| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 15G127 | A. BUILDING -- B. WING | 07/19/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| RES CARE COMMUNITY ALTERNATIVES SE IN | 1031 WEST ST NEW ALBANY, IN 47150 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.<br><br>Survey Date: 07/19/2021<br><br>Facility Number: 000664<br>Provider Number: 15G127<br>AIM Number: 100234310<br><br>At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475<br><br>The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 6.<br><br>Quality Review completed on 07/26/21<br><br>The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by: | E 0000 | | |
| E 0007<br><br>Bldg. -- | 403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3)<br>EP Program Patient Population<br>§403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), | | | |

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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| | §494.62(a)(3).<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]<br><br>(3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**<br><br>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following:<br>(3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.<br><br>*NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] | | | |
| | Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.4753(a)(3). This deficient practice | E 0007 | 1.The administrator has developed a Transfer Agreement that will ensure the emergency plan policies and procedures addresses the special needs of its client population, including, but not limited to, persons at risk, the type of services the ICF/IID facility has the ability to provide in an | 08/18/2021 |

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| | could affect all occupants.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the emergency preparedness plan for the facility did not address the special needs of its client population and the type of services the facility has the ability to provide in an emergency. Based on interview at the time of record review, the Area Supervisor indicated that in the event of an emergency the house would take in consumers for a short period of time. Based on interview at the time of record review, the Area Supervisor, acknowledged that client needs documentation was not available for review at the time of the survey.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | emergency, and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3).<br>2.The need for transfer of a person from YOUR FACILITY to RECEIVING FACILITY shall be determined and recommended by the person's healthcare team, possibly including the attending physician in such team's own judgment. When a transfer is recommended as medically appropriate, a person supported at YOUR FACILITY shall be transferred and admitted to RECEIVING FACILITY as promptly as possible under the circumstances, provided that beds and other appropriate resources are available.<br>3.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.<br>4.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>**The persons responsible** will be the, Program Manager, Area Supervisor, and Residential Manager | |

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| E 0009<br><br>Bldg. -- | 403.748(a)(4), 416.54(a)(4), 418.113(a)(4), 441.184(a)(4), 482.15(a)(4), 483.475(a)(4), 483.73(a)(4), 484.102(a)(4), 485.625(a)(4), 485.68(a)(4), 485.727(a)(5), 485.920(a)(4), 486.360(a)(4), 491.12(a)(4), 494.62(a)(4)<br>Local, State, Tribal Collaboration Process<br>§403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:]<br><br>(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. *<br><br>* [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.<br>Based on record review and interview, the facility failed to ensure the emergency preparedness plan | E 0009 | 1.The emergency plan policies | 08/18/2021 |

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| | included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the emergency preparedness plan did not include a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Based on interview at the time of record review, the Area Supervisor, agreed the plan did not include a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials and that no effort to contact and participate were documented.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | and procedures has been updated to include a continuity of operations plan which addresses notification of the Indiana State Department of Health during a disaster or emergency.<br>2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager | |
| E 0015 | 403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), | | | |

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| Bldg. -- | 485.625(b)(1)<br>Subsistence Needs for Staff and Patients<br>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must | | | |

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| | address the following:<br>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting.<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: water in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the emergency preparedness plan did not address policies and procedures to acquire water in an emergency. Based on interview at the time of record review, the Area Supervisor indicated that he knew where to obtain bottled water in the event of an emergency. Based on interview at the time of record review, the Area Supervisor acknowledged the EPP did not contain policies and procedures as he described them. | E 0015 | 1.The administrator will ensure the emergency plan policies and procedures addresses the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, including but not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain – (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1).<br>2.The area supervisor and program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster | 08/18/2021 |

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| | This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager | |
| E 0020<br><br>Bldg. -- | 403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2)<br>Policies for Evac. and Primary/Alt. Comm. §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>[(3) or (1), (2), (6)] Safe evacuation from the | | | |

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| | [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.<br><br>*[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):]<br>Safe evacuation from the [RNHCI or ASC] which includes the following:<br>(i) Consideration of care needs of evacuees.<br>(ii) Staff responsibilities.<br>(iii) Transportation.<br>(iv) Identification of evacuation location(s).<br>(v) Primary and alternate means of communication with external sources of assistance.<br><br>* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):]<br>Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.<br><br>* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. | | | |
| | Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the ICF/IID facility, which | E 0020 | 1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses safe | 08/18/2021 |

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| | includes consideration of care and treatment needs of evacuees and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.475(b)(3). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the EPP did not address care and treatment needs of evacuees (consumers) and alternate means of communication with external sources of assistance. Based on interview at the time of record review, the Area Supervisor described procedures that may be used in an evacuation but acknowledged the plan did not address policies and procedures for the care and treatment of evacuees (consumers) and alternative means of communication with external sources.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | evacuation of from the ICF/IID facility and includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.<br>2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum every two years.<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager<br>/p> | |
| E 0023<br><br>Bldg. -- | 403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4)<br>Policies/Procedures for Medical Documentation<br>§403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), | | | |

