STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING -- B. WING	08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 08/03/2021 Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510 At this Emergency Preparedness survey, Res Care Community Alternatives SE IN 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. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 08/10/21 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)			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING -- B. WING	08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(3), §491.12(a)(3), §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 type of services the ICF/IID facility has the ability to provide in an emergency in accordance with 42 CFR 483.4753(a)(3). This deficient practice could affect all occupants.	E 0007	E 007 EP Program Patient Population CFR(s): 483.475(a)(3) /p> /p> 1. The administrator has developed a Transfer Agreement that will ensure the emergency plan policies and procedures addresses the special needs of its	09/03/2021

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	15G157	A. BUILDING -- B. WING	08/03/2021

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RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) documentation and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, the EPP did not address the type of services the ICF/IID 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 Program Director acknowledged that types of service that might be provided to the community were not included in the EPP. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		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). 2. The need for transfer of a person from YOUR FACILITY to RECEIVING FACILITY shall be determined and recommended by the person's healthcare team, possibly including the attending physician in such team's own judgment. When a transfer is recommended as medically appropriate, a person supported at YOUR FACILITY shall be transferred and admitted to RECEIVING FACILITY as promptly as possible under the circumstances, provided that beds and other appropriate resources are available. 3. The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 4. The corrective action will be monitored and reviewed for effectiveness at a minimum of every two years	

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			The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0009 Bldg. --	403.748(a)(4), 416.54(a)(4), 418.113(a)(4), 441.184(a)(4), 482.15(a)(4), 483.475(a)(4), 483.73(a)(4), 484.102(a)(4), 485.625(a)(4), 485.68(a)(4), 485.727(a)(5), 485.920(a)(4), 486.360(a)(4), 491.12(a)(4), 494.62(a)(4) Local, State, Tribal Collaboration Process §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated			

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	15G157	A. BUILDING -- B. WING	08/03/2021

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RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, the emergency preparedness plan did not include a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Based on interview at the time of record review, the Program Director stated that developing a process and making contact with officials was accomplished at the corporate level of the organization. The Program Director acknowledged that the plan did not document the	E 0009	/p> 1. The emergency plan policies and procedures has been updated to include a continuity of operations plan which addresses notification of the Indiana State Department of Health during a disaster or emergency. To include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. 2. The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3. The corrective action will be monitored and reviewed for effectiveness at a minimum of every two years **The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager**	09/02/2021

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	process and contacts. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.			
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [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 every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting.			

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	(C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review, observation, and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, the provision of water in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, the EPP indicates that one gallon of water per occupant per day for no less than 3 days is to be stored at the facility. Based on observation during the facility tour on	E 0015	1. The administrator will ensure the emergency plan policies and procedures addresses the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, including but not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain – (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire	08/23/2021

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RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, the storage container in the basement for water had 13 gallons of bottled water. Based on interview at the time of observation, the Program Director we calculated the the total amount of of water that should be in storage is 30 gallons (8 consumers and 2 staff x 1 gallon per day x 3 days = 30 gallons). The Program Director agreed that the policy indicated that water was to be stored for an emergency and that only 13 gallons of water were found in emergency supply storage. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). 2. The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3. The program manger will purchase and will deliver 30 gallons of drinking water to be stored for emergency supply before 8/18/2021. 4. The program manager will train the residential manager and area supervisor on the storage is 30 gallons (8 consumers and 2 staff x1 gallon per day x 3 days = 30 gallons) 5. If less than 30 gallons of water is stored for emergency supply staff are to replenish supply, if unable staff will contact Residential Manager or Area Supervisor in order to obtain water. 6. ResCare Management Team will conduct random monthly site visits to ensure an adequate emergency supplies are available	

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			The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(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:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other			

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	location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with			

