

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

PRINTED: 04/25/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2023
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES	STREET ADDRESS, CITY, STATE, ZIP COD 912 N PARKWAY DR ANDERSON, IN 46013
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 03/28/23</p> <p>Facility Number: 000923 Provider Number: 15G409 AIM Number: 100244490</p> <p>At this Emergency Preparedness survey, Developmental Services Alternatives was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 8 certified beds. All beds are certified for Medicaid. At the time of the survey, the census was 7.</p> <p>Quality Review completed on 03/29/23</p> <p>42 CFR, Subpart 483.475 is NOT MET as evidenced by:</p>	E 0000		
E 0039 Bldg. --	<p>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)</p> <p>EP Testing Requirements</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenna Metcalfe	Director of Quality Assurance	04/21/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (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.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (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.</p> <p>(iii) Analyze the [facility's] response to and</p>			

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

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

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	<p>CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p>			
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	<p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not</p>			

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

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

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

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	<p>of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to analyze the facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events. The ICF/IID facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may</p>	E 0039	<p>QIDP will conduct a full-scale tabletop exercise for all staff in the home by 4/14/2023.</p> <p>QIDP will conduct one full-size exercise and one exercise of choice yearly. Regional Director or designee will establish timeframes for exercises and confirm completion.</p> <p>QIDP will conduct a full-scale tabletop exercise for all staff in the home by 4/14/2023.</p> <p>QIDP will conduct one full-size exercise and one exercise of</p>	04/20/2023	

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K 0000 Bldg. 01	<p>include, but is not limited to the following:</p> <ul style="list-style-type: none"> a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Program (EPP) with the Qualified Intellectual Disabilities Professional (QIDP) on 03/28/23 at 10:30 a.m., the documentation for the event on 04/12/22 was incomplete. There was no documentation of the complete scenario, if facility analyze the response, and if any updates were need to the EPP. Based on interview at the time of records review, the QIDP stated the exercise was completed but there was no documentation of an after action plan for the exercise. This finding was reviewed with the QIDP at the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in</p>	K 0000	<p>choice yearly.</p> <p>Regional Director or designee will establish timeframes for exercises and confirm completion. In April and October of each year, QIDP will complete a full-size exercise. Each exercise will include a different exercise of choice. By the 20th of April and October, Regional Director or designee will confirm with QIDP that exercise has taken place or is scheduled before the end of that month.</p>	

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K S345 Bldg. 01	<p>accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 03/28/23</p> <p>Facility Number: 000923 Provider Number: 15G409 AIM Number: 100244490</p> <p>At this Life Safety Code survey, Developmental Services Alternatives was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was sprinklered. The facility has a fire alarm system with smoke detection in the corridors, sleeping rooms and common living areas with heat detection in the attic. The facility has a capacity of 8 and had a census of 7 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches of Life Safety, Chapter 6, rated the facility Slow with an E- score of 2.52.</p> <p>Quality Review completed on 03/29/23</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70,</p>			

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	<p>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</p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:</p> <ul style="list-style-type: none"> a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices <p>This deficient practice could affect all building occupants.</p> <p>Findings include:</p> <p>Based on records review with the Qualified Intellectual Disabilities Professional (QIDP) on 03/28/23 at 10:30 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months before the annual fire alarm inspection completed on 01/13/23. Based on interview at the time of records review, the QIDP stated a visual inspection of the fire alarm system six months before the annual fire alarm inspection was not conducted.</p> <p>This finding was reviewed with the QIDP at the exit conference.</p>	K S345	<p>CG-DSA to ensure Koorsen completes semi-annual inspection yearly to include visual inspection of the fire alarm system.</p> <p>Regional Director to ensure compliance.</p> <p>CG-DSA to ensure Koorsen completes semi-annual inspection yearly to include visual inspection of the fire alarm system.</p> <p>Regional Director or designee to ensure compliance. Annual inspections are scheduled in January and semi-annual in July. By the 20th of January and July, Regional Director or designee will confirm that inspection has taken place and if not, they will call Koorsen to ensure it is scheduled.</p>	04/20/2023

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K S358 Bldg. 01	<p>NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING (Slow)</p> <p>In Slow Evacuation Capability facilities where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 9.6, as modified below. The adequacy of the water supply shall be documented.</p> <p>In Slow Evacuation Capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier.</p> <p>In Slow Evacuation Capability facilities, where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier.</p> <p>In Slow Evacuation Capability facilities, in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted.</p>			
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	<p>Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6.</p> <p>Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following:</p> <ol style="list-style-type: none"> 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. <p>33.2.3.5.3, 33.2.3.5.3.2 through 33.2.3.5.3.4, 33.2.3.5.3.6</p> <p>Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 closet larger than 24 square feet, in accordance with 33.2.3.5. NFPA 13, 2010 edition, Section 8.5.5.1, states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Section 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector that prevent the pattern from fully developing. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observation with the Qualified Intellectual Disabilities Professional (QIDP) on 03/28/23 at 11:10 a.m., the red bathroom closet had</p>	K S358	<p>Program Director will ensure the sprinkler in the red bathroom closet is not covered by clothing or any other items by 4/16/23.</p> <p>Program Director to complete weekly visual inspections of the sprinkler heads to ensure they are not obstructed.</p> <p>Program Director will ensure the sprinkler in the red bathroom closet is not covered by clothing or any other items by 4/22/23</p> <p>All staff will be trained on keeping sprinklers free from obstruction by 4/14/2023.</p> <p>Program Director to complete</p>	04/22/2023

