STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G763	A. BUILDING -- B. WING	05/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSITIONAL SERVICES SUB LLC	114 S CHESTNUT ST HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 05/23/23 Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380 At this Emergency Preparedness survey, Transitional Services SUB LLC 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 the survey, the census was 7. Quality Review completed on 05/30/23	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
Bret Beauchamp	Regional Director	06/23/2023

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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	§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: (i) Participate in an annual full-scale exercise			

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	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 (A) When a community-based exercise is not			

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	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, facility-based functional exercise; or (B) If the PACE experiences an actual natural			

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	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. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that			

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	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 requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual,			

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	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 individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2			

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	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. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

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	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: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or	E 0039	E0039 - The Program Supervisor and Program Director will be trained to complete emergency preparedness exercises that are community based, facility based or table top exercises at least annually ongoing. -All staff will be trained on Emergency Preparedness Plan -Program Director and Program Supervisor will be trained on documentation of Emergency Preparedness plan and ensuring plan is in the home -Once documentation for the Emergency Preparedness Plan is completed, a drill will be completed and scheduled twice per year -All staff trainings will be available in the home's safety book and	06/23/2023

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	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-Response Plan on 05/23/23 between 12:00 p.m. and 2:30 p.m. with the Program Director and Program Supervisor present, the facility was unable to provide emergency preparedness documentation for two exercises performed to test the emergency preparedness plan during the past 12 month period. Based on interview at the time of record review, the Program Supervisor said she was not sure if two exercises had been performed during the past 12 month period, and furthermore she could not find documentation of two exercises performed during the past 12 month period. This finding was reviewed with the Program Director and Program Supervisor during the exit conference.		employee files -Documentation of the emergency preparedness exercises will be maintained in the home for immediate review at any time. -Program Supervisor will monitor at least three times weekly during home visits -Program Director will monitor at least once weekly during Site Supervisory Visits Persons Responsible: Program Supervisor, Program Director, Area Director	
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).	K 0000		

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	Survey Date: 05/23/23 Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380 At this Life Safety Code survey, Transitional Services Sub, LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in all living areas and client sleeping rooms, plus heat detection in the attic connected to the fire alarm system. The facility has a capacity of 8 and had a census of 7 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 Slow with an E-Score of 3.68. Quality Review completed on 05/30/23			
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,			

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	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 observation, record review, and interview; the facility failed to ensure 1 of 1 fire alarm system was continuously in proper operating condition. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation of the fire alarm control panel (FACP) on 05/23/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Program Director and Program Supervisor, there was a red "Fire Alarm" and orange "Alarm Silenced" light(s) illuminated on the FACP and the display said "Pull Station", furthermore, the red light on the hard wired smoke detector in the dining room was illuminated. Based on interview at the time of observation, the Program Supervisor said someone had burnt toast last Monday (05/15/23) and set off the smoke detector in the Dining Room. The Program Supervisor further said staff must have pushed buttons on the FACP until the audible alarm was silenced and never reset the FACP properly. During a tour of the facility all pull stations were observed with no problems found. The Program Supervisor was not sure why the display on the FACP read "Pull Station" instead of smoke detector. The Program Supervisor was able to reset the FACP to "System Normal" mode before the conclusion of the survey. This finding was reviewed with the Program Director and Program Supervisor during the exit conference.	K S345	KO345 Fire Alarm System -Fire Alarm system will be inspected by the contractor -Program Director and Program Supervisor will be trained on ensuring the fire alarm system is inspected semi-annually and annually -Program Director and Program Supervisor will ensure the inspections are in the safety book for review -Program Director and Program Supervisor will ensure that any recommendations from the inspection are completed -Program Supervisor will monitor at least three times weekly during home visits -Program Director will monitor weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	06/23/2023

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	2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: 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 05/23/23 between 12:00 p.m. and 2:30 p.m. with the Program Director and Program Supervisor present, there was documentation that an annual fire alarm system inspection was performed on 05/01/23 by the facility's fire alarm system vendor, however, there was no documentation provided regarding a semi-annual visual fire alarm system inspection six months prior to the annual inspection. Based on interview at the time of record review, the Program Supervisor said she thought the inspection had been performed by the fire alarm system vendor, but, acknowledged there was no documentation for a semi-annual visual fire alarm system test/inspection during the past 12 months available for review.			

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	This finding was reviewed with the Program Director and Program Supervisor during the exit conference.			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in 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			

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	25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components	K S353	KO353 Sprinkler System -Contractor will be contacted to inspect and test sprinkler system	06/23/2023

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	had been inspected and tested during 4 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all clients, staff, and visitors in the facility. Findings include: Based on record review on 05/23/23 between 12:00 p.m. and 2:30 p.m. with the Program Director and Program Supervisor present, there were no quarterly sprinkler system inspection reports available for review for the past 12 month period. During an interview at the time of record review, the Program Supervisor said she knows the sprinkler inspection vendor has been to the facility several times during the past year, but confirmed there were no sprinkler system inspection reports available to review.		-Water flow alarm and supervisory alarm devices will be inspected quarterly -Waterflow testing will be scheduled semi-annually -Sprinkler heads will be cleaned in the east bathroom and west bedroom areas -Hole in the ceiling will be repaired -Contractor will replace escutcheon ring -All inspections in regards to safety will be kept in the Safety Book and the office -Program Director and Program Supervisor will ensure that monthly gauge and valve checks will be completed -Program Director and Program Supervisor will ensure that all sprinkler heads are clean and free of obstruction -Program Director and Program Supervisor will be trained on safety requirements in regards to the sprinkler system -All staff will be trained on notifying management of any issues with sprinkler system -Program Director and Program Supervisor will ensure the inspections are in the safety book for review -Program Director and Program Supervisor will ensure that any recommendations from the inspection are completed -Program Supervisor will monitor at least three times weekly during home visits	

