DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G182	A. BUILDING -- B. WING	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICE ALTERNATIVES	2326 BERWICK DR SHELBYVILLE, IN 46176

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/12/24 Facility Number: 000715 Provider Number: 15G182 AIM Number: 100234640 At this Emergency Preparedness survey, Developmental Service Alternatives was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 03/14/24 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shamepane Martin	Quality Assurance Manager	05/23/2024

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

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	*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (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			

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

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

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

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	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. (B) If the ICF/IID experiences an actual			

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	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, the HHA is exempt from engaging in its next required			

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	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 required testing exercise following the onset			

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	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 at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of 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 community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	POC – Berwick - FLS E39 The Facility was cited for failure of provision of documents demonstrating either a community or facility based functional exercise. The POC had stated, “The QIDP will conduct a training no later than 5/18/2024. It is submitted that a facility-based exercise was conducted on 5/17/2024 of a scenario depicting a massive fire necessitating evacuation of the facility with all consumers present. The exercise was planned by the QIDP but unannounced and commenced at 6:41pm. As per the facility’s	05/16/2024

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	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 "Emergency Preparedness Plan for Berwick" documentation dated 04/24/23 with the Qualified Intellectual Developmental Professional (QIDP) and the Residential Services Director during record review from 1:10 p.m. to 2:15 p.m. on 03/12/24, documentation of a community based disaster drill, an annual individual, facility-based functional exercise or an actual natural or man-made emergency that required activation of the emergency plan was not available for review. The facility documented a table top exercise on severe weather on 04/20/23. Based on interview at the time of record review, the QIDP agreed documentation of community based disaster drill, an annual individual, facility-based functional exercise or an actual natural or man-made emergency that required activation of the emergency plan was not available for review.		Emergency Evacuation Plan, the house was evacuated to Lakeview Group home. Please find attached a copy of the Fire/Evacuation Observer's Report for your information. A copy of the report is present in the facility's emergency binder.	

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	These findings were reviewed with the QIDP and the Residential Services Director during the exit conference.			
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: 03/12/24 Facility Number: 000715 Provider Number: 15G182 AIM Number: 100234640 At this Life Safety Code survey, Developmental Service Alternatives 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 with a basement was determined to be nonsprinklered. The facility has a fire alarm system with smoke detection on all levels in corridors, in all living areas and in all client sleeping rooms. The facility has a capacity of 6 and had a census of 6 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.1. Quality Review completed on 03/14/24	K 0000		

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K S100 Bldg. 01	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.			
	1. Based on observation and interview, the facility failed to ensure 4 of 4 portable fire extinguishers were 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 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:	K S100	K0100 The agency failed to ensure that the fire extinguisher was inspected monthly and signed off. The RSD will check weekly for the next four weeks to ensure we are following the monthly inspections and will fade into once-a-month inspections. The QIDP, or will check every Friday to make sure the inspection has been completed. The RSD will contact Koorsen immediately to get a new fire extinguisher bracket placed into the home by 5/20/2024. The QIDP, Area Director or designee will check no later than 5/23/2024 to ensure the issue has been resolved.	05/16/2024

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DEVELOPMENTAL SERVICE ALTERNATIVES	2326 BERWICK DR SHELBYVILLE, IN 46176

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Based on observations with the Qualified Intellectual Developmental Professional (QIDP) and the Residential Services Director during a tour of the facility from 2:15 p.m. to 2:25 p.m. on 03/12/24, each of the following four ABC type portable fire extinguisher locations in the facility had an affixed inspection and maintenance tag which lacked a monthly inspection for the following months:
a. in the Dining Room for April 2023 through December 2023.
b. the kitchen fire extinguisher, which was free standing on a table in the Dining Room, for April 2023 through December 2023.
c. on the second floor in the hallway near the east bedroom for April 2023 and for June 2023 through December 2023.
d. in the basement near the laundry room for April 2023 and for June 2023 through December 2023.
The fire extinguisher inspection contractor had documented on an affixed inspection and maintenance tag that the annual fire extinguisher inspection for each of the four fire extinguishers was in March 2023. Based on interview at the time of the observations, the QIDP and the Residential Services Director stated additional monthly inspection documentation was not available for review and agreed monthly inspection documentation for the aforementioned portable fire extinguishers was not available for review.

