STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G746	A. BUILDING -- B. WING	09/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16609 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 09/16/20 Facility Number: 011664 Provider Number: 15G746 AIM Number: 200902010 At this Emergency Preparedness survey, Res Care Southeast Indiana was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 4 certified beds. All 4 beds are certified for Medicaid. At the time of the survey, the census was 4. Quality Review completed on 09/23/20 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
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]:			

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

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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	(2) Testing. The [facility] must conduct 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]			

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	emergency plan, as needed. *[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.			

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	(3) Testing for hospices that provide inpatient 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, as			

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	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; (ii) conduct an additional exercise that may include,	E 0039	1.The Facility will conduct a community based disaster drill and provide documentation annually that consists of an actual natural or man-made emergency within the most recent twelve month period. 2.The Program Manager will schedule a community drill with local Emergency Services before October 19, 2020 and will be conducted no later than October 31, 2020. This drill will include Nursing, Quality Assurance, Area Supervisors, and Residential	10/31/2020

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	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 03/24/20 documentation with the Home Manager during record review from 10:50 a.m. to 12:30 p.m. on 09/16/20, documentation of two community based disaster drills conducted within the most recent twelve month period was not available for review. The facility did have documentation of a tabletop exercise on implementing Covid 19 safety measures within the most recent twelve month period but did not document a community based disaster drill. Based on interview at the time of record review, the Home Manager agreed the facility has not conducted and documented a community based disaster drill or experienced and documented an actual natural or man-made emergency within the most recent twelve month period and agreed additional testing documentation was not available for review at the time of the survey.		Managers. 3.The Program Manager will ensure the Facility conduct a community based disaster drill annually. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, Quality Assurance, Nursing.	
K 0000				

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Bldg. 01	A Life Safety Code Certification and Environmental Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/16/20 Facility Number: 011664 Provider Number: 15G746 AIM Number: 200902010 At this Life Safety Code survey, Res Care Southeast Indiana was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and in client sleeping rooms. The facility has a capacity of 4 and had a census of 4 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 Prompt with an E-Score of 0.7. Quality Review completed on 09/23/20	K 0000		
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC			

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	Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain 1 of 2 battery operated lighting systems. LSC 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Home Manager during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 09/16/20, the wall mounted battery lighting system by the Side A Laundry room failed to illuminate when its test button was pushed multiple times. Based on interview at the time of the observations, the Home Manager agreed the aforementioned battery lighting system failed to illuminate when its test button was pushed multiple times.	K S100	1.The Facility will ensure interior emergency lights are tested, maintained, and records of testing are maintained. 2.The Facility will ensure interior emergency lights are tested at a minimum of 3 weeks and a maximum of 5 weeks for no less than 30 seconds, records of test will be maintained by the facility. 3.The facility will ensure a functional test is conducted annually for a minimum of 1 ½ hour for all battery powered interior emergency lights, records of the test will be maintained by the facility. 4.The Program Manager will schedule a service order with Koorsen Fire and Security to repair or replace the emergency light Persons Responsible: Program Manager, Area Supervisor, and Residential Manager, DSP.	10/16/2020

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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 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 manual fire alarm systems was maintained in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, 14.2.1.2.1 states the requirements of Section 10.19 shall be applicable when a system is impaired. Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations at 10:40 a.m. on 09/16/20 at the time of entrance to the facility with each of the two Direct Service Providers (DSP) and the Home Manager, the remote fire panel by the main entrance door had no electrical power and was not in operation. Based on interview at the time of the observations, the Home Manager stated the fire alarm system was in the trouble mode starting on 09/14/20 and was shut down. The Home Manager stated a work order has been submitted for repairs	K S345	1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. **3.The Program Manager will meet with a representative from Koorsen Fire and Security, a tentative date has been set for October 10, 2020 pending the status of the**	10/16/2020

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	and the facility has been doing a fire watch since 09/14/20. Based on record review from 10:50 a.m. to 12:30 p.m. on 09/16/20, the Home Manager produced fire watch documentation starting 09/14/20 and e-mail documentation stating work orders had been submitted for repair. Based on interview at the time of record review, the Home Manager agreed the fire alarm system was inoperable and in need of repair. 2. Based on record review, observation and interview; the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency 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, 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. 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.		**COVID-19 response and suspense of none essential travel. The Facility will require schedule required testing and request copies of inspections and testing mailed to the program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany IN 47150.** 4.The Program Manager spoke with the Kris Carney from Koorsen Fire and Security effective immediately all sites will have an annual functional fire alarm inspection in the Month of February and a semiannual fire alarm visual inspection completed in August. Repair of the devices that failed the sensitivity test has been scheduled to be completed no later than October 16, 2020. Access to the device will be made available and that device will be tested no later than October 16, 2020. Koorsen Fire and Security was notified of ResCare's "In Scope Services Agreement" that automatically authorizes repair/service of fire systems. Koorsen will notify the Program Manger upon completion of all inspections to ensure any deficiencies are properly tracked and repaired. Koorsen will send documentation of all inspections, services and repair to ResCare main office at 4341 Security Parkway STE. 101 New Albany IN	

