STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G107	A. BUILDING -- B. WING	03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CAREY SERVICES INC	615 E NORTH ST HARTFORD CITY, IN 47348

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/24/21 Facility Number: 000644 Provider Number: 15G107 AIM Number: 100234170 At this Emergency Preparedness survey, Carey Services Inc was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey the census was 8. Quality Review completed on 03/26/21	E 0000		
E 0026 Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary [(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).] At a minimum, the policies and procedures must address the			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all clients. Findings include: Based on record review on 03/24/21 at 11:37 a.m. with the Community Living Manager (CLM) there was nothing in the Emergency Preparedness Plan (EPP) which addresses the facilities role in compliance with the 1135 waiver declared by the Secretary. Based on interview concurrent with record review with the CLM it was stated he did not know where to look in the EPP to find the 1135 waiver. This was discussed with the CLM during the exit conference.	E 0026	· The policy is written with the understanding that the BOD may edit the policy which would require retraining. The policy indicates that The Safety Committee will review the HVAs (Policy 7.6.5) and associated plans including the EP Policy 7.2.7 at least annually as a regularly scheduled agenda item. The assessments and associated plans may be updated and / or reviewed more frequently if/as needed. · Staff training will be completed by the Community Living Manager by 4/7/2021. *Documents: Policy 7.2.8, Policy 7.6.5, Staff Training*	04/07/2021

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K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/24/21 Facility Number: 000644 Provider Number: 15G107 AIM Number: 100234170 At this Life Safety Code survey, Carey Services Inc was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was sprinkled. The facility has a fire alarm system with smoke detection in the corridors common living areas, and no smoke detectors in client sleeping rooms. The attic was not used for living purposes, storage or fuel-fired equipment and was provided with a heat detection system to activate the fire alarm system. 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 (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.8. Quality Review completed on 03/26/21	K 0000		

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K S100 Bldg. 02	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 record review and interview; the facility failed to ensure 3 of 3 battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review on 03/24/21 at 11:38 a.m., with the Community Living Manager (CLM), there were three battery powered lights located throughout the facility and no documentation could be produced to indicate they had been tested for 30 seconds once a month for the following months: a. January, February and March of 2021. b. May, October, November and December of 2020. Based on interview at the time of record review,	K S100	· Staff Training will be completed by the Community Living Manager by 4/7/2021. o *Documents: Staff Training* *<u>REVISION:</u> During the staff training, the Drill Report was reviewed with staff. All areas of the drill report were reviewed to ensure staff were informed all areas of the form were to be completed. The drill report states that it will be reviewed by the Safety Committee - this is the monitoring that is being completed.*	04/07/2021

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	the CLM acknowledged the voracity of the findings and did not understand why staff neglected to record this information on the fire drill reports. This was discussed with the QIDP during the exit conference.			
K S341 Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm panel was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.15 states in areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s), notification appliance circuit power extenders, and supervising station transmitting equipment to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted. A.10.15 The fire alarm control unit(s) that are to be protected are those that provide notification of a fire to the occupants and responders. The term fire alarm control unit does not include equipment such as annunciators and addressable devices. Requiring smoke detection at the transmitting equipment is intended to increase the probability that an alarm signal will be transmitted to a supervising station prior to that transmitting	K S341	· The Community Living Manager has contacted Koorsen Fire and Security. The quote for parts was approved on 4/6/2021. This is scheduled to be completed by 4/16/2021.	04/16/2021

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	equipment being disabled due to the fire condition. CAUTION: The exception to 10.15 permits the use of a heat detector if ambient conditions are not suitable for smoke detection. It is important to also evaluate whether the area is suitable for the control unit. Where the area or room containing the control unit is provided with total smoke-detection coverage, additional smoke detection is not required to protect the control unit. Where total smoke-detection coverage is not provided, the Code intends that only one smoke detector is required at the control unit even when the area of the room would require more than one detector if installed according to the spacing rules in Chapter 17. The intent of selective coverage is to address the specific location of the equipment. Location of the required detection should be in accordance with one of the following: (1) Where the ceiling is 15 feet in height or less, the smoke detector should be located on the ceiling or the wall within 21 feet of the centerline of the fire alarm control unit being protected by the detector in accordance with 17.7.3.2.1. (2) Where the ceiling exceeds 15 feet in height, the automatic smoke detector should be installed on the wall above and within 6 feet from the top of the control unit. This deficient practice could affect all occupants. Findings include: Based on observation on 03/24/21 at 12:56 p.m., with the Community Living Manager (CLM), the fire alarm panel located in the Laundry room was provided with a heat detector, but not with an automatic smoke detector. Based on an interview at the time of observation, the CLM was asked the reason for the heat detector use to protect the fire alarm panel instead of a smoke detector and the			

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	reason was unknown. This was discussed with the CLM during the exit conference.			
K S353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2).			

