STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G137	A. BUILDING -- B. WING	03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORMAL LIFE OF INDIANA	8616 NORTHFIELD DR EVANSVILLE, IN 47713

(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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 01/17/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/04/24 Facility Number: 000674 Provider Number: 15G137 AIM Number: 100234390 At this PSR to the Emergency Preparedness survey, Normal Life of 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 8 certified beds. At the time of this survey, the census was 8. Quality Review completed on 03/06/24 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0007 Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3) EP Program Patient Population §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Danica Curtis	QA Manager	04/03/2024

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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	§494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice	E 0007	The facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations	04/05/2024

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	could affect all occupants. Findings include: Based on review of the Emergency/Disaster Preparedness Manual on 03/04/24 between 10:15 a.m. to 10:45 a.m. with the Group Home Manager present, the emergency preparedness plan for the facility did not address the special needs of its client population, continuity of operations during an emergency, or the type of services the facility has the ability to provide in an emergency. Additional documentation was not available for review at the time of the survey. Based on interview at the time of record review, the Group Home Manager said she was not aware of the necessary documentation needed and that it was not available for review at the time of the survey. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		of authority and succession plans. The emergency preparedness policies and procedures will be updated to include a plan to address the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. The Area Supervisor will in-serviced to include in the emergency preparedness policies and procedures the plan to address the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. The Program Manager will in-serviced to include in the emergency preparedness policies and procedures the plan to address the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. The Area Supervisor will monitor with monthly checks to ensure	

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			emergency preparedness manual is up to date. The Program Manager will monitor with monthly checks to ensure the emergency preparedness manual is up to date. Persons Responsible: Area Supervisor, Program Manager, QAM	
E 0025 Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event			

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	of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency/Disaster Preparedness Manual 03/04/24 between 10:15 a.m. and 10:45 a.m. with the Group Home Manager present, the emergency preparedness plan for the facility did not include policies and procedures for the development of arrangements with other ICF/IID facilities and other providers to receive	E 0025	=”” b=””> The emergency preparedness policies and procedures will be updated to include the development of arrangements with other ICF/IDD facilities or other providers to receive residents in the event of limitations or cessation operations to maintain the continuity of services to ICF/IID clients. The Area Supervisor will be in-serviced to include and monitor with monthly checks to ensure the the policy and procedure the development of arrangements with other ICF/IID facilities or other providers to receive residents in the event of limitations or	04/05/2024

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	residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients. Based on interview at the time of record review, the Group Home Manager said she was not aware of arrangements with other ICF/IID facilities, and agreed arrangement policies and procedures with other providers was not available for review at the time of this survey. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		cessation of operations to maintain the continuity of services to ICF/IID clients. The Program Manager will be in-serviced to include and monitor with monthly checks to ensure the policy and procedure the development of arrangements with other ICF/IID facilities or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients. Persons Responsible: Area Supervisor, Program Manager, QA Manager ="" bthe="">

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| E 0030 | 403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), | | | |

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Bldg. --	483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1) Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.			

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	*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff.			

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	(ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency/Disaster Preparedness Manual on 03/04/24 between 10:15 a.m. and 10:45 a.m. with the Group Home Manager present, incorrect name and contact information for the service provider for the fire alarm system and maintenance service provider were listed in Emergency Phone Numbers. The facility listed Van Guard as their service provider for their fire alarm system, however, Van Guard was purchased by another fire alarm system vendor several years ago. The Group Home Manager said the facility	E 0030	The emergency preparedness communication plan has been updated to include the correct name and contact information for the fire alarm system. The emergency phone contact information for maintenance was updated. The Area Supervisor was in-serviced to include the correct name and contact information for the service provider for the fire alarm system and maintenance personnel. The Program Manager was in-serviced to include the correct name and contact information for the service provider for the fire alarm system and maintenance personnel.	04/05/2024

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	uses a different vendor as their service for the fire alarm system. The facility also lists Aramark as their maintenance service provider, although the Group Home Manager said the facility does not use Aramark currently and has not for a long time. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		The Area Supervisor or designee will ensure with monthly checks that the emergency preparedness communication plans includes the correct name and contact information for the fire alarm system and the correct maintenance contact information. The Program Manager or designee will ensure with monthly checks that the emergency preparedness communication plans includes the correct name and contact information for the fire alarm system and the correct maintenance contact information. Persons Responsible: Area Supervisor, Program Manager, QA Manager	
E 0031 Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC			

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	facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) Other sources of assistance (iii) The State Licensing and Certification Agency (iv) The State Protection and Advocacy Agency in accordance with 42 CFR 483.475(c)(2). This deficient practice could affect all occupants. Findings include:	E 0031	The Emergency Preparedness Communication was updated to include the contact information for the Indiana Bureau of Development Disability Services. The Area Supervisor was in-serviced to include the contact information for the Indiana Bureau of Development Disability Services.	04/05/2024

