STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G655	A. BUILDING -- B. WING	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE BELT ARC INC	2606 H ST BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 09/02/21 Facility Number: 001166 Provider Number: 15G655 AIM Number: 100445440 At this Emergency Preparedness survey, Stone Belt ARC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has a capacity of six and had a census of six at the time of this survey. Quality Review completed on 09/13/21	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 §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). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	§491.12, and ESRD Facilities at §494.62]: (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] emergency plan, as needed.			

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

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	(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):] (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			

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	(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. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization 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,			

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	facility-based functional exercise; or (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. (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 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[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.			

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	(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 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			

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	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 needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a 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 every 2 years; or. (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 full-scale community-based or			

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	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 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.			

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	(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. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (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. (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.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility 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 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. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	**E 039 EP Testing Requirements CFR(s): 483.475(d)(2)** **Corrective action for resident(s) found to have been affected:** The agency has an Emergency Preparedness Plan that was revised in December 2020, which is based on a facility-based and community-based risk assessment and includes strategies for addressing the emergency events identified in the risk assessment. The staff working at the home will receive training on the emergency preparedness plan. The Director of SGL will develop a tabletop exercise includes a group discussion, using a narrated,	10/02/2021

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	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. (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 the facility's Emergency Preparedness plan on 09/02/21 between 9:45 a.m. and 11:45 a.m. with the Client Support Coordinator (CSC) present, the facility provided emergency preparedness documentation, however it was incomplete. There was documentation provided of the facility's response to the COVID-19 Public Health Emergency, however, the facility was unable to provide documentation of an additional exercise to test the emergency preparedness plan. Based on interview at the time of record review, the CSC acknowledged he was unable to provide documentation of an additional exercise. This finding was reviewed with the CSC during the exit conference.		clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge the agency's emergency plan. Once this is developed, the Director of SGL will schedule a staff meeting to conduct this tabletop exercise and document that the exercise was completed. **How facility will identify other residents potentially affected & what measures taken:** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence:** Once a tabletop exercise for testing the agency's emergency preparedness plan has been developed and all staff have participated in the exercise, the agency will schedule subsequent exercises to take place on an annual basis. The Director of SGL will put track the dates of each training on the Emergency Preparedness Plan in a spreadsheet to monitor when the facility is due to receive subsequent training, in order to meet compliance with Life Safety code. **How corrective actions will be monitored to ensure no**	

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			recurrence: The Director of SGL will track the dates of each tabletop exercise completed by the facility staff in a spreadsheet to monitor when the facility is due to receive subsequent training, in order to meet compliance with Life Safety code. Training sheets documenting the staff members' participation in the exercise will also be submitted to the QIDP for review.	
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: 09/02/21 Facility Number: 001166 Provider Number: 15G655 AIM Number: 100445440 At this Life Safety Code survey, Stone Belt ARC Inc. 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 sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors, sleeping rooms, and common living areas, plus heat	K 0000		

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	detection in the attic connected to the fire alarm system. The facility has a capacity of six and had a census of six 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 0.5. Quality Review completed on 09/13/21			
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 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 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.	K S100	K0100 General Requirements - Other CFR(s): NFPA 101 **Corrective action for resident(s) found to have been affected:** The agency currently uses a monthly Drill Safety Report. One component of this monthly form is to conduct a functional test of the emergency lighting system. House managers are responsible for completing these forms on a monthly basis and then turn them in to the Coordinator. In this case, the house manager had not been completing the Drill Safety reports	10/02/2021

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	(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 clients and staff. Findings include: Based on observations on 09/02/21 between 9:45 a.m. and 11:45 a.m. during a tour of the facility with the Client Support Coordinator (CSC), the facility had three battery powered emergency light units. Based on record review between 9:45 a.m. and 11:45 a.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 available for an annual 90 minute test during the past 12 months. Based on interview at the time of record review and observations, the CSC said there was no documentation to show a 30 monthly test for for the past 12 month period, plus an annual 90 minute test during the past 12 months for the three battery powered emergency lights. This finding was reviewed with the CSC during the exit conference.		on a monthly basis, so they were not available for review at the time of survey. The Coordinator will provide retraining to the house manager on how to complete the Drill Safety Report form to ensure that functional testing of the emergency lighting system is completed on a monthly basis. **How facility will identify other residents potentially affected & what measures taken:** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence:** The Coordinator will review monthly paperwork and ensure that the Drill Safety Reports have been completed each month. Additionally, Director of SGL will revise the Drill Safety Report to include prompts for staff members to itemize the emergency lighting devices by location in the home and to test each device for a minimum of 30 seconds on a monthly basis. The 90-minute testing of the emergency lighting will be conducted by facility maintenance staff on an annual basis. **How corrective actions will be monitored to ensure no recurrence:** The Coordinator will review	

