

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

PRINTED: 08/16/2024

FORM APPROVED

OMB NO. 0938-039

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|---|--|---|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G763 | | X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING | | X3) DATE SURVEY COMPLETED 07/25/2024 | |
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | | | | STREET ADDRESS, CITY, STATE, ZIP COD 114 S CHESTNUT ST HUNTINGBURG, IN 47542 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| E 0000 Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 07/25/24 Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380 At this Emergency Preparedness survey, Transitional Services Sub LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey, the census was 5. Quality Review completed on 07/30/24 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by: | | | 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), 485.542(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), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d) | | | | | | |

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

TITLE

(X6) DATE

Bret Beauchamp

Regional Director

08/13/2024

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 disclosable 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>(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or</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</p> | | | | | | |

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

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

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| | <p>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 accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> | | | | | | |

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

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| | <p>facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires</p> | | | | | | |

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| | <p>activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the</p> | | | | | | |

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| | <p>OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based;</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>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.</p> | | | E 0039 | <p>-A full scale Emergency Preparedness exercise will be conducted</p> <p>-The Program Supervisor and Program Director will be trained to complete emergency preparedness exercises that are community based, facility based or table top exercises at least twice per year.</p> <p>-All staff will be trained on Emergency Preparedness Plan</p> <p>-Program Director and Program Supervisor will be trained on documentation of Emergency Preparedness plan and ensuring</p> | | 08/24/2024 |

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| K 0000 Bldg. 01 | <p>(ii) Conduct an additional 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.</p> <p>b. A mock disaster drill; or</p> <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 the 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Emergency Preparedness Manual on 07/25/24 between 10:30 a.m. and 12:45 p.m. with the Direct Support Professional (DSP) present, no documentation for a second exercise was presented. The facility did provide documentation of an actual event which happened on 06/08/24 for a Tornado Warning. The DSP said she was not aware if the facility has documentation of a second exercise to review.</p> <p>This finding was reviewed with the DSP during the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in</p> | | | K 0000 | <p>plan is in the home</p> <p>-All staff trainings will be available in the home's safety book and employee files</p> <p>-Documentation of the emergency preparedness exercises will be maintained in the home for immediate review at any time.</p> <p>-Program Supervisor will monitor at least three times weekly during home visits</p> <p>-Program Director will monitor at least once weekly during Site Supervisory Visits</p> <p>Persons Responsible: Program Supervisor, Program Director, Area Director</p> | | |

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

PRINTED: 08/16/2024
FORM APPROVED
OMB NO. 0938-039

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| K S100 Bldg. 01 | <p>accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 07/25/24</p> <p>Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380</p> <p>At this Life Safety Code survey, Transitional Services Sub, LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in all living areas and client sleeping rooms, plus heat detection in the attic connected to the fire alarm system. The facility has a capacity of 8 and had a census of 5 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.6.</p> <p>Quality Review completed on 07/30/24</p> <p>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,</p> | | | | | | |

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| K S345 Bldg. 01 | <p>along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 fire extinguishers in the facility were protected. NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4 requires that portable fire extinguishers types shall be (1) secured on a hanger (2) in the bracket supplied by the manufacturer (3) in a listed bracket approved for such purpose (4) in cabinets or wall recesses. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations on 07/25/24 between 10:30 a.m. and 12:45 p.m. during a tour of the facility with the Direct Support Professional (DSP), there were two fire extinguishers placed on the floor and unsupported. One in the dining room area setting next to the chest freezer, and one in the living room area outside the staff office. Based on interview at the time of each observation, the DSP agreed the fire extinguishers should not have been setting unsupported on the floor.</p> <p>This finding was reviewed with the DSP during the exit conference.</p> | | | K S100 | <p>-All fire extinguishers will be checked and mounted</p> <p>-Staff will be trained on reporting any safety issues including fire extinguishers being mounted properly</p> <p>- The Program Director and Program Supervisor will be trained on ensuring fire extinguishers are checked monthly, annual inspections are conducted by the contractor, and all extinguishers are mounted properly</p> <p>-Program Supervisor will monitor at least three times weekly in the home</p> <p>-Program Director will monitor at least once weekly in the home</p> <p>Responsible parties: Area Director, Program Director, Program Supervisor</p> | | 08/24/2024 |
| | <p>NFPA 101</p> <p>Fire Alarm System - Testing and Maintenance</p> <p>Fire Alarm System - Testing and Maintenance</p> <p>2012 EXISTING (Prompt)</p> <p>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.</p> | | | | | | |

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| | <p>Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm system was accurate and complete. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:</p> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the</p> | | | K S345 | <p>-Contractor will be contacted for the results of the smoke detector sensitivity inspection -Program Director and Program Supervisor will be trained on ensuring the fire alarm system is inspected semi-annually and annually. - Program Director and Program Supervisor will ensure Gauge inspections are completed monthly -Program Director and Program Supervisor will ensure the inspections are in the safety book for review -Program Director and Program Supervisor will ensure that any recommendations from the inspection are completed -Program Supervisor will monitor at least three times weekly -Program Director will monitor weekly during Site Supervisory visit</p> <p>**Persons Responsible: Program Director, Program Supervisor, Area Director</p> | | 08/24/2024 |