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	external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff during and after an emergency. If on-duty staff during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all staff. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, there was nothing in the Emergency Preparedness policy which addressed a system to track the whereabouts of staff during an emergency. Based on interview at the time of record review, the Program Director indicated that staff keep their timesheets on-line. The Program Director acknowledged that the system did not account for the location of the staff. The Program Director acknowledged that there was no written policy and procedure which addressed the tracking of staff using the online	E 0018	1.The administrator will ensure the emergency plan policies and procedures addresses the tracking of staff and clients, whether they evacuate or shelter in place. Including the consideration of care and treatment needs of evacuees, staff responsibilities; transportation; identification of evacuation locations; and primary and means of communication with external assistance. 2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The Facility created a staff tracking form to work in conjunction with staff contact list to provided a means of tracking staff through an emergency event. The program Manager will	09/02/2021

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	program or otherwise. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		train the area supervisor and residential manager on the us of this form. 4.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual **The persons responsible** will be the, Program Manager, Area Supervisor, and Residential Manager	
E 0020 Bldg. --	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(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:]			

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	15G157	A. BUILDING -- B. WING	08/03/2021

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RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for	E 0020	1. The emergency plan policies and procedures will be updated to include a continuity of operations	09/02/2021

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RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	safe evacuation from the ICF/IID facility in accordance with 42 CFR 483.475(b)(3). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, the portion of the Emergency Preparedness Plan for Evacuation was a template and provided no site specific policies or procedures. The Program Director acknowledged that the information contained in the plan was a template or outline to be completed specifically for the facility site. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		plan which addresses safe evacuation of from the ICF/IID facility and includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. 2. In the event of an emergency event If possible, it is ideal for the consumers to remain in their own homes. If this is not possible, hotel accommodations need to be arranged or relocation to group homes Longest St, Apache Drive, or New Albany and/or Jasper offices. 3. The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 4. The corrective action will be monitored and reviewed for effectiveness at a minimum every two years. **The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0023 Bldg. --	403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4) Policies/Procedures for Medical Documentation §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(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:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient			

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	information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, no policies and procedures which include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records was available to review. Based on interview at the time of record review, the Program Director stated that the consumer "Red Books" could be reproduced because the nurse has an electronic copy of the document maintained off site. The Program Director acknowledged that the Emergency Preparedness Plan did not address the preservation of client information, protection of consumer confidentiality, and security of records.	E 0023	1. The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses a system of medical documentation of from the ICF/IID facility and includes consideration of maintaining protection of confidentiality of patient information and secures and maintains availability of records. 2. The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3. The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual **The persons responsible will be the, Program Manager, Area**	09/02/2021

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RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

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	This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		**Supervisor, and Residential Manager**	
E 0032 Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(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: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the facility failed to ensure the emergency	E 0032	1. The method of communicating using both a	09/02/2021

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	preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.475(c)(3). This deficient practice could affect all occupants. Findings Includes: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, the Emergency Preparedness Plan has as a alternate means of communication radios that would be brought to the facility. Based on interview at the time of record review, the Program Director there has been no training or exercise to ensure that this method of communication can be useful in an emergency. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies will be place in the EPP by the Program Manager. 2. All staff will be trained on the method of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies. 3. Area Supervisor will ensure the EPP includes a copy the method of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies. 4. The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home	

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			Visitor Sign In form located in each home. 5. Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. /p> /p> **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager.	
E 0034 Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7).			

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	[(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. Findings Include:	E 0034	1. The administrator will ensure the emergency plan policies and procedures will be updated to include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction. 2. The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority	09/02/2021

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	Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, no documentation was available in the Emergency Preparedness Plan to address a means of providing information about the facility's occupancy, needs, and its ability to provide assistance in an emergency. Based on interview at the time of record review, the Program Director acknowledged that the information was not contained in the plan. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed. 3. The corrective action will be monitored and reviewed for effectiveness at a minimum annually **The persons responsible will be the, Program Manager, Area Supervisor, and Residential 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 at least every 2 years. The communication plan must include all of the following:]			

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	(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 record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, a method for sharing information from the emergency plan with clients and their families was not available for review. Based on interview at the time of record review, the Program Director stated that an overview was provided to the families at the annual review. The Program Director agreed that documentation of the method for sharing Emergency Plan information with clients and their families was missing from the written Emergency Plan. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.	E 0035	1. The administrator will develop and maintain an emergency preparedness plan that complies with Federal, State and local laws that must be reviewed annually to include a method for sharing information the facility has determined appropriate, with clients and their family or representatives. 2. The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed. **The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager**	09/02/2021
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program			

