STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G486	A. BUILDING -- B. WING	01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO COURT INDIANAPOLIS, IN 46256

(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: 01/12/21 Facility Number: 001000 Provider Number: 15G486 AIM Number: 100245010 At this Emergency Preparedness survey, Community Alternatives-Adept 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 7. Quality Review completed on 01/14/21 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at			

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

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	paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting.			

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	(3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" documentation dated 01/07/20 and "Emergency, Disaster, Evacuation Plans & Response" documentation dated 10/01/20 with the Maintenance Aide during record review from 9:50 a.m. to 11:15 a.m. on 01/12/21, documentation of subsistence needs for the emergency preparedness program was incomplete. Based on interview at the time of record review, the Maintenance Aide agreed the facility's emergency preparedness program did not include provisions for sewage and waste disposal. This finding was reviewed with the Maintenance Aide during the exit conference.	E 0015	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: Food, water, medical, and pharmaceutical supplies; Alternate sources of energy to maintain temperatures to protect resident health and safety and for the safe and sanitary storage of provisions, emergency lighting fire detection, extinguishing, and alarm systems; and sewage and waste disposal. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components	02/11/2021

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			are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0024 Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an			

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	emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" documentation dated 01/07/20 and "Emergency, Disaster, Evacuation Plans & Response" documentation dated 10/01/20 with the Maintenance Aide during record review from 9:50 a.m. to 11:15 a.m. on 01/12/21, the emergency preparedness plan did not include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on interview at the time of record review, the Maintenance Aide agreed the emergency preparedness documentation did not include emergency preparedness policies and procedures for the use	E 0024	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Assistant Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled monthly audits to	02/11/2021

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	of volunteers in an emergency. This finding was reviewed with the Maintenance Aide during the exit conference.		assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0026 Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in			

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	accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" documentation dated 01/07/20 and "Emergency, Disaster, Evacuation Plans & Response" documentation dated 10/01/20 with the Maintenance Aide during record review from 9:50 a.m. to 11:15 a.m. on 01/12/21, the emergency preparedness plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview at the time of record review, the Maintenance Aide agreed the plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. This finding was reviewed with the Maintenance Aide during the exit conference.	E 0026	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: The role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential	02/11/2021

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			Manager, Direct Support Staff, Operations Team, Regional Director	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under			

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	arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.			

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	*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on			

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	the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the	E 0037	**CORRECTION:**	02/11/2021

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	facility failed to ensure staff received training in regard to emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" documentation dated 01/07/20 and "Emergency, Disaster, Evacuation Plans & Response" documentation dated 10/01/20 with the Maintenance Aide during record review from 9:50 a.m. to 11:15 a.m. on 01/12/21, the facility lacked documentation of staff training on the emergency preparedness plan within the most recent two year period. Based on interview at the time of record review, the Maintenance Aide stated the facility had not provided initial emergency preparedness policies and procedure training to staff within the most recent two year period. This finding was reviewed with the Maintenance Aide during the exit conference.		*The facility must have a training program on place with (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.* Specifically, the facility will provide an emergency preparedness training program that includes the following. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; and provide emergency preparedness training at least annually; and maintain documentation of the training; and demonstrate staff knowledge of emergency procedures. The QIDP Manager will work with the agency Training Coordinator to develop a specific emergency preparedness curriculum, including competency testing, that will be presented during new-hire orientation as will be included in the operation's annual retraining	

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			requirements. Development of the curriculum is in progress and will be completed by 2/11/21. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety Committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Safety Committee, Human Resources Department, Operations Team, Regional Director	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct			

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

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient			

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

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

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

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

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	as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event;	E 0039	**CORRECTION:** *The [facility] must conduct exercises to test the emergency plan at least annually.* Specifically, the agency's Quality Assurance Department has submitted a formal request to the Indianapolis Metropolitan Police Department/Department of Homeland Security Community Emergency Response Team (CERT) to conduct an initial "table talk" disaster exercise, with bi-annual exercises thereafter. Additionally the ResCare Quality	02/11/2021