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K S363 Bldg. 01	<p>a sprinkler head that was covered with clothes that were piled on a shelf. Based on interview at the time of observation, the QIDP acknowledged the aforementioned condition and had the clothes removed to uncover the sprinkler head.</p> <p>This finding was reviewed at the exit conference with the QIDP.</p> <p>NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements:</p> <ol style="list-style-type: none"> Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. No doors shall be arranged to prevent the occupant from closing the door. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 <p>Based on observation and interview, the facility failed to ensure 1 of 4 clients sleeping rooms were provided with a door which would close and latch securely in the door frame. This deficient practice could affect 1 client.</p> <p>Findings include:</p> <p>Based on observation with the Qualified Intellectual Disabilities Professional (QIDP) on 03/28/23 at 11:15 a.m., Southeast sleeping room door did not latch into the frame when tested.</p>	K S363	<p>weekly visual inspections of the sprinkler heads to ensure they are not obstructed.</p> <p>The door in southeast sleeping room will be repaired to ensure it latches.</p> <p>Program Director to complete weekly visits to ensure proper function and maintenance to complete monthly visit to home to ensure proper function.</p> <p>The door in southeast sleeping</p>	04/22/2023

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K S712 Bldg. 01	<p>Based on interview at the time of observation, the QIDP confirmed the door did not securely latch into the door frame.</p> <p>The finding was reviewed with the QIDP during the exit conference.</p> <p>NFPA 101 Fire Drills Fire Drills</p> <p>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:</p> <ul style="list-style-type: none"> a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. <p>2. The facility must:</p> <ul style="list-style-type: none"> a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. <p>3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)</p>		<p>room will be repaired to ensure it latches.</p> <p>Program Director to complete weekly visits to ensure proper function and maintenance to complete monthly visit to home to ensure proper function.</p>	

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K S741 Bldg. 01	<p>Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 2 of 12 shifts. This deficient practice affects all staff and clients.</p> <p>Findings include:</p> <p>Based on records review with the Qualified Intellectual Disabilities Professional (QIDP) on 03/28/23 at 10:15 am., the following shifts were missing fire drills: There was no documentation of a third shift fire drill in the third and fourth quarter for 2022.</p> <p>Based on interview at the time of record review, the QIDP stated they could not provide documentation of any of the missing fire drills. Findings were discussed with the QIDP at the exit conference.</p> <p>NFPA 101 Smoking Regulations Smoking Regulations</p>	K S712	<p>QIDP will ensure there are documented fire drills completed on 1st shift, 2nd shift, and 3rd shift. This will be completed no later than 4/16/23.</p> <p>Program Director will schedule and confirm completion of monthly fire drills on an ongoing basis.</p> <p>QIDP will train staff on monthly completion of fire drills no later than 4/14/2023.</p> <p>Regional Director to complete monthly audits of fire drills to ensure compliance.</p> <p>QIDP will ensure there are documented fire drills completed on 1st shift, 2nd shift, and 3rd shift. This will be completed no later than 4/22/23</p> <p>Program Director will schedule and confirm completion of monthly fire drills on an ongoing basis.</p> <p>QIDP will train staff on monthly completion of fire drills no later than 4/14/2023.</p> <p>Regional Director to complete monthly audits of fire drills to ensure compliance.</p>	04/22/2023

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	<p>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.</p> <p>32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2</p> <p>Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect up to all clients and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Qualified Intellectual Disabilities Professional (QIDP) on 03/28/23 at 11:00 a.m., in the back yard smoking area there were over 50 cigarette butts on the ground. Based on interview at the time of observation, the QIDP agreed there were cigarette butts on the ground in the back yard smoking area.</p> <p>This finding was reviewed with the QIDP during the exit conference.</p>	K S741	<p>Program Director will ensure all cigarette butts are picked up by 4/16/23.</p> <p>Program Director to train staff on smoking policy by 4/14/2023.</p> <p>Program Director to complete weekly visits to ensure compliance.</p> <p>Program Director will ensure all cigarette butts are picked up by 4/22/23</p> <p>Program Director to train staff on smoking policy by 4/14/2023.</p> <p>Program Director to complete weekly visits to ensure compliance.</p>	04/22/2023