

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G536 | (X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____ | (X3) DATE SURVEY COMPLETED 06/05/2024 |
|--|---|--|--|---|
| NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA | | STREET ADDRESS, CITY, STATE, ZIP COD 1008 SHORT DRIVE KNOX, IN 46534 | | |
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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 483.73.</p> <p>Survey Date: 06/05/24</p> <p>Facility Number: 001050 Provider Number: 15G536 AIM Number: 100245380</p> <p>At this Emergency Preparedness survey, Cardinal Services Inc. of Indiana was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 8 certified beds, with a current census of 8.</p> <p>Quality Review completed on 06/10/24</p> | E 0000 | | |
| E 0004 Bldg. -- | <p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable</p> | | | |

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

TITLE

(X6) DATE

Alyx Bates

Residential Director

06/23/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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>Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</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 all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>.</p> <p>Based on record review and interview, the facility failed to review and update the Emergency</p> | E 0004 | On 6/17/24, the Residential Director updated the Emergency | 06/22/2024 |

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| E 0013 Bldg. -- | <p>Preparedness Plan (EPP) at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the facility's EPP with the Direct Support Professional (DSP) on 06/05/24 between 08:30 a.m. and 10:05 a.m., the facility failed to review and update the EPP every two years. The EPP had a revision date listed on the front page as May 2019. Based on an interview during records review, the DSP acknowledged the listed date of review was May of 2019 and was unsure if the EPP has been reviewed within the past two years.</p> <p>The finding was reviewed with the DSP during the exit conference.</p> <p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)</p> <p>Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency 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</p> | | <p>Preparedness Binder to include an updated Emergency Preparedness Plan (attachment A). This plan was also reviewed with staff on 6/18/24 (attachment B).</p> <p>To ensure this deficiency does not occur again, the Residential QDP and/or Residential Assistant Director will review the EPP Binder monthly or as needed to check for all appropriate documents until competency is demonstrated.</p> <p>Residential Supervisor and Residential QDP responsible.</p> | |

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| | <p>section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency 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 annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based</p> | | | |

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| E 0029 Bldg. -- | <p>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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) policies and procedures at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the facility's EPP with the Direct Support Professional (DSP) on 06/05/24 between 08:30 a.m. and 10:05 a.m., the facility failed to review and update the EPP's policies and procedures every two years. The EPP had a revision date listed on the front page as May 2019. Based on an interview during records review, the DSP agreed the listed date of review was May of 2019 and stated they were unsure if the EPP has been updated since then.</p> <p>The finding was reviewed with the DSP during the exit conference.</p> <p>403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c)</p> | E 0013 | <p>On 6/17/24, the Residential Director updated the Emergency Preparedness Binder to include an updated Emergency Preparedness Plan (attachment A). This plan was also reviewed with staff on 6/18/24 (attachment B).</p> <p>To ensure this deficiency does not occur again, the Residential QDP and/or Residential Assistant Director will review the EPP Binder monthly or as needed to check for all appropriate documents until competency is demonstrated.</p> <p>Residential Supervisor and Residential QDP responsible.</p> | 06/22/2024 |

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| E 0036 | <p>Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).</p> <p>(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) communication plan at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the facility's EPP with the Direct Support Professional (DSP) on 06/05/24 between 08:30 a.m. and 10:05 a.m., the facility failed to review and update the EPP's communication plan every two years. The EPP had and revision date listed on the front page as May 2019. Based on an interview during record review, the DSP agreed the listed date of review was May of 2019 and stated they were unaware if the EPP has been updated within the past two years.</p> <p>The finding was reviewed with the DSP during the exit conference.</p> <p>403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d),</p> | E 0029 | <p>On 6/17/24, the Residential Director updated the EPP Communication Plan (attachment A, pages 3-11). On 6/18/24 all of the staff in the home, including the Residential Supervisor and Residential DSPs were trained on this plan and their role during a crisis (attachment B).</p> <p>To ensure this deficiency does not occur again, the Residential Assistant Director will review the EPP Binder monthly or as needed to check for all appropriate documents until competency is demonstrated.</p> <p>Residential Supervisor and Residential QDP responsible</p> | 06/22/2024 |

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| Bldg. -- | <p>484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)</p> <p>EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program</p> | | | |

