STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G763	A. BUILDING -- B. WING	12/30/2021

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

(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: 12/30/21 Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380 At this Emergency Preparedness survey, Transitional Services SUB LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey, the census was 7. Quality Review completed on 01/03/22	E 0000		
E 0004 Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

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
	15G763	A. BUILDING -- B. WING	12/30/2021

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an	E 0004	The Emergency Preparedness Plan will be updated and placed in	01/30/2022

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	emergency preparedness plan. The plan must do all of the following: 1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. 2) Include strategies for addressing emergency events identified by the risk assessment. 3) Address the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. 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 in accordance with 42 CFR 483.475(a). This deficient practice could affect all occupants. Findings include: Based on review of the emergency preparedness documentation on 12/30/21 between 10:00 a.m. and 12:30 p.m. with the Group Home Manager present, the most recent date to show the Emergency Preparedness plan was reviewed was 05/22/19. Based on interview at the time of record review, the Group Home Manager said she has only been at the facility for about three weeks and did not know if the Emergency Preparedness plan had been reviewed within the past 24 months. This finding was reviewed with the Group Home Manager during the exit conference.		the home by 1/30/22. The Program Director (QIDP) will be retrained on updating the Emergency Preparedness Plan (EPP) every two years, ensuring the EPP is in the home and available at all times for immediate review. Staff working in the home will be trained on the updated plan and where it is located to ensure safety of the home. The Program Director (QIDP) will send the updated EPP to the Area Director to ensure tracking of the updated plan is maintained by the Area Director. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	

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E 0013 Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (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 at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and			

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	procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants.	E 0013	The Emergency Preparedness Plan will be updated and placed in the home by 1/30/22. The Program Director (QIDP) will be retrained on updating the Emergency Preparedness Plan	01/30/2022

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	Findings include: Based on review of the facility's Emergency Preparedness plan on 12/30/21 between 10:00 a.m. and 12:30 p.m. with the Group Home Manager present, documentation for a complete emergency program reviewed by the facility within the most recent 24 month period was not available for review. Based on interview at the time of record review, the Group Home Manager acknowledged there was no other information to show that the policy and procedures portion of the Emergency Preparedness plan had been reviewed and updated since the last review on 05/22/19. This finding was reviewed with the Group Home Manager during the exit conference.		(EPP) every two years, ensuring the EPP is in the home and available at all times for immediate review. Staff working in the home will be trained on the updated plan and where it is located to ensure safety of the home. The Program Director (QIDP) will send the updated EPP to the Area Director to ensure tracking of the updated plan is maintained by the Area Director. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	
E 0029 Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (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]. Based on record review and interview, the facility failed to maintain an emergency	E 0029	The Emergency Preparedness Plan will be updated and placed in	01/30/2022

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	preparedness communication plan that complies with Federal, State, and local laws that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 12/30/21 between 10:00 a.m. and 12:30 p.m. with the Group Home Manager present, documentation for an emergency preparedness communication plan reviewed by the facility within the most recent 24 month period was not available for review. Based on interview at the time of record review, the Group Home Manager said she has only been at the facility for about three weeks and did not know if the Communication Plan within the Emergency Preparedness plan had been reviewed within the past 24 months. This finding was reviewed with the Group Home Manager during the exit conference.		the home by 1/30/22. The Program Director (QIDP) will be retrained on updating the Emergency Preparedness Plan (EPP) every two years, ensuring the EPP is in the home and available at all times for immediate review. Staff working in the home will be trained on the updated plan and where it is located to ensure safety of the home. The Program Director (QIDP) will send the updated EPP to the Area Director to ensure tracking of the updated plan is maintained by the Area Director. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	
E 0036 Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at			

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	15G763	A. BUILDING -- B. WING	12/30/2021

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	§441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section,			