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	Based on review of the Emergency/Disaster Preparedness Manual on 03/04/24 between 10:15 a.m. and 10:45 a.m. with the Group Home Manager present, no documentation of the contact information for the Indiana Bureau of Development Disability Services or Indiana Protection and Advocacy Services was presented. Based on interview at the time of record review, the Group Home Manager confirmed there was no contact information for the Indiana Bureau of Development Disability Services or Indiana Protection and Advocacy Services available for review. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		The Area Supervisor or designee will ensure with monthly checks that the emergency preparedness communication plans includes the the contact information for the Indiana Bureau of Development Disability Services. The Program Manager or designee will ensure with monthly checks that the emergency preparedness communication plans includes the the contact information for the Indiana Bureau of Development Disability Services. Persons Responsible: Area Supervisor, Program Manager, QA Manager	
E 0035 Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated			

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(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
	at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency/Disaster Preparedness Manual (E/DPM) on 03/04/24 between 10:15 a.m. and 10:45 a.m. with the Group Home Manager present, no documentation was provided regarding the facility's method for sharing appropriate emergency preparedness information with clients and family. The Group Home Manager acknowledged this information was not provided within the E/DPM as far as she knew. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0035	E35 ="" span="">Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives. ="" span="">="" span="">="" span="">="" span="">="" span="">="" p="">**b="">** ="" b="">="" b="">="" b="">**b="">** ="" b="">Ensure the home has the method for sharing information from the emergency plan in the emergency preparedness manual. The Area Supervisor will be in-serviced to ensure the emergency preparedness	04/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			communication plans method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives. The Program Manager will be in-serviced to ensure the emergency preparedness communication plans method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives. The Area Supervisor or designee will ensure with monthly checks that the emergency preparedness communication plans includes the method for sharing information with clients and their families. The Program Manager or designee will ensure with monthly checks that the emergency preparedness communication plans includes the method for sharing information with clients and their families. Persons Responsible: Area Supervisor, Program Manager, QA Manager, Executive Ma nager ="" span="">="" span="">="" p="">	
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),			

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	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 §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			

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	(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 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			

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	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: (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			

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	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 (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 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, 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):]			

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	(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 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			

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	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 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			

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	(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 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			

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	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. *[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; 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	E 0039	="" span="">Emergency exercise was completed to test the emergency preparedness plan on 4/2/24. ="" span="">Area Supervisor will be in-serviced on completing and documenting all quarterly tabletop exercises in lieu of a full-scale community based or facility-based functional exercise. The tabletop	04/05/2024

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	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 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: 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 the 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency/Disaster Preparedness Manual on 03/04/24 between 10:15 a.m. and 10:45 a.m. with the Group Home Manager present, no documentation for a full-scale community based exercise was presented. The facility did complete a few table top exercises on various dates. The Group Home Manager said she was not aware if the facility has documentation of a full-scale community based exercise to review. This finding was reviewed with the Group Home		exercise led by an Area Supervisor that includes a group discussion with clients and staff assigning job responsibilities and using a narrated, clinically-relevant emergency scenario and a set of problem statements, directed messages , or prepared questions designed to challenge the emergency plan. ="" span="">

="" span="">Area Supervisor or designee will ensure through monthly visits to home that all Emergency Preparedness guidelines are completed, documented, and placed in the Emergency Preparedness Manual.
="" span="">Program Manager or designee will ensure through monthly visits to home that all Emergency Preparedness guidelines are completed, documented, and placed in the Emergency Preparedness Manual.
="" span="">
="" span="">Persons Responsible: DSP, Area Supervisor, QIDP, and Program Manager

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	Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		=" span="">=" span="">=" span="">=" p="">**b="">**=" b="">=" b="">=" b="">**b="">**=" b="">|	
K 0000 Bldg. 02	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 01/17/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/04/24 Facility Number: 000674 Provider Number: 15G137 AIM Number: 100234390 At this PSR to the Life Safety Code survey, Normal Life of 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 not sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, sleeping rooms, and common living areas, plus heat detection in the attic connected to the fire alarm system. The	K 0000		

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	facility has a capacity of 8 and had a census of 8 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 0.32. Quality Review completed on 03/06/24			
K S222 Bldg. 02	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR			