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	§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness			

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	training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors,			

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	participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of			

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	emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff,			

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	individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure the emergency preparedness program (EPP) training and testing program includes a training program. The ICF/IID facility must do all of the following: provide emergency preparedness training at least every two years; maintain documentation of all emergency preparedness training; demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, no documentation of training or testing of staff every two years was documented in the emergency preparedness plan. Based on interview at the time of record review, the Program Director acknowledged that the plan only specifically requires that staff receive training at the time of hire. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.	E 0037	/p> 1. The administrator will ensure the emergency plan policies and procedures initial training in emergency preparedness policies and procedures to all new and existing staff, annual emergency training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed in accordance with CFR 483.475(d)(1) and present in the EPP manual. 2. The area supervisor and program manager will provide initial training to all existing staff and new staff and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed. 3. The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual **The persons responsible will be the, Program Manager, Area Supervisor, and Residential**	09/02/2021

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			Manager	
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 §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			

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	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. *[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			

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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 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 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			

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	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 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			

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	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 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,			

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	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 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			

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	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, 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			

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	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 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			

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	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 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			

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	the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct an additional exercise to test the emergency plan at least once per year. The ICF/IID facility must 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 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, documentation of an additional exercise was not available for review. Based on interview at the time of record review, the Program Director it was determined that the EPP did not include scheduled testing or an additional exercise. The Program Director acknowledges that an additional exercise was not accomplished. This deficiency was reviewed with the Program	E 0039	1. The administrator will ensure the emergency plan policies and procedures includes the participation in a full-scale community based exercise and a table top exercise in accordance with CFR 483.475(d)(2) and present in the EPP manual. 2. The area supervisor and program manager will conduct the table top exercise and ensure documentation of the table top exercise and the community based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed. 3. The Program Manager will schedule a training event with community based services the Area Supervisor, and Residential Manager ensure the facility takes part in the training. 4. The Program Manager will contact local community based services to schedule a community based table top exercise before October 21, 2021. **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager.	09/02/2021

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	Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.			
K 0000 Bldg. 03	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/03/2021 Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510 At this Life Safety Code survey, Res Care Community Alternatives SE IN 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 two-story building was determined to be fully sprinklered. Each story of the building has an exterior door at grade serving as the primary means of escape. The construction type was found to be V(000). The facility has a fire alarm system with smoke detection in corridors and all living areas. The attic of the facility is not used for living space, storage, or fuel-fired equipment. The attic is protected by heat detector(s) connected to the fire alarm control panel. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score	K 0000		

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	(E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.9. Quality Review completed on 08/10/21			
K S100 Bldg. 03	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 4 of 4 portable fire extinguisher located in the facility was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by	K S100	**1.** ResCare Maintenance will conduct monthly inspections of all facility fire extinguishers. Documented test dates will be kept onsite and with maintenance manager for review. 2. The AED met with ResCare Maintenance Manager on August 20, 2021 to ensure monthly checks are being performed. 3. The Facility will conduct random monthly inspections by the Residential Manager, Area Supervisor or Program Manager to ensure documentation of Fire Extinguisher Inspections are being completed as required and available for review. If documentation is not available the Program Manager, Area Supervisor or Residential Manager will contact Aramark (844)- RESCARE and create a	09/02/2021

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	an electronic method. Records shall be kept demonstrating that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, portable fire extinguishers have been marked each month with the inspectors initials without noting a specific date. This pattern has been in place for the last 12 months. Based on interview at the time of observation, the Program Director acknowledged that the inspector had not provided the date of the month on which the inspection was performed. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		service order and follow up to ensure completion within 5 days. 4. The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of inspecting Fire Extinguishers and maintaining proper documentation. 5. Random Monthly site visits will be conducted by the management team to verify the inspecting Fire Extinguishers and maintaining proper documentation **Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative.**	
K S345 Bldg. 03	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure the documentation for	K S345	1. The administrator will ensure annual functional testing for	09/02/2021