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| | <p>must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>Based on record review and interview, the facility failed to review and update the training and testing program at least every 2 years in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Direct Support</p> | E 0036 | On 6/17/24, the Residential Director updated the Emergency Preparedness Binder to include an updated Emergency Preparedness Plan (attachment A). The staff at Knox Group Home were trained on this plan on 6/18/24 (attachment B). | 06/22/2024 |

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| E 0037 Bldg. -- | <p>Professional (DSP) on 06/05/24 between 08:30 a.m. and 10:05 a.m., the EPP had a review date of May 2019 on the front page, no other date could be found to show the EPP's Training and Testing Plan was reviewed and updated within the last two years. Based on an interview during record review, the DSP acknowledged that the dates on the EPP were over two years old and was unsure when it has been last reviewed.</p> <p>This finding was reviewed with the DSP 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 §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>To ensure this deficiency does not occur again, the Residential QDP and/or Residential Assistant Director will review the EPP Binder monthly or as needed to check for all appropriate documents until competency is demonstrated.</p> <p>Residential Supervisor and Residential AD responsible.</p> | |

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| | <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 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</p> | | | |

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| | <p>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> <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,</p> | | | |

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| | <p>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> <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</p> | | | |

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| | <p>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. Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (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; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency</p> | E 0037 | <p>On 6/17/24, the Crisis Management and Business Continuity Plan (attachment A) was reviewed with the DSPs at the group home. This plan covers emergency preparedness policies and procedures, including the expected roles of the DSPs.</p> <p>To ensure this deficiency does not occur again, the Residential Assistant Director is creating a schedule for the home of when</p> | 06/22/2024 |

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| E 0039 Bldg. -- | <p>preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and 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 record review with the Direct Support Professional (DSP) on 06/05/24 between 08:30 a.m. and 10:05 a.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of record review, the DSP stated that they she had been trained on the EPP at orientation, however was unsure if other staff had been trained and also did not know where the documentation could be located.</p> <p>The finding was reviewed with the DSP during the exit conference.</p> <p>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).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at</p> | | <p>specific Emergency Preparedness documents should be reviewed.</p> <p>Residential Assistant Director Responsible.</p> | |

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| | <p>\$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</p> <p>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or 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 [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> | | | |

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| | <p>*[For Hospices at 418.113(d):]</p> <p>(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:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(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.</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 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>(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</p> | | | |

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| | <p>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):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan 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</p> | | | |

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| | <p>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> <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 PACE experiences an actual natural</p> | | | |

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| | <p>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:</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 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):]</p> <p>(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:</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.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that</p> | | | |

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| | <p>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 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,</p> | | | |

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| | <p>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 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</p> | | | |

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| | <p>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> <ul style="list-style-type: none"> (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <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> <ul style="list-style-type: none"> (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise | | | |

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| | <p>the [RNHCl's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCl must conduct exercises to test the emergency plan. The RNHCl must do the following:</p> <ul style="list-style-type: none"> (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCl's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCl's emergency plan, as needed. <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or <ul style="list-style-type: none"> a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional 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: <ul style="list-style-type: none"> a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or | E 0039 | <p>On 6/18/24, the Residential Assistant Director, QDPs, and Residential Supervisor were retrained on the requirement of having emergency preparedness drill completely timely. This training included reviewing the Drill Schedules (attachment C), which shows the due dates of both the tabletop drill and the drill. Furthermore, the Emergency Preparedness Activity Log (attachment D) was reviewed. A tabletop was completed on 06/18/24 (attachment E). To ensure this deficiency does not occur again, the Residential Assistant Director will review all drill and drill tracking paperwork to ensure compliance until competency is demonstrated. Residential</p> | 06/22/2024 |

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| K 0000 | <p>c. A tabletop exercise or workshop that is led by a facilitator 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.</p> <p>(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 record review with the Direct Support Professional (DSP) on 06/05/24 between 08:30 a.m. and 10:05 a.m., the following was not available for review:</p> <p>a) No documentation of an annual full-scale exercise that is community-based, a facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency.</p> <p>b) No documentation of an additional annual exercise of choice: a second full-scale exercise that is community-based, a facility-based functional exercise, a mock disaster drill, a tabletop exercise, or a workshop.</p> <p>Based on interview at the time of record review, the DSP stated they were unsure where the documentation could be and did not know if any drills have been conducted within the past year.</p> <p>This finding was reviewed with the DSP during the exit conference.</p> | | Director responsible. | |

