STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G074	A. BUILDING -- B. WING	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EASTER SEALS ARC OF NORTHEAST	2827 TILLMAN ROAD FORT WAYNE, IN 46816

(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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 12/04/23 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/02/24 Facility Number: 000618 Provider Number: 15G074 AIM Number: 100233730 At this PSR Survey, Easter Seals Arc of Northeast Indiana 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 02/07/24	E 0000		
E 0001 Bldg. --	403.748, 416.54, 418.113, 441.184, 482.15, 483.475, 483.73, 484.102, 485.625, 485.68, 485.727, 485.920, 486.360, 491.12 Establishment of the Emergency Program (EP) §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for			

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

Katlyn Rife | Vice President of Health and Residential Supp | 02/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G074	A. BUILDING -- B. WING	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EASTER SEALS ARC OF NORTHEAST	2827 TILLMAN ROAD FORT WAYNE, IN 46816

(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
	Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:			
	Based on record review and interview, the facility failed to meet the Condition of Participation to establish and maintain an emergency	E 0001	E001 In order to meet the Condition of Participation to establish and	02/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G074	A. BUILDING -- B. WING	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EASTER SEALS ARC OF NORTHEAST	2827 TILLMAN ROAD FORT WAYNE, IN 46816

(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
	preparedness program (EPP) in accordance with 42 CFR 483.475 that includes the following elements: a) An Emergency Plan b) Policies and Procedures c) A Communication Plan d) Training and Testing This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Manager on 02/02/24 at 11:20 a.m., the facility failed to ensure the EPP was always in the home (See E0004) and was unable to verify the All-Hazards Risk Assessment (See E0006) and unable to verify policies and procedures were aligned with identified hazards from an All-Hazards Risk Assessment and the facility's overall emergency preparedness program (See E0013). Furthermore, the Communications Plan could not be verified. (See E0029) Based on an interview during records review, the Maintenance Manager stated the EPP binder was at the office and not in the home. This was reviewed with the Maintenance Manager during the exit conference.		maintain an emergency preparedness program (EPP) including ensuring: the EPP is always in the home and verify the All-Hazards Risk Assessment and verify policies and procedures were aligned with identified hazards from an All-Hazards Risk Assessment and the facility's overall emergency preparedness program, in addition to the Communications Plan, the QIDP will submit photo evidence of the EPP, All-Hazards Risk Assessment, and Communication Plan to demonstrate all are in the home. Persons Responsible: QIDP/Director of Group Homes Completion Date: 2/19/2024 The QIDP of the home will complete an observation to confirm the EPP, All-Hazards Risk Assessment, and Communications Plan, is in the home, in it's designated place. The QIDP will ask the staff present to locate the EPP, All-Hazards Risk Assessment, and Communications Plan, in order to demonstrate knowledge of where the EPP, All-Hazards Risk Assessment, and Communications Plan are stored and can be accessed. Persons Responsible: QIDP/Director of Group Homes Completion Date: 2/19/2024	

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	15G074	A. BUILDING -- B. WING	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0004 Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.			

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	15G074	A. BUILDING -- B. WING	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	* [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. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to establish an Emergency Preparedness Plan (EPP) for the correct facility in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Manager on 02/02/24 at 11:20 a.m., the EPP binder was not in the home during survey and was unable to verify the review date. Based on an interview during records review, the Maintenance Manager stated the EPP binder was at the office and not in the home. This was reviewed with the Maintenance Manager during the exit conference. This deficiency was cited on 12/04/23. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0004	E004 The Emergency Preparedness Plan (EPP) for the updated location has been placed in the home. All house staff will be retrained on the changes made the EPP based on the change in location as well as retrained on where the EPP is stored and can be accessed within the home. Persons Responsible: QIDP/Director of Group Homes Completion Date: 2/19/2024 The QIDP of the home will complete an observation to confirm the EPP is in the home, in it's designated place. The QIDP will ask the staff present to locate the EPP in order to demonstrate knowledge of where the EPP is stored and can be accessed. Persons Responsible: QIDP/Director of Group Homes Completion Date: 2/19/2024	02/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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), §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			

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	15G074	A. BUILDING -- B. WING	02/02/2024

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	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 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 maintain an emergency preparedness plan (EPP) that was based on and includes a documented, facility-based and community-based	E 0006	E006 The Hazard Vulnerability Assessment (HVA) for the updated location has been placed	02/19/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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EASTER SEALS ARC OF NORTHEAST	2827 TILLMAN ROAD FORT WAYNE, IN 46816