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	8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system components in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and	K S353	· The Community Living Manager has contacted Koorsen Fire and Security. The quote for parts was approved on 4/6/2021.	04/16/2021

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	Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.5.8 states all damaged or missing components noted during inspection shall be repaired or replaced in accordance with manufacturer's instructions. Section 13.6.3.1 states maintenance of all backflow prevention assemblies shall be conducted by a trained individual following the manufacturer's. This deficient practice could affect 2 clients in the facility. Findings include: Based on record review on 03/24/21 at 12:11 p.m. with the Community Living Manager (CLM), the Sprinkler Report dated 02/02/21 stated in the deficiency section: "Missing fire sprinkler cover plate." Based on interview, the CLM stated she was aware the sprinkler head plate needed to be installed in MP's bedroom and was waiting for Koorsen Fire Protection to install one. This was discussed with the CLM during the exit conference.		This is scheduled to be completed by 4/16/2021.	
K S354 Bldg. 02	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy when	K S354	· The agency policy 7.2.1 for Fire Watch for ICF/IDD Group has	04/08/2021

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	the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. NFPA 25, 15.5.2 (4) requires where a required fire protection system is out of service for more than 10 hours in a 24-hour period, the impairment coordinator shall arrange for one of the following: (5) the fire department has been notified and (6) the insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. This deficient practice could affect all clients in the facility. Findings include: Based on record review on 03/24/21 at 11:40 a.m. with the Community Living Manager (CLM), the facility provided the most recent fire watch policy documentation but it was incomplete. The plan failed to include contacting a. Owner/Operator, and b. Heads of Staff, c. Insurance carrier and then calling all entities back once the sprinkler system has been restored to normal. Based on interview during the record review, the CLM confirmed the fire watch documentation provided did not address entities a, b and c or calling back all entities to inform them the sprinkler system was back to normal function. This was discussed with the AS and CLM during the exit conference.		been updated to reflect the required contacts and is pending Board approval. o *Documentation: Policy 7.2.1 – pending Board Approval, Staff Training*	
K S511 Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas 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	K S511	* The cover plates were installed	03/24/2021

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	failed to ensure 2 of 2 outside electrical receptacles were protected according to 33.2.5.1. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect all clients. Findings include: Based on observations on 03/24/21 during the tour between 12:12 p.m. to 12: 20 p.m. with the Community Living Manager (CLM), two GFCI electrical receptacles outside the Front porch and outside the Back porch were missing their cover plates. Based on interview at the time of observations, the CLM acknowledged the missing receptacle cover plates and remarked they would be replaced. This was discussed with the CLM during the exit conference.		by Maintenance on 3/24/2021. REVISION: This will be monitored in the quarterly home inspections completed by the Safety Committee.	
K S712 Bldg. 02	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;			

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	b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to evaluate staff and client conduct during fire drill evacuations for 4 of the last 4 quarters over the past year. This deficient practice could affect all clients. Findings include: Based on a review of Emergency Evacuation Drill Reports on 03/24/21 at 11:53 a.m. with the Community Living Manager (CLM) there was no record of staff and client evaluation noted on the fire drill evacuation reports. Based on an interview with the CLM at the time of record review, it was acknowledged the fire drill evacuation reports reviewed for the past year did not mention staff or client conduct during a fire drill evacuation. This was discussed with the CLM during the exit conference.	K S712	· The Emergency Evacuation Drill has been revised to add a column for Conduct during a drill. This form is currently pending Documentation Committee approval. Staff will be trained on the new form no later than 4/16/2021. o *Documentation: Emergency Evacuation Drill, Staff Training* *<u>REVISION:</u> The drill report states that it will be reviewed by the Safety Committee - this is the monitoring that is being completed.*	04/16/2021
K S741 Bldg. 02	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care			

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CAREY SERVICES INC	615 E NORTH ST HARTFORD CITY, IN 47348

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 areas where smoking was allowed. This deficient practice could affect staff and clients. Findings include: Based on observation on 03/24/21 at 1219 p.m. with the Community Living Manager (CLM), outside on the back porch where smoking was allowed there were more than 16 cigarette butts thrown on the ground instead of into the noncombustible container provided. The smoking policy provided did not address the proper disposal of cigarette butts. Based on interview concurrent with the observation this was acknowledged by the CLM and was discussed with the CLM during the exit conference.	K S741	· Per agency policy, smoking is not allowed on agency property. Per CLM report, the cigarette butts found on the ground were in the alley and at the entry of the driveway, not on the back porch. The alley is not Carey Services property. There is not a noncombustible container for cigarette butts on the back porch.	03/24/2021