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	and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to review and update the training and testing program at least every 2 years in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 12/30/21 between 10:00 a.m. and 12:30 p.m. with the Group Home Manager present, there was documentation available to show the facility had an emergency preparedness training and testing program, however, there was no documentation to show that the training and testing program has been reviewed and updated within the past 24 months. Based on interview at the time of record review, the Group Home Manager said she has only been at the facility for about three weeks and did not know if the	E 0036	The Emergency Preparedness Plan will be updated and placed in the home by 1/30/22. The Program Director (QIDP) will be retrained on updating the Emergency Preparedness Plan (EPP) every two years, ensuring the EPP is in the home and available at all times for immediate review. Staff working in the home will be trained on the updated plan and where it is located to ensure safety of the home. The Program Director (QIDP) will send the updated EPP to the Area Director to ensure tracking of the updated plan is maintained by the Area Director. Quarterly emergency trainings are	01/30/2022

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	training and testing program portion of the Emergency Preparedness plan had been reviewed within the past 24 months. This finding was reviewed with the Group Home Manager during the exit conference.		scheduled and will be completed in this home and will documented on training records. The Program Supervisor and Program Director will be retrained on completing these quarterly emergency trainings and keeping them in the home safety book for review as well as sending a copy of these trainings to the Office Coordinator for tracking purposes. A scheduled EPP test will be completed in the home at least quarterly to prepare staff for actual emergencies along with monthly evacuation drills to prepare individuals for emergencies as well. The Program Director will send a copy of the EPP test to the Office Coordinator for tracking purposes. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	
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,			

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	OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (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			

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	exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is 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			

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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
	exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise 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:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is			

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	not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least 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.			

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	(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (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,			

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	the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically 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			

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	required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.	E 0039	A full scale community exercise will be completed annually. A quarterly facility based exercise will be completed to prepare staff for actual emergencies along with monthly evacuation drills to prepare individuals for emergencies as well. The Program Director (QIDP), Program Supervisor and all staff in the home will be retrained on completing the annual full scale community exercise and quarterly facility based exercises. The Program Director (QIDP) will ensure a copy of the exercises are sent to the Office Coordinator	01/30/2022

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	(ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness plan on 12/30/21 between 10:00 a.m. and 12:30 p.m. with the Group Home Manager present, the facility provided emergency preparedness documentation, however it was incomplete. There was documentation provided of the facility's response to the COVID-19 Public Health Emergency, however, the facility was unable to provide documentation of an additional exercise to test the emergency preparedness plan. Based on interview at the time of record review, the Group Home Manager acknowledged she was unable to provide documentation of an additional exercise. This finding was reviewed with the Group Home Manager during the exit conference.		for tracking purposes and reviewed by the Area Director. Persons Responsible: Program Supervisor, Program Director (QIDP), Area Director	

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K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 12/30/21 Facility Number: 012289 Provider Number: 15G763 AIM Number: 100249380 At this Life Safety Code survey, Transitional Services Sub, LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in all living areas and client sleeping rooms, plus heat detection in the attic connected to the fire alarm system. The facility has a capacity of 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.04. Quality Review completed on 01/03/22	K 0000		
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other			

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	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 2 of 2 fire extinguishers in the facility were protected. NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4 requires that portable fire extinguishers types shall be (1) secured on a hanger (2) in the bracket supplied by the manufacturer (3) in a listed bracket approved for such purpose (4) in cabinets or wall recesses. This deficient practice could affect all occupants. Findings include: Based on observations on 12/30/21 between 10:00 a.m. and 12:30 p.m. during a tour of the facility with the Group Home Manager, the two fire extinguishers in the home were both sitting unsupported on the floor. Based on interview at the time of each observation, the Group Home Manager agreed the two fire extinguishers were both unsupported on the floor. This finding was reviewed with the Group Home Manager during the exit conference.	K S100	A maintenance request has been submitted in order to have the fire extinguishers secured on a hanger to the wall as required with the brackets supplied by the manufacturer. Repairs will be completed by 1/30/22. The Program Supervisor and Program Director (QIDP) will be retrained on completing the quarterly health and safety environmental checks to ensure all fire extinguishers are mounting according to regulations. The Program Director (QIDP) will send the quarterly health and safety checks to the Area Director for review. Responsible parties: Area Director, Program Director (QIDP), Program Supervisor	01/30/2022
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of			

