Supervisor, and Residential Manager	