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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G182	A. BUILDING -- B. WING	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICE ALTERNATIVES	2326 BERWICK DR SHELBYVILLE, IN 46176

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/14/23 Facility Number: 000715 Provider Number: 15G182 AIM Number: 100234640 At this Emergency Preparedness survey, Developmental Service Alternatives was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 02/23/23	E 0000		
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenna Metcalfe	Director of Quality Assurance	03/06/2023

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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	CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the 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. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop 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. (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. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (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. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or			

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	(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an			

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	actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (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 includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [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. *[For ICF/IIDs at §483.475(d)]: (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: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the 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			

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	full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (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. (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. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (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.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or 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. (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. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (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			

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	exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (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 RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	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 all of the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the 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 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: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.	E 0039	Program Director will conduct a full-scale tabletop exercise for all staff and consumers in the home by 3/12/2023. Area Director or designee to train Program Director on expectations for full-scale exercise and exercise of choice to take place yearly. Training to be completed by 3/12/2023. Program Director will conduct one full-size exercise and one exercise of choice yearly. Area Director will establish timeframes for exercises and confirm completion.	03/12/2023

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	b. A mock disaster drill; or 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. (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: During review of the emergency preparedness documentation on 02/14/23 between 12:40 p.m. and 1:30 P.M. and interview with the Program Director (PD) the facility lacked documentation of an actual emergency; a required full-scale exercise; and a second exercise of choice during the past year. Based on interview at the time of record review, the PS was not aware of any documentation which would verify an actual emergency; a required full-scale exercise and a second exercise of choice during the past year This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).	K 0000		

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	Survey Date: 02/14/23 Facility Number: 000715 Provider Number: 15G182 AIM Number: 100234640 At this Life Safety Code survey, Developmental Service Alternatives 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 two story building with a basement was determined to be nonsprinklered. The facility has a fire alarm system with smoke detection on all levels in corridors and in all living areas. The facility has a capacity of 6 and had a census of 6 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.4. Quality Review completed on 02/23/23			
K S100 Bldg. 01	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.			

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	Based on observation, records review, and interview, the facility failed to ensure all portable fire extinguishers located in the facility was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33. 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 to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations and interview on 02/14/23 during a tour of the facility between 1:30 p.m. and 2:00 p.m. with the Program Director (PD), 3 of 3 fire extinguishers in the home had affixed inspection and maintenance tags that were not complete. Furthermore, fire extinguishers located on the second floor behind the corridor door had an annual inspection tag from the facilities vendor dated 2/21, making it 2 years past the current month and year. Based on records review no	K S100	**Program Director will ensure monthly inspections of all fire extinguishers in the home. This will be completed by 3/12/23.** **Area Director or designee to train Program Director on expectation to complete monthly fire extinguisher checks. Training by 3/12/2023.** **Koorsen will return to home to update tags. Annual was completed by Koorsen on 2/3/2023, but they failed to provide updated tags. Visit to be scheduled prior to 3/12/2013.** **Fire extinguisher in laundry room has been placed in mount. Program Director to train staff on fire extinguisher placement by 3/12/2023.**	03/12/2023

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	other documentation was provided to show the aforementioned fire extinguishers were inspected monthly. This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference.			
K S331 Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING (Prompt) Interior wall and ceiling finish in accordance with section 10.2. In Prompt Evacuation Capability facilities, Class A, Class B, or Class C is permitted. There are no requirements for interior floor finish. 33.2.3.3, 33.2.3.3.3 Based on observation and interview, the facility failed to ensure the interior finish in the dining area was rated Class A, Class B or Class C for a Prompt rated facility. This deficient practice could affect all occupants. Findings include: Based on observations and interview on 02/14/23 during a tour of the facility between 1:30 p.m. and 2:00 p.m. with the Program Director (PD), the walls in the dining area were covered with wood paneling approximately 1/3rd of the way up. Based on an interview at the time of observation, the PD stated there was no documentation available to confirm the painted wood paneling was treated to provide a flame spread rating of a Class A, Class B or Class C interior finish. This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference.	K S331	Program Director to ensure documentation is present in the EPP binder to show that the painted wood paneling was treated to provide a flame spread rating of a Class A, B, or C interior finish.	03/12/2023

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K S345 Bldg. 01	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			
	1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on records review and Interview with the Program Director (PD) on 02/14/23 between 12:40 p.m. and 1:30 P.M. no documentation was provided regarding a visual inspection of the fire	K S345	CG-DSA to ensure Koorsen completes semi-annual inspection yearly. CG-DSA found the 2022 inspection documentation. Documentation has been placed in the EPP binder in the home. Area Director to ensure compliance.	03/06/2023

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	alarm system six months before the annual fire alarm inspection conducted on 2/18/22 and 2/11/21. Based on interview at the time of records review, the PD stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection was not conducted. The PD stated that they were aware of the requirement and would take care of it. This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference. 2. 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, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 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 records review and Interview with the Program Director (PD) on 02/14/23 between 12:40 p.m. and 1:30 P.M. no documentation was available for review to show a current smoke detector sensitivity test within the last two years. The most recent documentation provided of a sensitivity test was over 2 years old dating			