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	(ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" documentation dated 01/07/20 and "Emergency, Disaster, Evacuation Plans & Response" documentation dated 10/01/20 with the Maintenance Aide during record review from 9:50 a.m. to 11:15 a.m. on 01/12/21, the emergency preparedness plan did not include documentation of at least two exercises to test the emergency plan on an annual basis using the emergency procedures. Based on interview at the time of record review, the Maintenance Aide agreed the facility has not conducted at least two exercises to test the emergency preparedness plan within the most recent twelve month period. This finding was reviewed with the Maintenance Aide during the exit conference.		Assurance Department has requested assistance from the IMPD District Commander to coordinate with CERT to facilitate this process. ResCare Facility supervisors, the QIDP and administrative level management (Program Director, Program Managers, Quality Assurance Manager, QIDP Manager, Nurse Manager and Assistant Nurse Manager) will participate in the exercises to assure facility emergency preparedness protocols are consistent with community emergency management practices. The facility will reach out to local emergency management officials to schedule a full-scale exercise, by 2/11/21 using the current state of emergency as a platform. At the time of this exercise, a “table talk exercise will be scheduled within 6 months of the full-scale event. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility’s emergency preparedness program into scheduled twice monthly audits to assure all required components, including but not limited to	

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			bi-annual community-based disaster exercises, are present. Additionally, the agency Safety Committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
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: 01/12/21 Facility Number: 001000 Provider Number: 15G486 AIM Number: 100245010 At this Life Safety Code survey, Community Alternatives - Adept was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one-story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has a capacity of 8 and had a census of 7 at the time of this survey.	K 0000		

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	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 0.2. Quality Review completed on 01/14/21			
K S211 Bldg. 01	NFPA 101 Means of Egress - General Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 Based on observation and interview, the facility failed to ensure 1 of 4 designated means of egress were continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. This deficient practice could affect all clients, staff and visitors if needing to exit the facility from BC and BR's bedroom. Findings include: Based on observations with the Maintenance Aide during a tour of the facility from 11:15 a.m. to 11:45 a.m. on 01/12/21, the right arm of an upholstered chair was placed in front of the exit door to the outside of the facility in BC and BR's bedroom. The right arm prevented the exit door from opening. The Maintenance Aide moved the chair to the center of the room and the exit door fully opened when tested to open. Based on interview at the time of the observations, the Maintenance Aide agreed the exit door in BC and BR's bedroom was not continuously maintained clear of obstructions and impediments to full	K S211	**CORRECTION:** *Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency.* Specifically, the furnishings in client BC and BR's bedroom will be rearranged to allow the exit door to open completely and provide sufficient space to enter and exit the room comfortably. Observation of the remainder of the residence indicated this deficient practice did not affect any additional egresses **PREVENTION:** Supervisory and direct support staff will be retrained regarding the need to keep egresses clear of obstructions at all times. The Residential Manager will be present, supervising active treatment during no less than five	02/11/2021

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	instant use in the case of fire or emergency. This finding was reviewed with the Maintenance Aide during the exit conference.		active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to including but not limited to assuring egresses are clear of obstructions. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manger and Assistant Nurse Manager) will conduct administrative monitoring during varied shifts/times, weekly, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it.	

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			· If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative support at the home will include assuring egresses are clear of obstructions. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
K S341 Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 33.2.3.4.1. LSC 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6 unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC 9.6.2.10.1.1 states	K S341	**CORRECTION:** *A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire*	02/11/2021

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	single-station and multiple-station smoke alarms shall be in accordance with NFPA 72. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 17.7.3.2.1 states smoke detectors shall be located on the ceiling or, if on a sidewall, between the ceiling and 12 inches down from the ceiling to the top of the detector. Section 17.7.3.2.4.6 states for sloped ceilings with solid joists, the detectors shall be located on the bottom of the joist. Section 17.7.3.3 states detectors shall first be spaced and located within 36 inches of the peak, measured horizontally. The number and spacing of additional detectors, if any, shall be based on the horizontal projection of the ceiling. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Maintenance Aide during a tour of the facility from 11:15 a.m. to 11:45 a.m. on 01/12/21, the wall mounted fire alarm system smoke detector in the television room near the office was installed twenty inches below a joist attached to the sloping ceiling and twenty four inches below the peak of ceiling. Based on interview at the time of the observations, the Maintenance Aide agreed the smoke detector was not properly installed. This finding was reviewed with the Maintenance Aide during the exit conference.		*alarm box per floor arranged to continuously sound the required smoke alarms.* Specifically, the smoke alarm in the facility's television room will be raised so that it is no more than 12 inches from the ceiling's peak. **PREVENTION:** The QIDP Manager will review smoke alarm requirements with members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manger and Assistant Nurse Manager). Members of the Operations Team will incorporate reviews of the facility's smoke alarms into scheduled monthly audits to assure it is not being used for storage. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained			