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	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). 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,			

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	section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on observation and interview, the facility failed to ensure 6 of over 25 sprinkler heads in the facility were free of paint and corrosion. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could all clients and staff. Findings include:	K S353	Koorsen Fire and Security was contacted to replace the sprinkler heads that had paint or corrosion on them. Koorsen will complete the repairs by 1/30/22. When the repairs are completed, the Koorsen work order report will be placed in the safety book for review. Koorsen Fire and Security was contacted to provide the required spare sprinklers that will be maintained in the spare sprinkler cabinet. Koorsen will provide the	01/30/2022

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	Based on observations on 12/30/21 between 10:00 a.m. and 12:30 p.m. during a tour of the facility with the Group Home Manager, the following was noted: a. There was one sprinkler head in each of the two bathrooms covered with paint and corrosion b. There was one sprinkler head in the hall outside of each of the two bathrooms covered with corrosion c. There were two sprinkler heads in bedroom #3 (bedroom on left on east side of house hallway) partially covered with paint. Based on interview at the time of observations, the Group Home Manager agreed all six sprinkler heads in question were covered with paint and/or corrosion. This finding was reviewed with the Group Home Manager during the exit conference. 2. Based on observation and interview, the facility failed to keep the minimum amount of spare sprinklers on the premises in the spare sprinkler cabinet. LSC 9.7.5 requires automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced. The sprinklers shall be kept in a cabinet. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be		spare sprinklers by 1/30/22. All staff will be retrained to complete monthly checks of gauges and valves in the home. A tracking form was developed and is available in the home to review in the Safety Book. The Program Director (QIDP) will ensure that the monthly checks are completed. A maintenance request has been submitted in order to have the ceiling repaired in the sprinkler riser room and replace the missing sprinkler escutcheon ring in the west hall near the exit door. Repairs will be completed by 1/30/22. The cardboard boxes that were directly in front and leaning against the sprinkler system riser were removed by the Program Supervisor. All staff will be retrained on ensure that the sprinkler system riser is accessible and free from items to obstruct that accessibility. Responsible parties: Area Director, Program Director (QIDP), Program Supervisor	

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	15G763	A. BUILDING 01 B. WING	12/30/2021

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

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	exposed to a temperature exceeding 100°F (38°C). NFPA 25, Section 5.4.1.8 states sprinklers shall not be altered in any respect after shipment from the place of manufacture. This deficient practice could affect all clients, staff and visitors in the facility. Findings include: Based on observations on 12/30/21 between 10:00 a.m. and 12:30 p.m. during a tour of the facility with the Group Home Manager, a total of two spare sprinklers were noted on the premises in the spare sprinkler cabinet at the sprinkler system riser. Based on interview at the time of the observation, the Group Home Manager agreed a supply of at least six unaltered spare sprinklers were not stored in a cabinet on the premises for replacement purposes. This finding was reviewed with the Group Home Manager during the exit conference. 3. Based on record review and interview, the facility failed to completely document monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states an			

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	inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. This deficient practice could affect all clients in the facility. Findings include: Based on record review on 12/30/21 between 10:00 a.m. and 12:30 p.m. with the Group Home Manager present, there was documentation one sprinkler gauge was inspected on a monthly basis during the past 12 month period, however, the sprinkler riser is equipped with two pressure gauges and there was no documentation provided for the monthly reading on the second pressure gauge. Based on interview at the time of record review, the Group Home Manager said there was no other monthly inspection documentation of the second sprinkler system gauge reading available for the past 12 month period. This finding was reviewed with the Group Home Manager during the exit conference. 4. Based on observation and interview, the facility failed to ensure the ceiling in this sprinklered home was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect all occupants. Findings include: Based on observations on 12/30/21 between 10:00 a.m. and 12:30 p.m. during a tour of the facility with the Group Home Manager, there was a six inch by six inch section of the drywall ceiling damaged and missing next to the metal furnace duct in the sprinkler riser room,			