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| | §486.360(b)(2), §491.12(b)(3), §494.62(b)(4).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>[(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following:<br>(i) Preserves patient information.<br>(ii) Protects confidentiality of patient information.<br>(iii) Secures and maintains the availability of records.<br><br>*[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.<br>Based on record review and interview, the facility failed to ensure emergency preparedness policies | E 0023 | 1.The emergency plan policies and procedures will be updated to | 08/18/2021 |

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| | and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., no policies and procedures which include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records was available to review. Based on interview at the time of record review, the Area Supervisor acknowledged that documentation was not in the EPP and unavailable for review.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | include a continuity of operations plan which addresses a system of medical documentation of from the ICF/IID facility and includes consideration of maintaining protection of confidentiality of patient information and secures and maintains availability of records.<br>2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager | |
| E 0025<br><br>Bldg. -- | 403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph | | | |

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| | (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]<br><br>*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.<br><br>*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.<br>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities or other | E 0025 | 1.The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses | 08/18/2021 |

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| | providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the emergency preparedness plan for the facility did not include policies and procedures for the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients beyond the temporary relocation to the "Core Office". Based on interview at the time of record review, the Area Supervisor described a procedure to relocate consumers to other Res Care facilities in the area. Based on interview at the time of record review, the Area Supervisor acknowledged that policies and procedures addressing arrangements with other providers was documented in the EPP and unavailable for review at the time of this survey.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | arrangements with other ICF/IID facilities and/or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services.<br>2.The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager | |
| E 0030<br><br>Bldg. -- | 403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1)<br>Names and Contact Information<br>§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), | | | |

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| | §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).<br><br>[(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]<br><br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians<br>(iv) Other [facilities].<br>(v) Volunteers.<br><br>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians<br>(iv) Other [hospitals and CAHs].<br>(v) Volunteers.<br><br>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff. | | | |

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| | (ii) Entities providing services under arrangement.<br>(iii) Next of kin, guardian, or custodian.<br>(iv) Other RNHCIs.<br>(v) Volunteers.<br><br>*[For ASCs at §416.45(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For Hospices at §418.113(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Hospice employees.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Other hospices.<br><br>*[For HHAs at §484.102(c):] The communication plan must include all of the following:<br>(1) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Patients' physicians.<br>(iv) Volunteers.<br><br>*[For OPOs at §486.360(c):] The | | | |

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| | communication plan must include all of the following:<br>(2) Names and contact information for the following:<br>(i) Staff.<br>(ii) Entities providing services under arrangement.<br>(iii) Volunteers.<br>(iv) Other OPOs.<br>(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).<br>Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff , (iv) Other ICF/IID facilities, and (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants.<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the EPP has a contact list for employees entitled "Emergency Telephone Numbers" on page 17 and a list of staff to be contacted entitled "Staff Recall Procedures" on page 20. Based on interview at the time of record review, the Area Supervisor acknowledged that neither list has his contact information. A contact list of employees found in the EPP does not list alternative contact information. Based on interview at the time of record review, the Area Supervisor stated that some employees had no direct primary source of contact and the numbers listed might belong to a family members that would than personally contact the employee on behalf of the employer.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | E 0030 | 1.The administrator will ensure the emergency plan policies and procedures will be updated to include names and contact information for staff.<br>2.Due to screening and vetting of volunteers ResCare uses internal sources for assistance. ResCare's ResCare -On-Call Team (ROC) pulling from 54,000 current employees nationwide was developed to aid operations that are in need of additional support and staffing that is activated by the Executive Director or subordinate Manager. All staff in the facility will be trained on the development of this program and its purpose.<br>3.The area supervisor and program manager will train all staff on the policies and procedures updates and the updates will be placed in the Emergency Disaster Preparedness Manual for reference as required.<br>4.Emergency Disaster Preparedness Manual will be review Annually at a minimum by | 08/18/2021 |

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| | | | the Quality Assurance Manager to ensure all information remains up to date.<br><br>**Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP, Quality Assurance Department. | |
| E 0032<br><br>Bldg. -- | 403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3).<br><br>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:<br><br>(3) Primary and alternate means for communicating with the following:<br>(i) [Facility] staff.<br>(ii) Federal, State, tribal, regional, and local emergency management agencies.<br><br>*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management | | | |

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| | agencies.<br>Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.475(c)(3). This deficient practice could affect all occupants.<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the EPP has a contact list for employees entitled "Emergency Telephone Numbers" on page 17 and a list of staff to be contacted entitled "Staff Recall Procedures" on page 20. Based on interview at the time of record review, the Area Supervisor acknowledged that neither list has his contact information. A contact list of employees found in the EPP does not list alternative contact information.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | E 0032 | 1.The method of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies will be place in the EPP by the Program Manager.<br><br>1.All staff will be trained on the method of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies.<br><br>1.Area Supervisor will ensure the EPP includes a copy the method of communicating using both a primary and alternate means of communicating with ICF/IID staff, Federal, State, regional, and local emergency managements agencies.<br><br>1.The Area Supervisor will ensure the EPP is updated annually and all staff are trained on the Emergency Preparedness Manual and have knowledge of where it is kept in the home and all its content. Upon visiting a home, the Program Manager will review the Emergency Preparedness Manual and document the visit on the Home Visitor Sign In form located in each home. | 08/18/2021 |