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	483.470(j)(1)(ii) Based on observation and interview, the facility failed to ensure 1 of 3 bathroom doors was arranged so that staff could enter the bathroom in the event of an emergency if the bathroom door become locked. This deficient practice could affect the occupant of the bathroom. Findings include: Based on observation on 03/04/24 between 10:15 a.m. and 10:45 a.m. during a tour of the facility with the Group Home Manager, the door knob to the south hallway bathroom had the turnlock on the hall side of the door which would not allow the occupant of the bathroom to unlock the door from inside the bathroom without the use of a key. Based on an interview at the time of the observation, the Group Home Manager acknowledged the door knob was installed backwards and said there was no key to the door inside the bathroom. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S222	K222 Based on observation and interview, the facility failed to ensure 1 of 3-bathroom doors was arranged so that staff could enter the bathroom in the event of an emergency if the bathroom door become locked. This deficient practice could affect the occupant of the bathroom. Replace the turnlock on the hall side of the door in the south hallway. All turnlock have been replaced. In the service maintenance department that that the doors should not have a turnlock. Staff must be able to enter all doors in case of an emergency. In service Area Supervisor that that the doors should not have a turnlock. Staff must be able to enter all doors in case of an emergency. In the Program Manager that that the doors should not have a turnlock. Staff must be able to enter all doors in case of an emergency. Area Supervisor or designee will ensure through monthly visits to the home that there are no turnlocks on doors. Program Manager or designee will ensure through monthly visits to home that there are no turnlocks on doors.	04/05/2024

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			Person Responsible: Maintenance department, Area Supervisor, QIDP, Program Manager. ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b="">	
K S341 Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 heat detector in the laundry room was secured to the ceiling surface. NFPA 72, 2010 edition, at 17.4.4 states Initiating devices shall be supported independently of their attachment to the circuit conductors. This deficient practice could affect all occupants. Findings include: Based on observations on 03/04/24 between 10:15 a.m. and 10:45 a.m. during a tour of the facility with the Group Home Manager, there was a ceiling mounted heat detector in the laundry room hanging from the ceiling by its wires. Based on interview at the time of observation, the Group Home Manager agreed the heat detector in the	K S341	**b="">** **341** **Based on observation and interview, the facility failed to ensure 1 of 1 heat detector in the laundry room was secured to the ceiling surface.** **Maintenance department will contact Koorsen Fire and Safety to repair mounted heat detector in the laundry room.** **In service all staff to notify their chain of command immediately for any concerns**	04/05/2024

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	laundry room was hanging from the ceiling and not secured. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		**regarding the fire alarm.** **In service the Area Supervisor to notify their chain of command immediately for any concerns regarding the fire alarm.** **In service the QIDP to notify their chain of command immediately for any concerns regarding the fire alarm.** **In service the Program Manager to notify their chain of command immediately for any concerns regarding the fire alarm.** **Maintenance department or designee will monitor with monthly checks of home to ensure that heat detectors are secured to the ceiling surface.** **Area Supervisor or designee will monitor with monthly checks of home to ensure that heat detectors are secured to the ceiling surface.** **Program Manager or designee will monitor with monthly checks of home to ensure that heat detectors are secured to the ceiling surface.** **Persons Responsible: Maintenance Department, Area**	

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			Supervisor, QIDP, Program Manager ="" b=""> ="" b=""> ="" b=""> ="" b=""> **="" b="">** ="" b="">	
K S345 Bldg. 02	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 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. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:	K S345	**b="">** **345** **Based on record review, observation, and interview; the facility failed to ensure 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**	04/05/2024

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	a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients and staff. Findings include: Based on record review on 03/04/24 between 10:15 a.m. and 10:45 a.m. with the Group Home Manager present, there was no annual fire alarm inspection report available for review for the past twelve month period or prior. Furthermore, there was no semi-annual fire alarm system inspection report available for review for the past twelve month period or prior. Based on interview at the time of record review, the Group Home Manager confirmed there was no annual or semi-annual fire alarm system report available for review during the past twelve month period. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained 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		**shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:** **a. Control unit trouble signals** **b. Remote annunciators** **c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)** **d. Notification appliances** **e. Magnetic hold-open devices** **This deficient practice could affect all clients and staff.** **Maintenance Department will schedule Koorsen Fire and Safety to inspect visually: visually inspected semi-annually:** **a. Control unit trouble signals** **b. Remote annunciators** **c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)** **d. Notification appliances** **e. Magnetic hold-open devices** **f. Sensitivity Test**	

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	Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review on 03/04/24 between 10:15 a.m. and 10:45 a.m. with the Group Home Manager present, there was no smoke detector sensitivity test documentation available for review for the past 24 months or prior. Based on interview at the time of record review, the Group Home Manager confirmed there was no documentation of a sensitivity test of the smoke detectors available to review. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		**Area Supervisor will be in serviced to ensure with monthly checks that all inspections and documentation are completed and ready for review.** **Program Manager will be in serviced to ensure with monthly checks that all inspections and documentation are completed and ready for review.** **QAM will be in serviced to ensure that all inspections and documentation are completed and ready for review.** **Maintenance Department will be in serviced to ensure that all inspections and documentation are completed and ready for review.** **Responsible Persons: Program Manager, QAM, Maintenance Department.** ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> **b="">** ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b=""> ="" b="">	