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	This finding was reviewed with the Program Director and Program Supervisor during the exit conference. 2. Based on observation and interview, the facility failed to ensure 2 of over 25 sprinkler heads in the facility were free of corrosion, paint, or a foreign material. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could affect all clients and staff. Findings include: Based on observations on 05/23/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Program Director and Program Supervisor, the following was noted: a. The sprinkler head in the east bathroom was covered with paint, corrosion, and dust/lint. b. The sprinkler head in the west bedroom hall had a black plastic material attached to it. Based on interview at the time of observations, the Program Director agreed the sprinkler heads in the east bathroom and west bedroom hall were covered with paint, corrosion, dirt/lint, and a black plastic material. This finding was reviewed with the Program Director and Program Supervisor during the exit conference. 3. Based on record review, observation, and interview; the facility failed to document monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection,		-Program Director will monitor weekly during Site Supervisory visits Persons Responsible: Area Director, Program Director, Program Supervisor	

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	Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states an inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. This deficient practice could affect all clients in the facility. Findings include: Based on record review on 05/23/23 between 12:00 p.m. and 2:30 p.m. with the Program Director and Program Supervisor present, there was no documentation the sprinkler gauges had been inspected on a monthly basis during the past 12 month period. Based on interview at the time of record review, the Program Supervisor confirmed there was no monthly sprinkler gauge inspection documentation available for review. Based on observation during a tour of the facility with the Program Director and Program Supervisor the sprinkler riser was equipped with two pressure gauges. This finding was reviewed with the Program Director and Program Supervisor during the exit conference. 4. Based on observation and interview, the facility failed to ensure the ceiling in 2 of 2			

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	sprinklered smoke compartments of the facility was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect all clients, as well as staff and visitors. Findings include: Based on observations on 05/23/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Program Director and Program Supervisor, the following was noted: a. There was an escutcheon ring missing from a ceiling sprinkler head in the west hall near the rear exit door, which created a 1/2 inch gap around the sprinkler head to the attic space. b. There was a six inch hole in the ceiling on the back side of the air handling unit duct in the sprinkler riser room. Based on interview at the time of each observation, the Program Supervisor confirmed the missing sprinkler escutcheon ring and the hole in the ceiling on the back side of the air handling unit duct. This finding was reviewed with the Program Director and Program Supervisor during the exit conference.			
K S363 Bldg. 01	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			

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	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 1 of 4 client sleeping room doors would close completely and latch into its door frame. This deficient practice could affect all clients. Findings include: Based on observations on 05/23/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Program Director and Program Supervisor, the east hall bedroom door on the left would not close completely and latch into its frame when tested several times. The door appeared damaged around the latching area. Based on interview at the time of observation, the Program Director agreed the bedroom door did not close completely and latch properly when tested. This finding was reviewed with the Program Director and Program Supervisor during the exit conference.	K S363	/p> /p> /p> -Program Director and Program Supervisor will ensure that no obstructions inhibit any exits and that all doors are working correctly -All staff will be trained on reporting any safety issues in the home -Program Director and Program Supervisor will be trained on ensuring all safety issues are addressed -Program Supervisor will monitor at least three times weekly during home visits -Program Director will monitor during weekly Site Supervisory visits Persons Responsible: Program Supervisor, Program Director, Area Director	06/23/2023

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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 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 3 of 4 quarters during the past 12 months. This deficient practice could affect all clients. Findings include: Based on record review on 05/23/23 between 12:00 p.m. and 2:30 p.m. with the Program Director and	K S712	KO712 Fire Drills -All staff will be trained on completing fire drills every quarter for each shift -Program Director and Program Supervisor will be trained on ensuring fire drills are completed every quarter -Program Director and Program Supervisor will ensure that drills	06/23/2023

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	Program Supervisor present, there were only six documented fire drills available during the past 12 month period. There were no fire drill reports available for the following shifts and quarters: a. First (day) shift of the second quarter (April, May, and June) of 2022 and so far in 2023, third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2022. b. Second (evening) shift of the second quarter (April, May, and June) of 2022 and so far in 2023 c. Third (night) shift of the second quarter (April, May, and June) of 2022 and so far in 2023, third quarter (July, August, and September) of 2022 Based on interview at the time of record review, the Program Supervisor said knows there was a fire drill performed in April of 2023 but was unable to find the report, and there were no other fire drill reports available to review for the previously mentioned shifts and quarters. This finding was reviewed with the Program Director and Program Supervisor during the exit conference.		are placed in the safety book -Program Supervisor will monitor at least three times weekly during home visits -Program Director will monitor through weekly Site Supervisor Visits Persons Responsible: Program Supervisor, Program Director, Area Director	