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	the annual testing of all devices connected to 1 of 1 fire alarm system was complete. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative		initiating devices such as smoke detectors, heat detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2. The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. 3. The Program Manager will meet with a representative from Koorsen Fire and Security, a tentative date has been set for August 16, 2021 The Facility will require schedule required testing and request copies of inspections and testing mailed to the program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany IN 47150. 4. The Program Manager spoke with the Kris Carney from Koorsen Fire and Security effective immediately all sites will have an annual functional fire alarm inspection in the Month of February and a semiannual fire	

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	(19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, no documentation of the fire alarm inspection and testing was available for review. Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, a hanging tag was found at the fire alarm control panel dated 02/21/21. Based on interview at the time of record review, the Program Director acknowledged that the written reports of the fire alarm inspection and testing were not available at the facility. Records of the inspections and tests are maintained at the corporate office. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		alarm visual inspection completed in August. Repair of the devices that failed the sensitivity test has been scheduled to be completed no later than August 31,2021. Access to the device will be made available and that device will be tested no later than August 31, 2021. Koorsen Fire and Security was notified of ResCare's "In Scope Services Agreement" that automatically authorizes repair/service of fire systems. Koorsen will notify the Program Manger upon completion of all inspections to ensure any deficiencies are properly tracked and repaired. Koorsen will send documentation of all inspections, services and repair to ResCare main office at 4341 Security Parkway STE. 101 New Albany IN 47150 within 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required. /b>	
K S347 Bldg. 03	NFPA 101 Smoke Detection Smoke Alarms 2012 EXISTING (Prompt) Approved smoke alarms shall be provided in accordance with 9.6.2.10, unless either of the following exist: 1. Buildings protected throughout by an			

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	approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system, or 2. Buildings are protected throughout by an approved automatic sprinkler system, in accordance with 33.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms. Smoke alarms shall be installed on all levels, including basement but excluding crawl spaces and unfinished attics. Additional smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. These alarms shall be powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas. 33.2.3.4.3.			
	Based on observation and interview; the facility failed to ensure smoke alarms shall be installed in 1 of 6 sleeping rooms. This deficient practice could affect all clients, staff and visitors. LSC section 33.2.3.4.3.1 Approved smoke alarms shall be provided in accordance with 9.6.2.10, unless otherwise indicated in 33.2.3.4.3.6 and 33.2.3.4.3.7. LSC section 9.6.2.10.1.2 The installation of smoke alarms in sleeping rooms shall be required where required by Chapters 11 through 43.	K S347	1.The Program Manager will ensure the installation of a smoke alarm in the sleeping room formerly the garage is installed. The Program manager contacted ResCare maintenance coordinator Dave Danzo to create a work order for the installation of the device by Koorsen Fire and Security no later than September 30, 2021. Installation may be delayed due to COVID 19 shelter	09/30/2021

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	Findings include: Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, no smoke alarms was found in the sleeping room formerly the garage. A heat detector was noted in the room. Based on interview at the time of observation, the Program Director acknowledged the lack of a smoke alarm in the sleeping room. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		in place. 2.The program manager will verify the installation of the smoke alarm and verify functionality. 3.The Associate Executive Director contacted Eric Grey with Koorsen Fire and Security on August 17, 2021 to verify the installation of a smoke detector in the sleeping room that was formally the garage. Upon completion no later than September 30, 2021 documentation will be made available for review. **Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance Manager.**	
K S362 Bldg. 03	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING (Prompt) Unless otherwise indicated below, corridor walls shall meet all of the following: * Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier. * Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater			

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	stability and fire integrity. * Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are wired glass not exceeding 9 square feet each in area and installed in approved frames. This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels. In Prompt Evacuation facilities, all sleeping rooms shall be separated from the escape route by smoke partitions in accordance with 8.2.4. Sleeping arrangements that are not located in sleeping rooms shall be permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping. In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms shall be separated from escape routes by walls and doors that are smoke resistant. 33.2.3.6			
	1. Based on observation and interview, the facility failed to ensure 5 of 5 sleeping room doors were substantial construction; 1 3/4 inches thick, solid bonded wood core construction or of other construction of equal or greater stability and fire integrity. This deficient practice could affect 7 consumers sleeping on the second story, staff and visitors. Findings include:	K S362	1. The AED will meet with ResCare Maintenance Manager on August 30, 2021 to ensure all doors in the facility meet or exceed LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and	11/30/2021