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	02/11/21 and the most recent annual inspection dated 2/18/22 did not include complete sensitivity test documentation. This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference.			
K S346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6			
	Based on record review and interview, the facility failed to provide a complete written fire watch policy for when the fire alarm system is out of service for more than four hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on records review and Interview with the Program Director (PD) on 02/14/23 between 12:40 p.m. and 1:30 P.M. the documentation provided did not include a Fire watch plan for fire alarm system impairment. During the survey no plan could be located for review. This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference.	K S346	Program Director will ensure there is a Fire watch plan for any alarm system impairments. This will be completed no later than 3/20/23. Program Director to provide staff training on fire watch procedure. Training no later than 3/12/2023.	03/20/2023

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K S347 Bldg. 01	NFPA 101 Smoke Detection Smoke Alarms 2012 EXISTING (Prompt) Approved smoke alarms shall be provided in accordance with 9.6.2.10, unless either of the following exist: 1. Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system, or 2. Buildings are protected throughout by an approved automatic sprinkler system, in accordance with 33.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms. Smoke alarms shall be installed on all levels, including basement but excluding crawl spaces and unfinished attics. Additional smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. These alarms shall be powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas. 33.2.3.4.3.			
	Based on observation and interview, the facility failed to ensure smoke detectors were installed in 3 of 3 client sleeping rooms in non-sprinklered homes. This deficient practice could affect all	K S347	The fire safety vendor has been contacted to install the required smoke detecting in each bedroom. Program Director will	03/20/2023

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	clients, staff, and visitors. Findings include: Based on observations and interview on 02/14/23 during a tour of the facility between 1:30 p.m. and 2:00 p.m. with the Program Director (PD), 3 of 3 consumer sleeping rooms in the non-sprinklered facility were not equipped with any type of smoke detection. This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference.		assure the general condition of the smoke detectors when completing the monthly physical plant inspection. The smoke detectors will be maintained in accordance with regulatory requirements. Person Responsible: Program Director	
K S363 Bldg. 01	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. 33.2.3.6.4, 33.7.7			
	Based on observation and interview, the facility failed to ensure 1 of 3 clients sleeping rooms were provided with a door which would self-close and latch securely in the door frame in accordance with LSC 7.2.1.8. LSC 7.2.1.8.1 states a door leaf normally required to be kept closed shall not be	K S363	Maintenance will repair door by 3/20/23. PD will confirm completion and check for correct function on a monthly basis.	03/20/2023

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	secured in the open position at any time and shall be self-closing or automatic-closing in accordance with LSC 7.2.1.8.2 which states in any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door leaf becomes self-closing. This deficient practice could affect 2 clients. Findings include: Based on observations and interview on 02/14/23 during a tour of the facility between 1:30 p.m. and 2:00 p.m. with the Program Director (PD), sleeping room door #3, equipped with a self-closing device, was held open with the self-closing device and when opened completely would not self-close and latch in the door frame. This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference.			

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K S712 Bldg. 01	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 evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 7 of 12 shifts. This deficient practice affects all staff and clients. Findings include: Based on records review and Interview with the Program Director on 02/14/23 between 12:40 p.m.	K S712	Program Director will ensure there are documented fire drills completed on 1st shift, 2nd shift, and 3rd shift. This will be completed no later than 3/12/23. Program Director will schedule and confirm completion of monthly fire drills on an ongoing basis.	03/12/2023

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	and 1:30 P.M. the following shifts were missing fire drills: a) There was no documentation for a first shift fire drill in the 1st, 3rd and 4th quarter of 2022 b) There was no documentation for a second shift fire drill in the 1st quarter of 2022 c) There was no documentation for a third shift fire drill in all 4 quarters of 2022 The PD stated that no other documentation for fire drills could be located. This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference.		Program Director will train staff on monthly completion of fire drills no later than 3/12/2023. Area Director or designee to train Program Director on fire drill schedule and expectations no later than 3/12/2023. Area Director to complete monthly audits of fire drills to ensure compliance.	
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in the provided metal or noncombustible containers with self-closing cover devices. This deficient practice could affect up to all clients and staff. Findings include: Based on observations and interview on 02/14/23 during a tour of the facility between 1:30 p.m. and 2:00 p.m. with the Program Director (PD), in the driveway smoking area there were over 100 cigarette butts on the ground in and around the pine mulch. The PD stated that it appeared they	K S741	Program Director will purchase a new Smokers Outpost and clean up all cigarette butts at the home. This will be completed no later than 3/1/23. Program Director to train staff on smoking policy by 3/12/23. Program Director to complete weekly visits to ensure compliance and Area Director to complete monthly visit to home to ensure compliance.	03/01/2023

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	got close to the receptacle but not in it. This deficiency was discussed with the PD at the time of discovery and again with the PD during the exit conference.			