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K S363 Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure 3 of 4 client bedroom doors/frames were not damaged, would close completely and latch automatically, and were smoke resistant in this non-sprinklered home. This deficient practice could affect all clients. Findings include: Based on observations on 03/04/24 between 10:15 a.m. and 10:45 a.m. during a tour of the facility with the Group Home Manager, the following was noted: a. Client bedroom door #1 (south side of house,	K S363	Direct Support Staff will be in-serviced regarding ensuring that all bedroom doors automatically close and latch and that rooms are smoke resistant and to report all discrepancies to maintenance immediately via protocol. Area Supervisor will be in-serviced regarding ensuring that all bedroom doors automatically close and latch and that rooms are smoke resistant and to report all discrepancies to maintenance	03/29/2024

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	first door on left) was provided with a self closing device, however, the door would not self close when opened fully, plus there were ten small holes completely through the door, each about a quarter inch in size, at the top of the door near the self closing device. b. Client bedroom door #2 (south side of house, second door on left) had a missing strip of wood from the latching side of the door frame which created a quarter inch space between the door and door frame. c. Client bedroom door #4 (only bedroom on north side of house) had a missing strip of wood from the latching side of the door frame which created a quarter inch space between the door and door frame. Based on interview at the time of each observation, the Group Home Manager acknowledged the issues with the bedroom doors and door frames. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		immediately via protocol. QIDP will be in-serviced regarding ensuring that all bedroom doors automatically close and latch and that rooms are smoke resistant and to report all discrepancies to maintenance immediately via protocol. Program Manager will be in-serviced regarding ensuring that all bedroom doors automatically close and latch and that rooms are smoke resistant and to report all discrepancies to maintenance immediately via protocol. Direct Support Staff will monitor facility daily to ensure compliance with Life & Safety Guidelines to include but not limited to ensuring all bedroom doors automatically close and latch and that rooms are smoke resistant and report discrepancies to maintenance immediately via protocol. Area Supervisor will monitor facility weekly to ensure compliance with Life & Safety Guidelines to include but not limited to ensuring all bedroom doors automatically close and latch and that rooms are smoke resistant and report discrepancies to maintenance immediately via protocol. QIDP will monitor facility weekly to ensure compliance with Life &	

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			Safety Guidelines to include but not limited to ensuring all bedroom doors automatically close and latch and that rooms are smoke resistant and report discrepancies to maintenance immediately via protocol. Program Manager will monitor facility monthly to ensure compliance with Life & Safety Guidelines to include but not limited to ensuring all bedroom doors automatically close and latch and that rooms are smoke resistant and report discrepancies to maintenance immediately via protocol. Persons Responsible: DSP, Area Supervisor, Program Manager, QA Manager ="" b=""> ="" b=""> ="" b=""> ="" b=""> **b="">** ="" b=""> ="" b=""> ="" b=""> ="" b=""> **b="">** ="" b="">	
K S511 Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas			

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	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 an electrical receptacle in 1 of 4 client bedrooms was protected in according with 33.2.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect at least two clients. Findings include: Based on observations on 03/04/24 between 10:15 a.m. and 10:45 a.m. during a tour of the facility with the Group Home Manager, the electrical receptacle on the wall near bed #1 in client bedroom #3 (south side of house, bedroom on the right) had a missing cover plate which exposed metal and wires. Based on interview at the time of observation, the Group Home Manager acknowledged the cover plate was missing from the electrical receptacle in client bedroom #3. This finding was reviewed with the Group Home Manager during the exit conference. This deficiency was cited on 01/17/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S511	To correct tag 0511 Staff will be in-serviced regarding the requirement that all electrical receptacles must be protected by a receptacle faceplate (cover plate), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. No medical equipment can be plugged into a power strip. Area Supervisor will be in-serviced regarding the requirement that all electrical receptacles must be protected by a receptacle faceplate (cover plate), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. No medical equipment can be plugged into a power strip. QIDP will be in-serviced regarding the requirement that all electrical receptacles must be protected by a receptacle faceplate (cover plate), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. No medical equipment can be plugged into a power strip. Program Manager Area Supervisor will be in-serviced regarding the	04/05/2024

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			requirement that all electrical receptacles must be protected by a receptacle faceplate (cover plate), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. No medical equipment can be plugged into a power strip. Area Supervisor will monitor with monthly site audits to ensure that all electrical receptacles are protected by a receptacle faceplate. QIDP will monitor with monthly site audits to ensure that all electrical receptacles are protected by a receptacle faceplate. Program Manager will monitor with monthly site audits to ensure that all electrical receptacles are protected by a receptacle faceplate. Persons Responsible: Staff, Residential Manager, QIDP, Area Supervisor and program Manager. ="" b=""> ="" b=""> ="" b=""> ="" b=""> **b="">** ="" b="">	