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	Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, the 5 sleeping room doors are hollow core wood construction. Based on interview at the time of observation, the Program Director stated the doors were existing and had not been replaced since the last survey. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 6 sleeping rooms was separated using a minimum 1/2-hour fire resistance rated assembly. This deficient practice could affect 1 consumers sleeping on the first story. Findings include: Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, the one consumer sleeping room (area) on the first floor was separated from the remainder of the story using a curtain suspended from a curtain track. Based on interview at the time of observation, the Program Director stated that sleeping area provided the consumer with a quiet space and the condition had been unchanged in the last 12 months. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 4.8.4.2 states the clearance under the bottom of a door shall be a maximum of 3/4 inch. 1.The AED will meet with ResCare Maintenance Manager on August 30, 2021 to schedule the replacement of 5 of 5 sleeping doors. Work will be delayed due to a COVID 19 Shelter In Place. This will delay measuring and ordering door. Without measurements the vendor has given a tentative delivery date between 6 and 12 weeks due to supply chain issues. Upon delivery door will be installed with in 2 weeks. Estimated install date will be no later than November 30, 2021. 2.The installation of a minimum 1/2-hour fire resistance rated assembly for the first floor sleeping area, installation will be complete no later than September 30,2021 there will be a delay in installation due to COVID 19 Shelter in place. 3.The program manager will verify the installation upon	

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			completion. **Persons Responsible: AED, Aramark Program Manager, Area Supervisor, and Residential Manager, DSP**	
K S363 Bldg. 03	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			
	1. Based on observation and interview, the facility failed to ensure 1 of 5 consumer sleeping rooms doors was provided with a latch. This deficient practice could affect the occupant of Bedroom #1. Findings include: Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, the door to bedroom #1 had been forced open and the strike and door	K S363	1. The Program Manager will ensure clients bedroom doors positively latch to the frame. 2. The maintenance coordinator will ensure all clients bedroom doors will positively latch as required. 1.The AED will meet with ResCare Maintenance Manager on August 30, 2021 to schedule	11/30/2021

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	frame are broken. The door is not equipped with a latch (and strike). Based on interview at the time of observation, the Program Director acknowledged that the door was damaged and had not been repaired yet. The door has been in this condition for several days. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m. 2. Based on observation and interview, the facility failed to ensure 3 of 5 consumer sleeping rooms doors was provided with a self-closing device that closed the door. This deficient practice could affect the occupants of Bedroom #2, #3, and #5. Findings include: Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, the door to bedroom #1 did not close completely upon release of the door from the fully open position. The self-closing device did not apply enough pressure to allow the latch to engage the strike. Based on interview at the time of observation, the Program Director acknowledged that the doors were not closed upon release of the door. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m. 3. Based on observation and interview, the facility failed to ensure 1 of 5 consumer sleeping rooms doors was obstructed from closing. This deficient practice could affect the occupant of Bedroom #4.		the replacement of Bedroom #1 #2 #3 #4 and #5 sleeping doors. Work will be delayed due to a COVID 19 Shelter In Place. This will delay measuring and ordering door. Without measurements the vendor has given a tentative delivery date between 6 and 12 weeks due to supply chain issues. Upon delivery door will be installed with in 2 weeks. Estimated install date will be no later than November 30, 2021. 2.The Program Manager will train the Residential Manager and DSPs to inspect doors daily to ensure doors operation is not impeded. The Residential manager will inspect the house weekly to ensure bedroom door operate as required. Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure bedroom doors positively latch to frame as required. 3.Staff will notify ResCare Maintenance upon discovery of any damage that prevents Clients Bedroom Doors from positively latching to the frame as required by calling 844-ResCare. **Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance Manager.**	

