STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G596	A. BUILDING -- B. WING	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REHABILITATION CENTER DEVELOPMENTAL SERVICES	1426 S ALVORD LN EVANSVILLE, IN 47714

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 07/22/24 Facility Number: 001110 Provider Number: 15G596 AIM Number: 100240090 At this Emergency Preparedness survey, Rehabilitation Center Developmental Services was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. At the time of the survey, the census was 7. Quality Review completed on 07/24/24	E 0000		
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: 07/22/24 Facility Number: 001110 Provider Number: 15G596 AIM Number: 100240090 At this Life Safety Code survey, Rehabilitation Center Developmental Services was found not in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy Gogel	Director of Residential Services	08/08/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	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 facility was fully sprinklered. The facility has a monitored fire alarm system with hard wired smoke detectors in the corridors, sleeping rooms, and common living areas. The facility did not have heat detection in the attic, but the attic is provided with sprinkler coverage. The facility has a capacity of eight and had a census of seven at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Impractical with an E-Score of 6.32. Quality Review completed on 07/24/24			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation, and interview; the facility failed to ensure 3 of 3 interior emergency lights were tested, maintained, and the records of the testing maintained. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety	K S100	K S100 Easterseals group homes utilize a Fire Extinguisher Checklist and an Emergency Light Checklist that is to be completed one time per month in each group home.	09/08/2024

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	features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. (2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the test. (5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction. This deficient practice could affect all occupants in the facility. Findings include: Based on observations on 07/22/24 between 12:30 p.m. and 3:30 p.m. during a tour of the facility with the Group Home Coordinator, the facility had three battery powered emergency light units. Based on record review between 12:30 p.m. and 3:30 p.m., there was no documentation to show the battery powered emergency lights were tested for 30 seconds monthly during the past 12 month period, furthermore, there was no documentation to show the battery powered emergency lights were tested for 90 minutes during the past 12 month period. Based on interview at the time of record review, the Group Home Manager acknowledged there was no documentation available to show a 30 second monthly test or a 90		These checklists include checking all three fire extinguishers, as well verifying that all three back-up emergency lights are in functional order. The manager or coordinator then document the date checked and if the fire extinguishers and back-up emergency lights are in functional order. Additionally, the form outlines that if one of the items is not functioning properly, that the Easterseals Maintenance department is contacted immediately in order for the issue to be fixed/corrected immediately. The management team at Alvord (both Manager and Coordinator) are fairly new to their roles in our agency. As we were discussing the lack of checks being completed, it was realized that the training for the Emergency Drill Book is not a part of our current management training that is completed. Therefore, newer members of the management team are shown how to complete fire drills and given a quick overview of the drill and emergency processes, but it is not trained on in detail as far as completion of all quarterly drills, checking emergency lights, etc. This training has now been added to our managerial training, which is divided between different members of the management team based on their strengths in certain areas. A group home coordinator who has been with us for over 30	

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	minute annual test for the three battery back up emergency light units. This finding was reviewed with the Group Home Coordinator during the exit conference.		years will be the trainer on emergency preparedness and life safety drills. The management team at Alvord is aware of the life safety citations at Alvord and the necessary corrections that must be completed going forward. They have now been trained on drills and emergency preparedness in its entirety. They are currently working on getting all life safety paperwork up to date and moving forward will ensure it is being consistently completed and checked as required. Additionally, systemically, all eight group homes management teams, specifically the Alvord management team, have been retrained on the necessity for the Fire Extinguisher Checklist and Emergency Light Checklists to be completed monthly as outlined on the Manager's Monthly Checklist and then turned into the Office Coordinator with the end of the month paperwork. As an additional checks and balance, the Office Coordinator who receives and logs all paperwork, will ensure the Fire Extinguisher Checklist and Emergency Light Checklists are received from all eight group homes monthly as required. If these items are not received the Office Coordinator will contact the Group Coordinators for follow up to ensure the checklists are completed as outlined by life safety regulations and turned in for	

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			filing purposes and for reference during life safety surveys.	
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 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 and interview, the facility failed to provide complete documentation for the inspection of 1 of 1 fire alarm system in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. This deficient practice could affect all clients and staff. Findings include: Based on record review on 07/22/24 between 12:30 p.m. and 3:30 p.m. with the Group Home Coordinator present, there was documentation available for an annual fire alarm system inspection dated 03/27/24. This report did not include an itemized list of the inspection and location of the facility's smoke detectors, heat detectors, and pull stations. Based on interview at the time of record review, the Group Home	K S345	K S345 In looking at the inspection from Sonitrol from 3/27/24, it appears Sonitrol failed to complete the report which includes a list of the inspection and location of the facility's smoke detectors, heat detectors, and pull stations. Sonitrol stated that this form is generally only used in Illinois, but they are sending a tech out to complete this for Alvord and Fuquay as soon as possible. No one in our organization was aware that the other form was required to meet life safety regulations as it had not been requested prior to this survey. Preventatively, going forward the office coordinator is aware of the required document and she will ensure we are getting the appropriate documentation. Additionally, group home	09/08/2024

