STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G563	A. BUILDING -- B. WING	04/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE OF INDIANA, INC	2999 WESTLANE RD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 04/26/21 Facility Number: 001077 Provider Number: 15G563 AIM Number: 100245490 At this Emergency Preparedness survey, New Hope of Indiana Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 05/03/21	E 0000		
E 0006 Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2),			

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

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	§485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[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. The plan must			

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	do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan which was based on a facility-based and community-based risk assessment, utilizing an all-hazards approach that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(a). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of an all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants.	E 0006	All facility all-hazard assessments were revised to include emerging infectious disease as a notable risk to the facility and inhabitants. NHI has developed and implemented policy and procedure to address the noted risk.	05/26/2021

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	Findings include: Based on review of "Emergency Preparedness Program" documentation dated April 2021 with the Director of Group Homes (DGH) during record review from 11:30 a.m. to 1:00 p.m. on 04/26/21, the facility-based and community-based risk assessment documentation did not include emerging infectious diseases. No emerging infectious diseases hazard risk assessment was available for review at the time of the survey. Based on interview at the time of record review, the DGH agreed the facility-based and community-based risk assessment documentation did not include emerging infectious diseases. This finding was reviewed with the Director of Group Homes 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). Survey Date: 04/26/21 Facility Number: 001077 Provider Number: 15G563 AIM Number: 100245490 At this Life Safety Code survey, New Hope of Indiana, Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety	K 0000		

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	Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building was determined to be fully sprinklered except for the screened in back porch area. The facility has a fire alarm system with with heat detection in the attic and smoke detection in corridors, sleeping rooms and all living areas. The facility has a capacity of 8 and had a census of 8 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 Slow with an E-Score of 2.2. Quality Review completed on 05/03/21			
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. Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier doors which were arranged to self close or automatic close with fire alarm system activation would resist the passage of smoke. LSC Section 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC Section 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or	K S100	All doors have continued to be assessed for needed compliance. On 5/12/21 GH Director and Maintenance Team Leader were able to discuss in person the compliance standards for the variety of door openings and areas for all facilities. Compliance needs were clarified and the remaining noncompliant doors will be addressed by NHI	05/26/2021

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	operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Director of Group Homes (DGH) during a tour of the facility from 1:00 p.m. to 1:30 p.m. on 04/26/21, the smoke barrier door in the south hallway was held open with a wall mounted magnetic holding device set to release with fire alarm system activation. The door self closed and latched into the door frame when tested to close but left a one inch gap between the bottom of the door and the floor when closed and latched. The undercut gap would not resist the passage of smoke. Based on interview at the time of the observations, the DGH agreed the smoke barrier door would not resist the passage of smoke when closed and latched into the door frame. This finding was reviewed with the Director of Group Homes during the exit conference.		Maintenance Team. Upon completion of the remaining corrections, the NHI Maintenance team will continue to assess door closures monthly during preventive maintenance operations.	
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for			

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	Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).			

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	14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review, observation, and interview; the facility failed to ensure the sprinkler system would function as required by conducting the sprinkler test at 20-years old. Section 33.2.3.5.8.10 of NFPA 101 requires the testing of a representative sample of fast-response sprinklers in accordance with Section 5.3.1.1.1.3 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. If the sample fails the test, all of the sprinklers represented by that sample shall be replaced. If the sprinklers pass the test, the test shall be repeated every ten years thereafter. This deficient practice could affect all clients and staff in the facility. Findings include: Based on review of the sprinkler system	K S353	NHI maintenance team conducts routine monthly gauge and valve inspections. The aforementioned periods were completed but documentation was noncompliant. Documentation of all necessary gauge and valve inspections will continue to remain an expectation of the monthly preventative maintenance operations and will continue to be monitored for completion. Sprinkler head inspections, sprinkler head repairs and screened porch area sprinkler head requirements were assessed by contracted fire and sprinkler company on 5/12/21, approval for repairs was received and approved on 5/14/21.	05/26/2021

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	contractor's "Inspection & Test Report" documentation for the most recent twelve month period with the Director of Group Homes (DGH) during record review from 11:30 a.m. to 1:00 p.m. on 04/26/21, documentation of the 20-year test or subsequent 10-year test of a representative sample of sprinklers was not available for review. Based on interview with the DGH stated the home became an ICF/MR facility sometime in the 1990's and was not aware of any 20-year test or subsequent 10-year test of a representative sample of sprinklers for the facility. Based on observations with the DGH during a tour of the facility from 1:00 p.m. to 1:30 p.m. on 04/26/21, residential sprinklers were found throughout the facility. This finding was reviewed with the Director of Group Homes during the exit conference. 2. Based on record review, observation and interview; the facility failed to document 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 connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request.		Corrective action to correct these deficiencies remains pending parts and equipment and scheduling for completion. It is expected that may surpass the 5/26/21 corrective action date. if the completion surpasses 6/1/21, Director of GH will advise IDOH of updated timeline expectations. Upon completion of the remaining corrections, the NHI Maintenance team will continue to assess sprinkler head systems during preventive maintenance operations.	