These findings were reviewed with the QIDP and the Residential Services Director during the exit conference.

2. Based on observation and interview, the facility failed to ensure 1 of 4 portable fire extinguishers in the facility was protected. NFPA 10, Standard for Portable Fire Extinguishers. LSC 4.6.12.4 requires

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any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, Section 6.1.3.4 requires portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means:
(1) Securely on a hanger intended for the extinguisher
(2) In the bracket supplied by the extinguisher manufacturer
(3) In a listed bracket approved for such purpose
(4) In cabinets or wall recesses.
In addition, the facility failed to ensure the portable fire extinguisher would be installed in accordance with NFPA 10. NFPA 10, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect all clients, staff and visitors.

Findings include:

Based on observations with the Qualified Intellectual Developmental Professional (QIDP) and the Residential Services Director during a tour of the facility from 2:15 p.m. to 2:25 p.m. on 03/12/24, one ABC type portable fire extinguisher was freestanding on a table in the Dining Room and was not secured. Based on interview at the time of the observations, the Residential Services Director agreed the fire extinguisher was not secured and stated the fire extinguisher is supposed to be installed in the kitchen in a mounting bracket affixed to a cabinet but the fire extinguisher is too large for the bracket and would

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	not fit into the bracket. The mounting bracket was installed such that a proper fire extinguisher for the bracket would result in the fire extinguisher being installed with the top of the fire extinguisher more than five feet five inches above the floor. These findings were reviewed with the QIDP and the Residential Services Director during the exit conference.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or 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 corridor doors to 1 of 3 client bedrooms was self-closing or automatic closing for a non-sprinklered facility. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Qualified Intellectual Developmental Professional (QIDP) and the Residential Services Director during a tour	K S363	K0363 The Residential Service Director (RSD) will work with maintenance/Koorsen to fix the closer arm for the self-closing device to be connected to the door of the client's bedroom in case the individuals would like the door open. The RSD will also train staff on safety procedures regarding objects blocking the doorway. This	05/16/2024

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	of the facility from 2:15 p.m. to 2:25 p.m. on 03/12/24, the corridor door to the east bedroom on the second floor was equipped with a self-closing device but the closer arm for the device was not connected to the door which caused the door to not be self-closing or automatic closing when tested to close multiple times. Based on interview at the time of the observations, the QIDP and the Residential Services Director agreed the aforementioned bedroom door was not self-closing or automatic closing because the closer arm for the self-closing device was not connected to the door. These findings were reviewed with the QIDP and the Residential Services Director during the exit conference.		will be completed by May 18, 2024. Area director or will check to ensure it has been completed no later than May 20, 2024.	
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			

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	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 provide documentation of a fire drill conducted on the: a. first shift for 2 of 4 quarters. b. on the second shift for 3 of 4 quarters. c. on the third shift for 4 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Qualified Intellectual Developmental Professional (QIDP) and the Residential Services Director during record review from 1:10 p.m. to 2:15 p.m. on 03/12/24, documentation of a fire drill conducted on the first shift in the third quarter (July, August, September) and in the fourth quarter (October, November, December) 2023 was not available for review. Documentation of a fire drill conducted on the second shift in the second quarter (April, May, June) 2023, in the third quarter 2023 and in the fourth quarter 2023 was also not available for review. In addition, documentation of a fire drill conducted on the third shift in the first quarter (January, February, March) 2023, the second quarter 2023, the third quarter 2023 and the fourth quarter 2023 was also not available for review. Based on interview at the time of record review, the QIDP and the Residential Services Director stated the facility operates three shifts per day,	K S712	K0712 The QIDP will plan the required drills and assign them for completion on the staff schedule. The QIPD will collect the required documentation and assure the required storage of the documentation of the drill within 24 hours of its required completion. If the was not completed as assigned, the QIPD will personally complete the drill and provide additional training support to the staff so they can comply with requirements as assigned in the future. Drills for all shifts will be completed by the compliance date.	05/16/2024

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	the facility has not yet done a third shift first quarter 2024 fire drill, additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the aforementioned shifts and quarters was not was not available for review. These findings were reviewed with the QIDP and the Residential Services Director during the exit conference.			