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	in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to ensure all fire alarm system initiating devices were inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6 unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Table 14.3.1 at 9(f) states heat detectors shall be visually inspected semiannually. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Initial/Reacceptance testing shall be performed at the time of installation. Table 14.4.5 at 15(e) states the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with 14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year. NFPA 72, 2010 Edition, Table 14.4.2.2 at 14(d)(2) states fixed-temperature, nonrestorable line type heat detectors functionality shall be tested mechanically and electrically. Loop resistance	K S345	**CORRECTION:** *A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.* Specifically, the facility's contracted Environmental Services Specialist will conduct semi-annual inspections of the facility's alarm system, as required. **PREVENTION:** The facility's contracted Environmental Services Specialist will utilize a form provided by the alarm company for semi-annual visual inspections to assure that all components of the facility's system are inspected appropriately. The QIDP will retrain members of the Operations Team comprised of the Quality Assurance Manager, Quality Assurance Coordinators, QIDP, Area Supervisors, Executive Director, Program Managers, Assistant Nurse Manager, and Nurse	02/11/2021

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	shall be measured and recorded. Changes from acceptance test shall be investigated. Records shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Periodic Fire Alarm Inspection and Testing Report" documentation dated 06/23/20 with the visiting Maintenance Aide during record review from 9:50 a.m. to 11:15 a.m. on 01/12/21, heat detector testing documentation within the most recent twelve month period was not available for review. The aforementioned documentation listed 2 heat detectors, one in the kitchen and one in the attic, as being visually inspected but were not tested. Based on interview at the time of record review, the Maintenance Aide stated semiannual visual inspection documentation for the two heat detectors within the most recent twelve month period was not available for review. The Maintenance Aide stated the two heat detectors were visually inspected on 06/23/20 and have not been tested within the most recent twelve month period. Based on observations with the Maintenance Aide during a tour of the facility from 11:15 a.m. to 11:45 a.m. on 01/12/21, a heat detector was installed in the kitchen and one heat detector was installed in the attic as observed from the attic access door in the garage. This finding was reviewed with the Maintenance Aide during the exit conference.		Manager to assure their familiarity with Life Safety code requirements for semi-annual visual inspections of the facility alarm systems. Members of the Operations Team will review alarm system inspection records to assure all required components of the system are tested as required, as part of a routine audit process that will occur no less than monthly. **RESPONSIBLE PARTIES:** Contracted Environmental Services Specialist, Area Supervisor, Operations Team	

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K S351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 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 Section 9.6, as modified below. The adequacy of the water supply shall be documented. In Prompt Evacuation 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 Prompt 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 Prompt 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			

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	Residential Occupancies up to and including Four Stories in Height, shall be permitted. 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 by July 5, 2019. 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, 33.2.3.5.3.1, 33.2.3.5.3.3, 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7			
	Based on observation and interview, the facility failed to ensure the sprinkler system was installed per NFPA 13D. NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, 2010 Edition, Section 6.5.3 states a warning sign, with minimum 1/4 inch letters, shall be affixed adjacent to the main shut off valve and state the following: Warning: The water system for this home supplies fire sprinklers that require certain flows and pressure to fight a fire. Devices that restrict the flow or decrease the pressure or automatically shut off the water to the fire sprinkler system, such as water softeners, filtration systems, and automatic shutoff valves, shall not be added to this system without a review of the fire sprinkler system by a	K S351	**CORRECTION:** *Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7.* Specifically, the missing signage for the sprinkler shut-off valve will be replaced. **PREVENTION:** The QIDP manager will retrain Members of the Operations Team (the Quality Assurance Manager, Quality Assurance Coordinators, QIDP, Area Supervisors, Executive Director, Program Managers, Assistant Nurse	02/11/2021