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	This deficient practice could affect all clients, staff, and visitors in the facility. Findings include: Based on review of "Monthly Gauge Inspection" documentation with the Director of Group Homes (DGH) during record review from 11:30 a.m. to 1:00 p.m. on 04/26/21, sprinkler system gauge inspection documentation for October and December 2020 was not available for review. Review of "Monthly Control Valve Inspection" documentation indicated sprinkler system control valve inspection documentation for October and December 2020 was also not available for review. Based on interview at the time of record review, the DGH stated the facility's maintenance staff performs monthly sprinkler system gauge and control valve inspections but agreed sprinkler system gauge and control valve inspection documentation for the aforementioned monthly periods was not available for review. Based on observations with the DGH during a tour of the facility from 1:00 p.m. to 1:30 p.m. on 04/26/21, the facility has a supervised wet sprinkler system. This finding was reviewed with the Director of Group Homes during the exit conference. 3. Based on observation and interview, the facility failed to ensure 1 of over 10 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect all clients and staff in the facility.			

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	Findings include: Based on observations with the Director of Group Homes (DGH) during a tour of the facility from 1:00 p.m. to 1:30 p.m. on 04/26/21, the sprinkler head located in the gas fired water heater room which contained the fire alarm control panel had an escutcheon plate but the plate was not in alignment with the ceiling which left a two inch opening in the ceiling. Based on interview at the time of the observations, the DGH agreed the aforementioned sprinkler head escutcheon plate was out of position which left a two inch opening in the ceiling. This finding was reviewed with the Director of Group Homes during the exit conference. 4. Based on observation and interview, the facility failed to ensure 2 of over 10 sprinkler heads in the facility were free of paint, corrosion and foreign materials in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler			

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	manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Director of Group Homes (DGH) during a tour of the facility from 1:00 p.m. to 1:30 p.m. on 04/26/21, the following was noted for sprinkler head locations; a. the ceiling mounted sprinkler in the alcove for shelved diaper storage in the south hallway had a tarry substance on the deflector. b. the ceiling mounted sprinkler in the alcove for towel storage in the south hallway had a tarry substance on the deflector and also appeared to be leaking but not dripping with any residue below the sprinkler. Based on interview at the time of the observations, the DGH agreed the aforementioned automatic sprinkler locations were not free of foreign materials. This finding was reviewed with the Director of Group Homes during the exit conference. 5. Based on observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 1 of 2 bathrooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Further NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from			

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	sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states suspended horizontal obstructions more than thirty inches in length shall maintain a minimum vertical distance below the sprinkler deflector of 18 inches. Section 8.6.5.2.2.1 states, in light hazard occupancies, privacy curtains shall not be considered obstructions where all of the following are met: (1) The curtains are supported by fabric mesh on ceiling track. (2) Openings in the mesh are equal to 70 percent or greater. (3) The mesh extends a minimum of 22 inches down from the ceiling. This deficient practice could affect all clients, staff and visitors. Finding includes: Based on observations with the Director of Group Homes (DGH) during a tour of the facility from 1:00 p.m. to 1:30 p.m. on 04/26/21, a privacy curtain was hung from the ceiling of the south hallway bathroom which blocked the spray pattern of the one ceiling mounted sprinkler in the room. The curtain had no mesh at the top of the curtain to extend a minimum of 22 inches down from the ceiling. Based on interview at the time of the observations, the DGH agreed the curtain in the south hallway bathroom blocked the spray pattern for the one ceiling mounted sprinkler in the room and provided sprinkler spray pattern obstruction less than 18 inches from the ceiling. This finding was reviewed with the Director of Group Homes during the exit conference.			