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| Bldg. 02 | <p>A Life Safety Code Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 06/05/24</p> <p>Facility Number: 001050 Provider Number: 15G536 AIM Number: 100245380</p> <p>At this Life Safety Code survey, Cardinal Services Inc. of Indiana 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 32, New Residential Board and Care Occupancies.</p> <p>The one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, sleeping rooms and common living areas and heat detection in the attic. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> <p>, Quality Review completed on 06/10/24</p> | K 0000 | | |
| K S100 Bldg. 02 | <p>NFPA 101 General Requirements - Other General Requirements - Other 2012 NEW</p> <p>List in the REMARKS section any LSC Section 32.1 or 32.2 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> | | | |

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| | <p>Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 32. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept demonstrating that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/05/24 during the tour from 10:06 a.m. to 10:28 a.m. with the Direct Support Professional (DSP), the kitchen portable fire extinguisher had an affixed inspection and maintenance tag and lacked monthly inspection for the months of February through May 2024. Based on interview at the time of observation, the DSP confirmed the affixed maintenance tag did not have monthly signatures. She later indicated that the fire extinguisher is checked on a monthly basis</p> | K S100 | <p>On 6/18/24, the House Supervisor was retrained on the observation form, which includes a task item of checking the portable fire extinguishers monthly (attachment F)</p> <p>To ensure this deficiency does not occur again, the Residential Assistant Director will review all monthly observation forms until competency is demonstrated.</p> <p>House Supervisor and Residential Assistant Director responsible</p> | 06/22/2024 |

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| K S353 Bldg. 02 | <p>when fire drills are conducted, however the fire extinguisher may not have had inspections during those times or staff forgot to sign off on the tags.</p> <p>Findings were discussed with the DSP at exit conference.</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 NEW 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.</p> <p>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"> 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). | | | |

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| | <p>6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1)).</p> <p>7. Visible pipe inspected annually (NFPA 25, section 5.2.2).</p> <p>8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).</p> <p>9. Buildings inspected annually prior to 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&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>32.2.3.5.3, 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were tested and/or inspected in accordance with</p> | K S353 | On 6/20/24, the paperwork in the Emergency Preparedness Binder was reorganized. The inspections | 06/22/2024 |

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| | <p>NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on record review with the Direct Support Professional (DSP) on 06/05/24 between 08:30 a.m. and 10:05 a.m., the only sprinkler quarterly inspection produced during the survey was from October 2023 (fourth quarter). No other inspections were found at the time of the survey. When further investigation on the sprinkler riser, the most recent dated inspection tag was April 2024. Based on interview at the time of observation, the DSP acknowledged the missing inspection paperwork and further clarified she was unsure if the paperwork would be in the home or somewhere else.</p> <p>The finding was discussed with the DSP at exit conference.</p> <p>2. Based on record review and interview, the facility failed to maintain monthly inspection documentation for 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for</p> | | <p>had been completed as scheduled and the documentation was placed in the binder (attachment G).</p> <p>On 6/19/24 the House Supervisor was retrained that there should be a clear path to the sprinkler riser area in case of emergency.</p> <p>On 6/20/24 the sprinkler cover in the southeast bedroom was replaced.</p> <p>To ensure this deficiency does not occur again, the Residential QDP and/or Residential Assistant Director will review the EPP Binder monthly or as needed to check for all appropriate documents until competency is demonstrated.</p> <p>Residential Assistant Director and Maintenance team responsible.</p> | |

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| | <p>the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states an inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. This deficient practice could affect all clients and staff in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Direct Support Professional (DSP) on 06/05/24 between 08:30 a.m. and 10:06 a.m., there was no documentation of a monthly gauge and valve checks for the home's sprinkler system for the months of April and May of 2024. Based on an interview at the time of record review, the DSP acknowledged the missing inspections and stated that the Maintenance department are the ones to do those inspections and was unsure where else the documentation could be.</p> <p>Findings were discussed with the DSP at exit conference.</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler system riser was easily accessible and properly protected. NFPA 13, 2010 Edition, 9.3.4.1, Clearance shall be</p> | | | |