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	Findings include: Based on record review with the Home Manager from 10:50 a.m. to 12:30 p.m. on 09/16/20, Initial/Reacceptance testing documentation for heat detectors installed the attic was not available for review. Review of the fire alarm system contractor's "Sensitivity and Detection Inspection Report" documentation dated 08/26/20, three heat detectors were visually inspected. The heat detector locations were identified as in the kitchen, above the fire panel and in the garage. No heat detectors were listed in the attic. Based on interview at the time of record review, the Home Manager agreed Initial/Reacceptance testing documentation or testing or visual inspection documentation for attic heat detectors within the most recent twelve month period was not available for review. Based on observations with the Home Manager during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 09/16/20, an attic access door and ladder was noted in the garage. One heat detector was noted installed in the attic		47150 with in 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required. Persons Responsible: Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative.	
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.			

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	NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section			

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	13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 sprinkler systems was tested and/or inspected in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.4 states the freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solution if necessary. Solutions shall be in accordance with Table 5.3.4.1(a) and Table 5.3.4.1(b). Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all clients, staff and visitors. Findings include: Based on review of the sprinkler system	K S353	1.The Program Manager will order two additional spare sprinkler heads from Koorsen Fire and Security to ensure there are at least six spare sprinkler heads are available in the spare sprinkler head cabinet. 1.The Staff will conduct monthly inspections to ensure six spare sprinkler heads are available if not staff will call 844-RESCARE and set up a service ticket with Koorsen Fire and Security to provided needed spare sprinkler heads. **Persons Responsible:** Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security	10/16/2020

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	inspection contractor's "Systems Service" documentation dated 11/14/19 and 05/19/20 with the Home Manager during record review from 10:50 a.m. to 12:30 p.m. on 09/16/20, annual testing documentation of the antifreeze solution for the facility's sprinkler system was not available for review. Based on interview at the time of record review, the Home Manager stated additional sprinkler system inspection documentation was not available for review. Based on observations with the Home Manager during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 09/16/20, the sprinkler system inspection contractor affixed a hanging tag to the sprinkler system riser in the garage which stated the antifreeze solution was last tested in February 2019 and tested at - 15 degrees Fahrenheit. Based on interview at the time of the observations, the Home Manager stated antifreeze testing documentation within the most recent twelve month period was not available for review. 2. Based on observation and interview, the facility failed to ensure 2 of over 10 sprinkler heads in the facility were maintained. NFPA 13R, Standard for the Installation of Sprinkler Systems in Low Rise Residential Occupancies, 2010 Edition, Section 5.1.1.6.3 states cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observations with the Home Manager during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 09/16/20, the concealed sprinkler on the ceiling in the Side A restroom and the concealed sprinkler on the ceiling in the Side A Laundry Room each was missing its cover plate. Based on		Representative.	

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	interview at the time of the observations, the Home Manager agreed the aforementioned sprinkler head locations were each missing their cover plate. 3. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers on the premises. NFPA 13R, Standard for the Installation of Sprinkler Systems in Low Rise Residential Occupancies, 2010 Edition, Section 11.1 states at least three spare sprinklers of each type, temperature rating, and orifice size used in the system shall be installed on the premises. NFPA 13R, Section 11.3 states sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25. 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. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Home Manager during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 09/16/20, only four spare sprinklers were noted on the premises inside the spare sprinkler			

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	cabinet near the sprinkler system riser in the garage. Based on interview at the time of the observations, the Home Manager agreed fewer than six spare sprinklers were noted on the premises.			
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical wiring in the facility was maintained in safe operating condition. LSC 33.2.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3)(c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Home Manager during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 09/16/20, electrical wiring confined within a wall mounted junction box behind the sprinkler system riser in the garage was not provided with a cover compatible with the box. Based on interview at the time of the observations, the Home Manager agreed the aforementioned junction box was not provided with a cover	K S511	1.The Program Manager will ensure electrical wiring confined within the wall mounted junction box behind the system riser in the garage is provided with a cover compatible with the box. 2.The Program Manager will contact ResCare Maintenance and schedule a service call to ensure electrical wiring confined within the wall mounted junction box behind the system riser in the garage is provided with a cover compatible with the box installed as required by NFPA 101. 3.Any delay in the installation due to delays created by COVID-19 protocols or restrictions will be reported to the Program Manager and updated daily until the installation is complete. Persons Responsible: Program	10/16/2020

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	compatible with the box.		Manager, ResCare Maintenance.	