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	Coordinator agreed the 03/27/24 fire alarm system inspection documentation did not include an itemized list of the location of the facility's smoke detectors, heat detectors, and pull stations. This finding was reviewed with the Group Home Coordinator during the exit conference.		management will be trained on the required documentation from Sonitrol, and the detail required in the report in order to meet life safety regulations. The annual inspections from Sonitrol will be scanned to the group homes by the office coordinator going forward in order to be filed in the Emergency Drill Books. The group home management team will be a secondary check to ensure the document is comprehensive and includes the inspection and location of the smoke detectors, heat detectors, and pull stations.	
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 Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in			

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	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, section 13.4.4). A. Date sprinkler system last checked and			

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	necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 6 of over 25 sprinkler heads in the facility were free of corrosion or loading. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could affect all clients and staff. Findings include: Based on observations on 07/22/24 between 12:30 p.m. and 3:30 p.m. during a tour of the facility with the Group Home Coordinator, one sprinkler head in the dining room, three sprinkler heads in the living room, and two sprinkler heads in the kitchen were covered with rust and corrosion or heavily discolored. Based on interview at the time of observations, the Group Home Coordinator agreed the sprinkler heads mentioned were covered with rust and corrosion and heavily discolored. This finding was reviewed with the Group Home Coordinator during the exit conference.	K S353	K S353 Maintenance has been informed of the sprinkler heads that need replaced throughout the home at Alvord, based on the life safety report. They have been ordered and will be replaced at the group home once they arrive. The Human Rights Committee form, that is completed quarterly, includes a check of the sprinkler heads to ensure they are free of paint, rust, corrosion, etc. Additionally, maintenance also monitors the sprinkler heads when they are in the homes. Also, our maintenance supervisor has begun ordering a white powder coated sprinkler head, that we hope will not rust/corrode as our previous ones have been doing. To ensure management awareness, the House Repair checklist, which is completed by group home management in all eight homes every month, will also be updated to include checking the sprinkler heads as well to ensure they are	09/08/2024

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	2. Based on record review, observation, and interview; the facility failed to document monthly sprinkler system inspections in accordance with NFPA 25 for 2 of the past 12 months. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states an inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. This deficient practice could affect all clients in the facility. Findings include: Based on record review on 07/22/24 between 12:30 p.m. and 3:30 p.m. with the Group Home Coordinator present, there was no documentation the sprinkler gauge and sprinkler control valve has been inspected on a monthly basis during February and June of 2024. Based on interview at the time of record review, the Group Home Coordinator confirmed there was no monthly sprinkler gauge or sprinkler control valve inspection documentation available for review for February and June of 2024. Based on observation during a tour of the facility with the Group Home Coordinator the sprinkler riser was equipped with one pressure gauge and one main control valve.		free of dust, debris, and corrosion. The checks and balances in place will continue to ensure the sprinkler heads are replaced when they need to be going forward in all nine Easterseals Group Homes. The group home maintenance department has now been assigned the task of checking the sprinkler gauge and sprinkler control valves in all eight group homes on a monthly basis. The newer management team did not reach out to the office coordinator for the two missing months of the sprinkler valve checks. These documents were in the file at the office. Since giving this responsibility to our maintenance department, the checks have been getting completed, regardless of it being a wet or dry system, and the checks have been done timely and correctly. Maintenance will continue to complete the monthly paperwork for the sprinkler gauge and sprinkler control valve checks, and then turn the paperwork into the office coordinator monthly. Once the Office Coordinator receives the completed checks it is filed but also a copy will be sent to the group home to file in the Emergency Drill Binder. The management team has been trained on the expectations for completion with the sprinkler checks, and when the	

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	This finding was reviewed with the Group Home Coordinator during the exit conference.		documentation is received from the office coordinator, they will ensure it is completed monthly as outlined per life safety regulations, prior to filing it in the Emergency Drill Book. This will create an additional checks and balance to ensure paperwork is completed and filed to meet our life safety regulations in the group homes.	
K S711 Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan The administration of every resident board and care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility. All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation			

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	training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk. 32.7.1, 32.7.2, 33.7.1, 33.7.2 Based on record review and interview, the facility failed to provide documentation of periodic staff instruction on the written fire plan not less than every two months for the protection of all clients. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review on 07/22/24 between 12:30 p.m. and 3:30 p.m. with the Group Home Coordinator present, there was no documentation available for periodic staff instruction at least every two months on the written fire plan available for review for the past 12 month period. Based on interview at the time of record review, the Group Home Coordinator confirmed there was no documentation to show periodic staff instruction on the written fire plan. This finding was review with the Group Home Coordinator during the exit conference.	K S711	K S711 The Group Home Staff Meeting Form has been updated to include bi-monthly in-service of the written group home fire plan for evacuation (completed in January, March, May, July, September, and November). The update to the staff meeting form will ensure regular in-service is occurring with our group home staff in regard to the evacuation fire plan. All group homes have at least one to two staff meetings every month. The Alvord management team, as well as the other seven group home management teams, have been trained on the update to the Staff Meeting Form and we have also added a place in our Emergency Preparedness Binder for the Staff Meeting Form to be filed, showing all staff have been trained on the fire plan bi-monthly throughout the year per life safety regulation. The checks and balance with the updated form, along with retraining will prevent future occurrence.	09/08/2024
K S712	NFPA 101 Fire Drills			