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NEW HOPE OF INDIANA, INC	2999 WESTLANE RD INDIANAPOLIS, IN 46268

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K S358 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING (Slow) In Slow Evacuation Capability facilities where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 9.6, as modified below. The adequacy of the water supply shall be documented. In Slow Evacuation Capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. In Slow Evacuation Capability facilities, where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier. In Slow Evacuation Capability facilities, in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted.			

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	Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.2 through 33.2.3.5.3.4, 33.2.3.5.3.6			
	Based on observation and interview, the Slow-rated facility failed to ensure all habitable areas, such as 1 of 1 screened porch areas, in a sprinklered facility were sprinklered in accordance with LSC Section 33.2.3.5.3.2. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Director of Group Homes (DGH) during a tour of the facility from 1:00 p.m. to 1:30 p.m. on 04/26/21, the back porch was screened in and contained chairs and furniture indicating it was a habitable area. The screened in structure was attached to the building, and extended more than four feet from the building. The ceiling was constructed of wood. The screened in back porch was not sprinklered. Based on interview at the time of	K S358	Sprinkler head inspections, sprinkler head repairs and screened porch area sprinkler head requirements were assessed by contracted fire and sprinkler company on 5/12/21, approval for repairs was received and approved on 5/14/21. Corrective action to correct these deficiencies remains pending parts and equipment and scheduling for completion. It is expected that may surpass the 5/26/21 corrective action date. if the completion surpasses 6/1/21, Director of GH will advise IDOH of updated timeline expectations.	05/26/2021

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	the observations, the DGH agreed the screened in back porch was not sprinklered. This finding was reviewed with the Director of Group Homes during a telephone interview at 8:50 a.m. on 04/29/21.			
K S362 Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING (Prompt) Unless otherwise indicated below, corridor walls shall meet all of the following: * Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier. * Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity. * Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are wired glass not exceeding 9 square feet each in area and installed in approved frames. This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels. In Prompt Evacuation facilities, all sleeping rooms shall be separated from the escape route by smoke partitions in accordance with 8.2.4. Sleeping arrangements that are not located			

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	in sleeping rooms shall be permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping. In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms shall be separated from escape routes by walls and doors that are smoke resistant. 33.2.3.6 Based on observation and interview, the facility failed to ensure 1 of 4 sleeping room doors were capable of resisting smoke for at least 1/2 hour. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 4.8.4.2 states the clearance under the bottom of a door shall be a maximum of 3/4 inch. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Director of Group Homes (DGH) during a tour of the facility from 1:00 p.m. to 1:30 p.m. on 04/26/21, a one inch gap was noted in between the bottom of the door and the floor for the bedroom door to the southeast bedroom in the south hallway. Based	K S362	All doors have continued to be assessed for needed compliance. On 5/12/21 GH Director and Maintenance Team Leader were able to discuss in person the compliance standards for the variety of door openings and areas for all facilities. Compliance needs were clarified and the remaining noncompliant doors will be addressed by NHI Maintenance Team. Upon completion of the remaining corrections, the NHI Maintenance team will continue to assess door closures monthly during preventive maintenance operations.	05/26/2021

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	on interview at the time of the observations, the DGH agreed the gap at the bottom of the door was not capable of resisting the passage of smoke. This finding was reviewed with the Director of Group Homes during the exit conference.			
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	K S712	GH Director reviewed fire drill	05/26/2021

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	facility failed to practice the actual evacuation of all residents to an assembly point during at least one drill on each shift for the most recent four calendar quarters. This deficient practice could affect all clients and staff in the facility. Findings include: Based on review of "New Hope of Indiana Fire Drill/Fire Report" documentation with the Director of Group Homes (DGH) during record review from 11:30 a.m. to 1:00 p.m. on 04/26/21, two of eight residents were not evacuated from the house at least once per shift for the most recent four calendar quarters. The reports indicate that the two residents were "secured" during the fire drill. Based on interview at the time of record review, the DGH stated the facility operates three shifts per day. The DGH indicated that "secured" meant that the bedroom door was closed, and a damp towel placed over the space under the door. The DGH indicated that the two individuals were not bedridden and should have been evacuated from the house when not in bed. Based on interview at the time of record review, the DGH agreed that evacuation of residents is required annually at least once per shift. This finding was reviewed with the Director of Group Homes during the exit conference.		evacuation requirements with GH Leadership team. Evacuation drills are scheduled in alignment with the standards for compliance. Documentation requirements were clarified and will continue to be monitored to ensure all drills reflect accurate evacuation. GH Manager team will continue to monitor drill scheduling, completion and accuracy on a monthly basis when drills are completed and submitted.	