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			monthly paperwork and ensure that the Drill Safety Reports have been completed and documented each month. These reports will also be forwarded to the head of the agency's Safety Committee for review.	
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 ensure complete documentation was provided for 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 09/02/21 between 9:45 a.m. and 11:45 a.m. with the Client Support Coordinator (CSC) present, there was documentation for an annual fire alarm system	K S345	**K0345 Fire Alarm System - Testing and Maintenance** **CFR(s): NFPA 101** **Corrective action for resident(s) found to have been affected:** The facility maintenance staff will contact the fire alarm system inspection contractor to request a more detailed inspection report, which includes an itemized listing of all heat detectors. **How facility will identify other residents potentially affected & what measures taken:** All residents potentially are	10/02/2021

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	test/inspection dated 05/10/21 by the facility's fire alarm system vendor, however, the documentation was incomplete. The inspection report provided did not include an inspection of the heat detectors in the attic. There was no means of inspecting the attic for heat detectors during this survey, however, there was a document available from the facility's fire alarm system vendor stating that four heat detectors were installed in 2019. Based on interview at the time of record review, the CSC acknowledged the lack of information about attic heat detectors being inspected during the annual fire alarm system test/inspections dated 05/10/21. This finding was reviewed with the CSC at the exit conference.		affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence:** The facility will consult with the inspection company to request that the inspection of heat detectors be included in each annual inspection report moving forward. **How corrective actions will be monitored to ensure no recurrence:** The Director of SGL will inform the facility maintenance staff of the actions taken to correct this deficiency. The facility maintenance staff will monitor this, as well, when conducting semiannual visual inspections of the fire alarm system.	
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 Based on record review and interview, the facility failed to document monthly sprinkler system inspections in accordance with NFPA 25. 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.	K S353	K0353 Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 **Corrective action for resident(s) found to have been affected:** The agency currently uses a monthly Drill Safety Report. One component of this monthly form is to conduct a functional test of the emergency lighting system. House managers are responsible for completing these forms on a monthly basis and then turn them in to the Coordinator. In this case, the house manager had not been completing the Drill Safety reports on a monthly basis, so they were not available for review at the time of survey. The Coordinator will provide retraining to the house	10/02/2021

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	Findings include: Based on record review on 09/02/21 between 9:45 a.m. and 11:45 a.m. with the Client Support Coordinator (CSC) present, there was no documentation the sprinkler gauges and control valves were inspected on a monthly during 12 of the past 12 months. Based on interview at the time of record review, the CSC said there was no monthly inspection documentation of the sprinkler system gauge readings and control valves available for review. This finding was reviewed with the CSC during the exit conference.		manager on how to complete the Drill Safety Report form to ensure that sprinkler system gauge readings and inspections of the control valves are completed on a monthly basis. **How facility will identify other residents potentially affected & what measures taken:** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence:** The Coordinator will review monthly paperwork and ensure that the Drill Safety Reports have been completed each month. **How corrective actions will be monitored to ensure no recurrence:** The Coordinator will review monthly paperwork and ensure that the Drill Safety Reports have been completed and documented each month. These reports will also be forwarded to the head of the agency's Safety Committee for review.	
K S712 Bldg. 01	NFPA 101 Fire Drills 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			

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	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 review of the facility's fire drill reports on 09/02/21 between 9:45 a.m. and 11:45 a.m. with the Client Support Coordinator (CSC) present, there were no fire drill report available for the following shifts and quarters: a. First shift (day) of the fourth quarter (October, November, and December) of 2020, first quarter (January, February, and March), and	K S712	K0712 Fire Drills CFR(s): NFPA 101 **Corrective action for resident(s) found to have been affected** The QIDP will provide retraining to house staff members on how to complete evacuation drills and how to document that drills are completed. The agency uses a drill calendar that all staff can access. **How facility will identify other residents potentially affected & what measures taken**	10/02/2021

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	second quarter (April, May, and June) of 2021 b. Second shift (evening) of the fourth quarter (October, November, and December) of 2020, and second quarter (April, May, and June) of 2021 c. Third shift (night) of the third quarter (July, August, and September) of 2020 and so far in 2021, and fourth quarter (October, November, and December) of 2020, and first quarter (January, February, and March) of 2021. Based on interview at the time of record review, the CSC confirmed the lack of fire drills during the previously mentioned shifts and quarters of 2020 and 2021. This finding was reviewed with the CSC during the exit conference.		All residents potentially are affected, therefore corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** The agency currently uses a Group Home Audit form, which is a checklist of items to review at each facility on at least a quarterly basis. The Director of SGL and Associate Director of SGL will review and revise the facility audit form to add evacuation drill documentation as an item to be reviewed by the QIDP on at least a quarterly basis. If the QIDP identifies deficiencies through this review process, corrective action will be taken. **How corrective actions will be monitored to ensure no recurrence** The agency currently uses a Group Home Audit form, which is a checklist of items to review at each facility on at least a quarterly basis. As stated above, the Director of SGL and Associate Director of SGL will review and revise the facility audit form to add evacuation drills as an item to be reviewed by the QIDP on at least a quarterly basis. When QIDPs complete a form, the audit form will be turned into the Director and Associate Director of SGL, so that they will be made aware of any	

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			deficiencies and corrective actions taken.	