STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G107	A. BUILDING -- B. WING	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CAREY SERVICES INC	615 E NORTH ST HARTFORD CITY, IN 47348

(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 Department of Health in accordance with 42 CFR 483.475. Survey Date: 07/11/22 Facility Number: 000644 Provider Number: 15G107 AIM Number: 100234170 At this Emergency Preparedness survey, Carey Services Inc was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 7. Quality Review completed on 07/13/22 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0026 Bldg. --	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) Roles Under a Waiver Declared by Secretary §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). [(b) Policies and procedures. The [facilities] must develop and implement emergency			

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

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

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	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:] (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. *[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. Based on record review and interview, the facility failed to ensure emergency preparedness plan (EPP) 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. Findings include: Based on record review with the Residential Director on 07/11/22 at 12:00 p.m., the EPP was missing roles of the ICF/IID facility under a waiver	E 0026	· The policy is written with the understanding that the BOD may edit the policy which would require retraining. The policy indicates that The Safety Committee will review the HVAs (Policy 7.6.5) and associated plans including the EP Policy 7.2.8 at least annually as a regularly scheduled agenda item. The assessments and associated plans may be updated and / or reviewed more frequently if/as needed. We have also included our 7.2.5 Emergency Management Plan.	07/19/2022

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	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 Director stated the policy was not in the EPP and could not be found. This finding was reviewed with the Residential Director during the exit conference.		o *Documents: 7.2.5 Emergency Management Plan, 7.2.8 EP Policy*	
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 07/11/22 Facility Number: 000644 Provider Number: 15G107 AIM Number: 100234170 At this Life Safety Code survey, Carey Services Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR subpart 483.470(j), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was sprinklered. The facility has a fire alarm system with smoke detectors in the corridors and common living areas. Hard wired smoke detectors were in all client sleeping rooms. The facility did not have an attic. The facility has a capacity of 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score	K 0000		

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	(E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-score of 3.36. Quality Review completed on 07/13/22			
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 observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. LSC 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observation of the fire alarm control	K S345	· The Group Home Manager has contacted Koorsen Fire and Security and they are scheduled to come to the home on 7/28/2022. Addendum: Staff will document the date, time and time displayed on the FCP and report any discrepancies to the Group Home Manager. The Group Home Manager will review the document at least 3 times weekly to ensure compliance. *Documents : FCP Time Tracking Sheet*	07/19/2022

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	panel (FCP) with the Residential Manager on 07/11/22 at 11:01 a.m., the FCP did not display the correct time. The time displayed on the FCP was 11:55 a.m. when checked at 11:01 a.m. Based on interview at the time of observation, the Residential Manager agreed the FCP displayed the wrong time. The finding was reviewed with the Residential Manager during the exit conference.			