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	fire protection specialist. Do not remove this sign. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Maintenance Aide during a tour of the facility from 11:15 a.m. to 11:45 a.m. on 01/12/21, the hydraulic design information affixed to the wall adjacent to wet sprinkler system in the garage stated the system was designed and installed pursuant to NFPA 13D. No additional signage was affixed adjacent to the main shut off valve. Based on interview at the time of the observations, the Maintenance Aide agreed the sprinkler system shutoff control valve was not marked with an identification sign. This finding was reviewed with the Maintenance Aide during the exit conference.		Manager, and Nurse Manager) to assure their familiarity with Life Safety code requirements for Sprinkler systems. The Operations Team will incorporate reviews of the facility's sprinkler system into monthly environmental audits, to assure compliance. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
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 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			

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	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). 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,			

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	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 Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, except as discussed in 14.2.1.1 and 14.2.1.4, an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Maintenance Aide from 9:50 a.m. to 11:15 a.m. on 01/12/21, documentation of an internal pipe inspection within the most recent five year period was not available for review. Based on interview at the	K S353	**CORRECTION:** *NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced.* Specifically, the facility's contracted environmental specialist will arrange an inspection of piping and branch line conditions in the facility's sprinkler system. **PREVENTION:** The facility's contracted environmental specialist will meet with the QIDP Manager no less than annually to review sprinkler system inspection documentation to assure compliance. **RESPONSIBLE PARTIES:** QIDP,	02/11/2021

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	time of record review, the Maintenance Aide stated documentation of an internal pipe inspection within the most recent five year period was not available for review. Based on observations with the Maintenance Aide during a tour of the facility from 11:15 a.m. to 11:45 a.m. on 01/12/21, sprinkler piping in the attic was metal as observed from the attic access door in the garage. This finding was reviewed with the Maintenance Aide at the exit conference.		Area Supervisor, Residential Manager, Environmental Services Staff, Operations Team	
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 1. Based on record review, observation, and interview; the facility failed to provide a smoking policy for a facility allowing client smoking. LSC Section A.33.7.4.1(2) and (3) states: (2) Smoking by residents classified as not responsible with regard to their ability to safely use and dispose of smoking materials should be prohibited. (3) Where a resident, as specified in A.33.7.4.1(2), is under direct supervision by staff or by a person approved by the administration, smoking might be permitted. This deficient practice affects all clients, staff, and visitors. Findings include:	K S741	**CORRECTION:** *Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations.* Specifically, The QIDP will retrain staff who smoke, and staff who supervise clients who smoke, to assure clients use the provided noncombustible covered ash containers. The agency will develop a smoking policy for implementation at the facility that clearly defines staff supervision	02/11/2021

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	Based on record review with the Maintenance Aide and the Residential Manager for the Richardt House from 9:50 a.m. to 11:15 a.m. on 01/12/21, a facility smoking policy which addresses staff and client smoking was not available for review. Based on interview at the time of record review, the Residential Manager for the Richardt House stated one of seven current clients, MN, currently smokes. The Residential Manager stated MN is allowed to smoke outside on the front porch with staff supervision but a smoking assessment and a smoking policy which addresses staff and client smoking was not available for review at the time of the survey. Based on observations with the Maintenance Aide during a tour of the facility from 11:15 a.m. to 11:45 a.m. on 01/12/21, a smoking tower for dispensing cigarette butts was noted on the front porch and the back patio. This finding was reviewed with the Maintenance Aide during the exit conference. 2. Based on observation and interview, the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 2 areas where smoking is permitted. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations with the Maintenance Aide during the exit conference at 12:00 p.m. on 01/12/21, over 50 extinguished cigarette butts were on the ground near the sidewalk by the front porch and were not placed in the smoking tower for extinguished butts on the front porch. Based		expectations for clients who smoke. Additionally, the team will complete a smoking assessment for client MN. **PREVENTION:** The facility's new QIDP will be trained to complete smoking assessments for all clients who smoke to be updated as needed, but no less than annually. Members of the Operations Team (the Quality Assurance Manager, Quality Assurance Coordinators, QIDP, Area Supervisors, Executive Director, Program Managers, Assistant Nurse Manager, and Nurse Manager) will incorporate reviews of the designated smoking areas into scheduled monthly audits to assure clients and staff use the provided noncombustible covered ash containers. The team will also review assessment documents no less than annually to assure clients who smoke receive the appropriate level of supervision and support. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	on interview at the time of the observations, the Maintenance Aide agreed over 50 extinguished cigarette butts were on the ground near the sidewalk by the front porch. This finding was reviewed with the Maintenance Aide during the exit conference			