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	furthermore, there was a missing sprinkler escutcheon ring in the west hall near the exit door. This was acknowledged by the Group Home Manager at the time of each observation, who further said she would have the drywall repaired and the escutcheon ring replaced as soon as possible. This finding was reviewed with the Group Home Manager during the exit conference. 5. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler system riser was easily accessible and properly protected. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems states at 13.2.3, all system valves shall be protected from physical damage and shall be accessible. This deficient practice could affect all clients, as well as staff and visitors in the facility. Findings include: Based on observations on 12/30/21 between 10:00 a.m. and 12:30 p.m. with the Group Home Manager present, there were several cardboard boxes stored directly in front of and leaning against the sprinkler system riser in the sprinkler riser room. This was acknowledged by the Group Home Manager at the time of observation. Furthermore, the Group Home Manager removed all cardboard boxes during the time of the survey. This finding was reviewed with the Group Home Manager during the exit conference.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors			

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	Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure 1 of 4 client sleeping room doors would latch into the door frame. This deficient practice could affect all clients. Findings include: Based on observations on 12/30/21 between 10:00 a.m. and 12:30 p.m. during a tour of the facility with the Group Home Manager, client sleeping room door #3 (sleeping room on left in east side of house hallway) would not latch into its door frame when tested several times. The door kept swinging open two inches when attempting to close. Based on interview at the time of observation, the Group Home Manager agreed bedroom door #3 did not latch when tested several times and said they have a work order to maintenance to fix the door. This finding was reviewed with the Group Home Manager during the exit conference.	K S363	A maintenance request has been submitted in order to have the bedroom door #3 repaired so that the door will completely close and latches to the door frame. Repairs will be completed by 1/30/22. The Program Supervisor and Program Director (QIDP) will be retrained on completing the quarterly health and safety environmental checks to ensure all doors latch as require per regulations. The Program Director (QIDP) will send the quarterly health and safety checks to the Area Director for review. Responsible parties: Area Director, Program Director (QIDP), Program Supervisor	01/30/2022

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K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 3 of 3 shifts during 4 of 4 quarters during the past 12 months. This deficient practice could affect all clients. Findings include: Based on review of the facility's fire drill reports	K S712	Staff in the home will be retrained to complete evacuation drills as scheduled. The Program Supervisor and Program Director (QIDP) will be retrained to ensure that all evacuations drills are completed according to the schedule and drills are completed at varied times on each shift each	01/30/2022

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	on 12/30/21 between 10:00 a.m. and 12:30 p.m. with the Group Home Manager present, there were only two fire drill reports available during the past 12 month period, with no fire drill reports available for the following shifts and quarters: a. First shift (day) of the first quarter (January, February, and March), second quarter (April,, May, and June), third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2021. b. Second shift (evening) of the first quarter (January, February, and March), second quarter (April,, May, and June), and fourth quarter (October, November, and December) of 2021. c. Third shift (night) of the first quarter (January, February, and March), third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2021. Based on interview at the time of record review, the Group Home Manager confirmed the lack of fire drills during the previously mentioned shifts and quarters of 2021. This finding was reviewed with the Group Home Manager during the exit conference.		quarter. Past drills cannot be completed due to them not being completed at the time there were due. Moving forward, all drills will be due by the 25th of each month to ensure there is ample to complete the drill if it has not yet been completed or re-do the drill if issues or concerns were noted during the drill completed that month. If drills are not completed in a timely manner (by the end of the month) corrective action will be given to supervisory staff for non-compliance. The Program Director (QIDP) and/or Area Director will review all drills after completion and will ensure they are completed correctly or another drill will be completed. The Area Director and/or the Office Coordinator will maintain a copy of all completed drills for immediate review. Responsible parties: Area Director, Program Director (QIDP), Program Supervisor	