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| K S353 Bldg. 01 | <p>detector. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on record review on 07/25/24 between 10:30 a.m. and 12:45 p.m. with the Direct Support Professional (DSP) present, there were three fire alarm system reports available for review with smoke detector sensitivity test documentation provided. Those reports were dated 05/01/23, 10/26/23, and 04/01/24. All three reports were titled as "Annual" reports, and all three reports presented the question under "System Details" on the cover page, "Was sensitivity performed during the inspection?" And the answer was "Yes" on each report. Furthermore, all three reports did not include the name of the manufacturer's calibrated sensitivity test instrument. Based on interview at the time of record review, the DSP indicated she did not know which fire alarm system report was the actual smoke detector sensitivity test report. Based on interview via phone call at 2:30 p.m., the Program Director said he spoke with the fire alarm system vendor, and it was determined the 04/01/24 fire alarm system inspection/test was when sensitivity testing was performed on the facility's smoke detectors. He also said the vendor would correct and update the report to include the test instrument that was used to test the smoke detectors for sensitivity.</p> <p>This finding was reviewed with the DSP during the exit conference.</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt)</p> | | | | | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| | <p>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). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years | | | | | | |

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| | <p>(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>(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.)</p> <p>33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>1. Based on record review, observation, and interview; the facility failed to accurately document monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for 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</p> | | | K S353 | <p>-Program Director and Program Supervisor will ensure that monthly gauge and valve checks will be completed</p> <p>-Program Director and Program Supervisor will be trained on safety requirements in regards to the sprinkler system and ensuring all documentation is placed in the safety book for review</p> <p>-All staff will be trained on notifying</p> | | 08/24/2024 |

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| | <p>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 in the facility.</p> <p>Findings include:</p> <p>Based on record review on 07/25/24 between 10:30 a.m. and 12:45 p.m. with the Direct Support Professional (DSP) present, there was documentation the sprinkler gauges had been inspected on a monthly basis during the past 12 month period, however, there was only one pressure gauge reading provided and each month it was documented as 150 PSI. Based on observation during a tour of the facility with the DSP, there were two pressure gauges on the sprinkler riser, and both indicated 60 PSI. Based on record review after observation of the sprinkler gauges, it was determined the four most recent quarterly sprinkler reports documented the two gauge readings to be 60 PSI. Based on interview at the time of record review, the DSP acknowledged the monthly sprinkler gauge inspection documentation only included readings for one sprinkler gauge and it was not recorded accurately.</p> <p>This finding was reviewed with the DSP during the exit conference.</p> <p>2. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 3</p> | | | <p>management of any issues with sprinkler system and ensuring monthly checks are completed</p> <p>-Program Director and Program Supervisor will ensure the inspections are in the safety book for review</p> <p>-Program Director and Program Supervisor will ensure that any recommendations from the inspection are completed</p> <p>-Program Supervisor will monitor at least three times weekly in the home</p> <p>-Program Director will monitor weekly during Site Supervisory visits</p> <p>Persons Responsible: Area Director, Program Director, Program Supervisor</p> | | | |

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| K S363 Bldg. 01 | <p>sprinklered smoke compartments of the facility was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect all clients, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 07/25/24 between 10:30 a.m. and 12:45 p.m. during a tour of the facility with the Direct Support Professional (DSP), there was a four inch by two foot gap behind the square HVAC duct which penetrated the ceiling to the attic space in the sprinkler riser room. It appeared the drywall ceiling had been damaged between the HVAC duct and the wall. Based on interview at the time of observation, the DSP acknowledged the gap in the ceiling behind the HVAC duct and the wall in the sprinkler riser room and said she was not aware the gap was there.</p> <p>This finding was reviewed with the DSP during the exit conference.</p> <p>NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements:</p> <ol style="list-style-type: none">Doors shall be provided with latches or other mechanisms suitable for keeping the door closed.No doors shall be arranged to prevent the occupant from closing the door.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 | | | | | | |

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| | <p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 client bedroom doors would latch into the door frame. This deficient practice could affect four clients.</p> <p>Findings include:</p> <p>Based on observations on 07/25/24 between 10:30 a.m. and 12:45 p.m. during a tour of the facility with the Direct Support Professional (DSP), the client bedroom door #1 (west hall on left) would not latch into its door frame when tested several times. Based on interview at the time of observation, the DSP acknowledged that bedroom door #1 would not latch into its door frame.</p> <p>This finding was reviewed with the DSP during the exit conference.</p> | | | K S363 | <p>/p> /p> -All staff will be trained on reporting any safety issues in the home -Program Director and Program Supervisor will be trained on ensuring all safety issues are addressed -Program Supervisor will monitor at least three times weekly -Program Director will monitor during weekly Site Supervisory visits Persons Responsible: Program Supervisor, Program Director, Area Director</p> | | 08/24/2024 |