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Bldg. 01	Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)			
	Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 3 of 3 shifts during 4 of 4 quarters during the past 12 months. This deficient practice could affect all clients. Findings include: Based on record review on 07/22/24 between 12:30 p.m. and 3:30 p.m. with the Group Home Coordinator present, there were only two fire drill reports available to review for the past 12 month	K S712	K S712 Due to the management team being new at Alvord, as well as lack of training, drills were not run and documented per life safety code requirements. RCDS has a specific drill schedule that is followed in all eight homes. This drill schedule outlines the month that each drill should be done and the shift it needs to be completed	09/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G596	A. BUILDING 01 B. WING	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REHABILITATION CENTER DEVELOPMENTAL SERVICES	1426 S ALVORD LN EVANSVILLE, IN 47714

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	period, furthermore, there were no fire drill reports available for the following shifts and quarters: a. First shift (day) of the third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2023, and first quarter (January, February, and March), and second quarter (April, May, and June) of 2024. b. Second shift (evening) of the fourth quarter (October, November, and December) of 2023, and first quarter (January, February, and March), and second quarter (April, May, and June) of 2024. c. Third shift (night) of the third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2023, and the first quarter (January, February, and March), and second quarter (April, May, and June) of 2024. Based on interview at the time of record review, the Group Home Coordinator said additional fire drills were not performed for the missing shifts and quarters. This finding was reviewed with the Group Home Coordinator during the exit conference.		in order to meet the life safety code regulations. Our office coordinator sends an email each month instructing the management team on what drills are to be completed and for what shift. To prevent future occurrence, all drills are being added to our staff scheduling system so the drill will be assigned to a specific staff member on shift. All group home staff are being trained that if a drill that is scheduled for their shift is missed, due to extenuating circumstances, then they must notify management so the drill can be reassigned to the same shift on another day. These changes in our staff scheduling system along with the retraining of the management team will prevent future occurrence and ensure all drills are ran on the correct date and time in order to meet life safety regulations. All group home management have been in-serviced on the necessity for drills to be placed on the When 2 Work scheduling system and assigned to a specific staff member. Management staff at Alvord, as well as in the other seven group homes, were retrained on their responsibility to not only ensure the drills are ran per the life safety code schedule regulations, but also that the forms are documented in their entirety and all necessary	

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			information is noted on the drills and filed in the drill book. The Group Home Coordinators, who supervise the Group Home Managers, will also double check fire drills at least one time per month to ensure completion as well as thorough documentation and filing going forward.	
K S762 Bldg. 01	Based on record review and interview, the facility failed to maintain staffing levels for 2 of 7 clients in accordance with 33.7.6 which states that staff shall be on duty in the facility at all times when clients requiring evacuation assistance are present. This deficient practice could affect all clients. Findings include: Based on record review on 07/22/24 between 12:30 p.m. and 3:30 p.m. with the Group Home Coordinator present, the F-1 forms provided by the facility indicated two of seven clients needed full assistance from two staff to evacuate. Based on interview at the time of record review, the Group Home Coordinator stated the facility is only staffed by one staff member during the overnight hours and there are two clients that need the full assistance of two staff members during an evacuation. This finding was reviewed with the Group Home Coordinator during the exit conference.	K S762	K S762 Alvord's client evacuation protocol was not filled out correctly, and had not been updated as it should have been for 2024. The evacuation protocol is showing the correct way to transfer clients per the physical therapist's recommendations during normal transfers for their safety. However, on our client evacuation protocols (if it were a true emergency), the client is lifted by staff as quickly as possible into their wheelchair or onto a blanket to be removed from the home. Each client who is listed as a 2 person lift/hoyer lift is for safety during normal transfers. During a true emergency, these clients can be lifted by one person in order to evacuate. Alvord's client evacuation protocol has been updated to reflect these changes, that the clients can be lifted as needed to remove them from the home as quickly and safely as possible. The team met	09/08/2024

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			to discuss this, and we do feel that one person on third shift is adequate, as in a true emergency, the alarm would sound so help would be on the way, while the staff person removes each client as quickly as possible to safety. All group home management has been trained on ensuring their evacuation protocols are written per emergency management transfers for each client, not per physical therapy recommendations. The other seven group home client evacuation protocols are being reviewed to ensure they are accurate and have been updated for 2024 at this time as well.	