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| | <p>provided around all piping extending through walls, floors, platforms and foundations, including drains, fire department connections and other auxiliary piping. This deficient practice could affect all clients, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 06/05/24 between 10:06 a.m. and 10:28 a.m. with the Direct Support Professional (DSP) present, there were approximately three boxes of furnace filters and miscellaneous items that were placed in front of the sprinkler riser area which impeded access to the riser in an event of an emergency. Based on interview at the time of observation, the DSP confirmed that the sprinkler riser had been impeded from the boxes and they would have to be moved to another area.</p> <p>Findings were discussed with the DSP at exit conference.</p> <p>4. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 6 bedroom ceilings. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on observation with the Direct Support Professional (DSP) on 06/05/24 between 10:06 a.m. and 10:28 a.m., the Southeast bedroom contained</p> | | | |

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| K S511 Bldg. 02 | <p>one sprinkler head above a bed which did not have its cover plate installed. This exposed to inside sprinkler head which also contained penetrations inside the sprinkler head unit. This can cause delays for the activation of the fire suppression system. Based on interview at the time of observation, the DSP confirmed that the cover plate was off and further stated that she was unaware that it had been off and did not know how long it had been like that.</p> <p>Findings were discussed with the DSP at exit conference.</p> <p>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 NFPA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect approximately two clients and staff.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Direct Support Professional (DSP) on 06/05/24 between 10:06 a.m. and 10:28 a.m., the</p> | K S511 | <p>On 6/18/24, the staff at Knox Group Home were retrained on the importance of not plugging power strips into other power strips due to the fire hazard that this could cause. The house supervisor was also retrained on the Observation Form which has a prompt to look for unapproved use of power strips (attachment F).</p> <p>The 'daisy-chain' of power strips was removed on 6/20/24</p> <p>To ensure this deficiency does not occur again, the Residential Assistant Director will increase</p> | 06/22/2024 |

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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 |
| | <p>Northwest bedroom, next to the employee office, had a power strip that was used to power electronics that was plugged into and supplied power to another power strip. The second power strip was used to power a reclining chair. Based on interview at the time of observation, the DSP confirmed that the power strips were daisy chained and was unaware that it was an issue.</p> <p>Findings were discussed with the DSP at exit conference.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical panel in the facility were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B).</p> <p>(A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B).</p> <p>(B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all clients and staff</p> <p>Findings include:</p> <p>Based on observation with Direct Support Professional (DSP) on 06/05/24 between 10:06 a.m. and 10:28 a.m., the electrical panel in between the washer and dryers was unlocked when tested. The panel included breakers to the HVAC system, security system, client rooms, etc. Based on interview at the time of observation, the DSP</p> | | <p>oversight in the home to ensure power strips are being used appropriately until competency is demonstrated.</p> <p>Residential Assistant Director Responsible.</p> | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G536 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 06/05/2024 |
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| K S712 Bldg. 02 | <p>acknowledged that the breaker panel was unsecured and agreed that the panel could be accessed by clients within the home.</p> <p>The finding was reviewed with the DSP at exit conference.</p> <p>NFPA 101 Fire Drills Fire Drills</p> <p>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:</p> <ul style="list-style-type: none"> 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. <p>2. The facility must:</p> <ul style="list-style-type: none"> 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. <p>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.</p> <p>42 CFR 483.470(i)</p> <p>Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under</p> | K S712 | On 6/18/24, the QDPs, Residential Supervisors, and DSPs were retrained on the | 06/22/2024 |

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| | <p>varied conditions for 1 of 12 shifts. This deficient practice affects all staff and clients.</p> <p>Findings include:</p> <p>Based on interview at the time of record review with the Direct Support Professional (DSP) on 06/05/24 between 10:06 a.m. and 10:28 a.m., documentation for a first shift fire drill in the first quarter (January, February, or March) of 2024 was unable to be found during the survey. Based on interview during the survey, the DSP acknowledged that the fire drill was missing and further stated that the fire drill was marked completed on their schedules, however they were unsure why the documentation was not in the drill book.</p> <p>Findings were discussed with the DSP at exit conference.</p> | | <p>requirements to follow a drill schedule for each location (attachment C). Furthermore, they were retrained on the requirement to have drills on each shift as in the regulations.</p> <p>To ensure this deficiency does not occur again, the Residential Assistant Director will review all drill and drill tracking paperwork to ensure compliance until competency is demonstrated. QDP and Residential Assistant Director responsible</p> | |