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	Findings include: Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, the door to bedroom #4 had a door hung shoe rack that rubs on the frame during closing. The door did not close to engage the latch in the strike. Based on interview at the time of observation, the Program Director acknowledged that the door was not closing as a result of the shoe rack. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.			
K S511 Bldg. 03	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical panels was provided with clear work space in accordance to 33.2.5.1. NFPA 70, 2011 Edition, Article 110.26 Spaces About Electrical Equipment. Access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while	K S511	**1.The Program Manager will train the area supervisor residential manager, and DSPs on removing obstructions and combustibles from the working space for electrical panels.** **2.All combustibles were removed from the workspace on 8/3/2021** **3.The Residential manager will conduct weekly inspections to ensure no combustibles are stored in the electric panel workspace. The Area**	08/03/2021

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	energized shall comply with the dimensions of 110.26(A)(1), (A)(2), and (A)(3) or as required or permitted elsewhere in this Code. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. Findings include: Based on observation during the facility tour on 08/03/2021 between 12:30 p.m. and 2:00 p.m. with the Program Director, the electrical panel located in the closet of the sleeping room formerly used as the garage was obstructed by stored combustibles. Based on interview at the time of observation, the Program Director acknowledged that the work space in front of the panel was used for storage. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		**Supervisor will conduct monthly inspections to ensure no combustibles are stored in the work space.** **Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP,**	
K S711 Bldg. 03	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan The administration of every resident board and care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the safety of any resident, and shall be amended			

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	or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility. All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk. 32.7.1, 32.7.2, 33.7.1, 33.7.2 Based on record review and interview, the facility administration failed to ensure all consumers are periodically instructed and drill the use of the secondary exit from the sleeping room under the written fire safety plan. This deficient practice affects all consumers. LSC section 33.7.3.4 Exits and means of escape not used in any drill shall not be credited in meeting the requirements of this Code for board and care facilities. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, the facility failed to schedule fire drills to practice the use of the	K S711	1.The Program Manager will retrain the staff ensure all consumers are periodically instructed and drill the use of the secondary exit from the sleeping room under the written fire safety plan. 2.QIDP will train all residents participating in the emergency plan will be trained in the proper actions to be taken in the event of fire. Training will include proper actions to be taken if the primary escape route is blocked. 3.The area supervisor will monitor random fire drill to ensure all consumers are periodically	09/02/2021

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	secondary exits of the sleeping rooms. Based on interview at the time of record review, the Program Director acknowledged that the fire drills did not include the exit windows. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.		instructed and drill the use of the secondary exit from the sleeping room under the written fire safety plan. **Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP,**	
K S712 Bldg. 03	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			

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	any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct fire drills quarterly on the first shift for 2 of the last 4 calendar quarters. This deficient practice could affect all clients. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, there was no record of a fire drill conducted on the first shift for the first and second quarters of the year 2021. Based on interview at the time of record review, the Program Director acknowledged that the documentation of the drills was absent from the binder and he could not verify that the drills had occurred. This was verified by the program manager at the time of record review and acknowledged at the exit conference on 04/05/17 at 12:25 p.m.	K S712	1. All staff at the Facility will be re-trained on conducting fire drills quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff. 2. The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date. 3. The Residential Manager will submit monthly drills to the QA Department upon completion. The QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required. 4. The Area supervisor will ensure drills are completed as required. /p> **Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP**	09/02/2021
K S741 Bldg. 03	NFPA 101 Smoking Regulations Smoking Regulations			

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	Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on record review and interview the facility failed to maintain a smoking policy for a facility for consumers and staff smoking. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review and interview on 08/03/2021 between 10:50 a.m. to 12:30 p.m. with the Program Director, documentation of a facility smoking policy was not available for review. Based on interview at the time of record review, the Program Director stated that the smoking policy was in the employee handbook but not available. This deficiency was reviewed with the Program Director during the Exit Conference held on 08/03/2021 between 2:30 p.m. and 3:00 p.m.	K S741	1. All staff at the home will be re-trained the Facilities smoking policy, and use of the designated smoking area. 2. The Facility will in service staff on the use of the smoking tower used to dispensing cigarette butts. 3. All staff in the facility will be inserviced on ensure smoking materials are deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design 4. The Facility will ensure the smoking area is cleaned and all cigarette butts are removed from the ground and disposed of properly 5. The Program Manager, Area Supervisor, and Residential Manager will randomly inspect the facility monthly to ensure the proper use of the smoking tower and that cigarette butts are not being thrown on the ground.	09/02/2021

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			Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP.	