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	risk assessment, utilizing an all-hazards approach, including missing clients and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475(a) (1) and 42 CFR 483.475(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Manager on 02/02/24 at 11:20 a.m., the EPP binder was not in the home during the survey and was unable to verify if the Hazard Vulnerability Assessment was updated for the home. Based on an interview during records review, the Maintenance Manager stated the EPP binder was at the office and not in the home. This was reviewed with the Maintenance Manager during the exit conference. This deficiency was cited on 12/04/23. The facility failed to implement a systemic plan of correction to prevent recurrence.		in the home. All house staff will be retrained on the assessment based on the change in location as well as retrained on where the HVA is stored and can be accessed within the home. Persons Responsible: QIDP/Director of Group Homes Completion Date: 2/19/2024 The QIDP of the home will complete an observation to confirm the HVA is in the home, in it's designated place. The QIDP will ask the staff present to locate the HVA in order to demonstrate knowledge of where the HVA is stored and can be accessed. Persons Responsible: QIDP/Director of Group Homes Completion Date: 2/19/2024	
E 0013 Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency			

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	preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.			

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	*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to establish Emergency Policies and Procedures for the correct facility in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Manager on 02/02/24 at 11:20 a.m., the EPP binder was not in the home during the survey and was unable to verify if the EPP Policies and Procedures were updated for the home. Based on an interview during records review, the Maintenance Manager stated the EPP binder was at the office and not in the home. This was reviewed with the Maintenance Manager during the exit conference. This deficiency was cited on 12/04/23. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0013	E013 The Emergency Preparedness Plan (EPP) for the updated location has been placed in the home. All house staff will be retrained on the changes made the EPP based on the change in location as well as retrained on where the EPP is stored and can be accessed within the home. Persons Responsible: QIDP/Director of Group Homes Completion Date: 2/19/2024 The QIDP of the home will complete an observation to conform the EPP is in the home, in it's designated place. The QIDP will ask the staff present to locate the EPP in order to demonstrate knowledge of where the EPP is stored and can be accessed. Persons Responsible:	02/19/2024

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			QIDP/Director of Group Homes Completion Date: 2/19/2024	
E 0029 Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) communication program at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Manager on 02/02/24 at 11:20 a.m., the EPP binder was not in the home during survey and was unable to verify if the communication plan was updated for the home. Based on an interview during records review, the Maintenance Manager stated the EPP binder was at the office and not in the home.	E 0029	The QIDP of the home will complete an observation to confirm the Communications Plan is in the home, in it's designated place. The QIDP will ask the staff present to locate the Communications Plan in order to demonstrate knowledge of where the Communications Plan are stored and can be accessed. Persons Responsible: QIDP/Director of Group Homes Completion Date: 2/19/2024	02/19/2024

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	This was reviewed with the Maintenance Manager during the exit conference.			
K 0000 Bldg. 03	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 12/04/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 02/02/24 Facility Number: 000618 Provider Number: 15G074 AIM Number: 100233730 At this PSR, Easter Seals Arc of Northeast Indiana was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, New Residential Board and Care Occupancies. This one-story replacement facility was fully sprinklered. The facility has a fire alarm system with heat detection in the attic and garage, smoke detection in the corridors, sleeping rooms, and common living areas. The facility is protected by and automatic generator. 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 of Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.48.	K 0000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EASTER SEALS ARC OF NORTHEAST	2827 TILLMAN ROAD FORT WAYNE, IN 46816

(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
	Quality Review completed on 02/07/24			
K S353 Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 NEW NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G074	A. BUILDING 03 B. WING	02/02/2024

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EASTER SEALS ARC OF NORTHEAST	2827 TILLMAN ROAD FORT WAYNE, IN 46816

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	(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). 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._____ ____ 32.2.3.5.3, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to	K S353	K0353 The maintenance staff will be retrained on completing the "Monthly Group home Chek Sheet", including documentation of the sprinkler systems-ensuring gauges on wet pipe sprinkler systems shall are inspected	02/19/2024

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	15G074	A. BUILDING 03 B. WING	02/02/2024

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	verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or pre-action valves. This deficient practice could affect all clients and staff. Findings include: Based on records review with the Maintenance Manager on 02/02/24 at 11:20 a.m., there was no sprinkler inspection documentation for the water flow alarm device available for review for the third and fourth quarter of 2023. The last known inspection was on 04/26/23. Based on interview at the time of observation, the Maintenance Manager stated the sprinkler inspection documentation could not be found. This was reviewed with the Maintenance Manager during the exit conference. This deficiency was cited on 12/04/23. The facility failed to implement a systemic plan of correction to prevent recurrence.		monthly to ensure good condition and normal water supply pressure is being maintained, and valves secured with locks are inspected monthly. Person Responsible: Maintenance Supervisor/Director of Facilities and Property Management Completion Date: 2/19/2024 Maintenance Supervisor/Director of Facilities and Property Management will review the "Monthly Group Home Chek Sheet" to ensure documentation of the sprinkler systems including inspections of gauges and valves are being completed monthly. Person Responsible: Maintenance Supervisor/Director of Facilities and Property Management Completion Date: 2/19/2024	