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| | | | 1.Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP-D's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues. | |
| E 0033<br><br>Bldg. -- | 403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6)<br>Methods for Sharing Information<br>§403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6).<br><br>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: | | | |

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| | (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.<br><br>(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)]<br><br>(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).<br><br>*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.<br><br>*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).<br>Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about | E 0033 | 1.The emergency plan policies and procedures will develop and maintain an emergency preparedness plan that complies with Federal, State and local laws that must be reviewed annually to include a method for sharing information and medical documentation for patients under the facility's care; a means of | 08/18/2021 |

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| (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 |
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| | the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants.<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the EPP was found to have no information concerning the sharing of information on consumers medical documentation. Based on interview at the time of record review, the Area Supervisor described the computer-based record documentation system used by the facility. The Area Supervisor indicated that the documentation system could be viewed on computers at the "Core Office", which is the first location to be used in the event of a facility evacuation. The Area Supervisor explained that the facility had a "Red Book" that contained all of the medical information necessary for each consumer. Based on interview at the time of record review, the Area Supervisor acknowledged that policies and procedures of the on-line record-keeping and "Red Book" were not part of the EPP documentation.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | releasing patient information as permitted under 45 CFR 164.510(b)(1)(ii); a means of providing information general information and location of patients as permitted under 45 CFR 164.510(b)(1)(ii).<br>2.The area supervisor and program manager will train all staff on the communication plan and the plan will be present in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager | |
| E 0034<br><br>Bldg. -- | 403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7)<br>Information on Occupancy/Needs<br>§403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c) | | | |

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| | 15G127 | A. BUILDING -- B. WING | 07/19/2021 |

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| | (6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7).<br><br>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:<br><br>(7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.<br><br>*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.<br><br>*[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.<br>Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. | E 0034 | 1.The administrator will ensure the emergency plan policies and procedures will be updated to include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction.<br>2.The area supervisor and program manager will ensure the policies and procedures update | 08/18/2021 |

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| | Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the EPP was found to have no information concerning the sharing of information on consumers medical documentation. Based on interview at the time of record review, the Area Supervisor described the computer-based record documentation system used by the facility. The Area Supervisor indicated that the documentation system could be viewed on computers at the "Core Office", which is the first location to be used in the event of a facility evacuation. The Area Supervisor explained that the facility had a "Red Book" that contained all of the medical information necessary for each consumer. Based on interview at the time of record review, the Area Supervisor acknowledged that policies and procedures of the on-line record-keeping and "Red Book" were not part of the EPP documentation.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | including a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager | |
| E 0035<br><br>Bldg. -- | 483.475(c)(8), 483.73(c)(8)<br>LTC and ICF/IID Sharing Plan with Patients<br>§483.73(c)(8); §483.475(c)(8)<br><br>*[For LTC Facilities at §483.73(c):]<br>[(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]<br><br>*[For ICF/IIDs at §483.475(c):]<br>[(c) The ICF/IID must develop and maintain an | | | |

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| | emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:]<br><br>(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.<br>Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants.<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., the EPP was found to contain no information on the policies and procedures for sharing EPP information appropriate with consumers and their families. Based on interview at the time of record review, the Area Supervisor described a practice of meeting with families and guardians of the consumers on an annual basis in which information was shared concerning the EPP. No agenda or written documentation of the meeting was available for review. No record of attendance ensuring that each consumer was represented was available for review. Based on interview at the time of record review, the Area Supervisor acknowledged that the EPP had no written policies and procedures pertaining to the methods of sharing information from the EPP with clients and their families. | E 0035 | 1.The administrator will develop and maintain an emergency preparedness plan that complies with Federal, State and local laws that must be reviewed annually to include a method for sharing information the facility has determined appropriate, with clients and their family or representatives.<br>2.The area supervisor and program manager will ensure the policies and procedures update including a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction is present in the Emergency Disaster Preparedness Manual for reference as needed.<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager | 08/18/2021 |

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| | This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | | |
| 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)<br>EP Training and Testing<br>§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).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §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.<br><br>*[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 | | | |

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| | 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.<br><br>*[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, 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).<br><br>*[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 develop an emergency preparedness testing program in accordance with 42 CFR | E 0036 | 1.The administrator will ensure the emergency plan policies and procedures annual emergency | 08/18/2021 |

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| | 483.475(d). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., documentation of the required testing of employees on the Emergency Preparedness Plan was not available for review. The section of the EPP for training & Education had an outline or template only. Based on interview at the time of record review, the Area Supervisor acknowledged that no testing of staff and documentation over the subject matter was included in the EPP.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | training and testing program in accordance with CFR 483.475(d) is implemented in all locations and evidence of the annual training and testing is present in the EPP manual.<br>2.The area supervisor and program manager will train all staff on the annual training and testing and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager | |
| E 0037<br><br>Bldg. -- | 403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)<br>EP Training Program<br>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under | | | |

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| | §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br>(1) Training program. The [facility] must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies | | | |

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| | and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies | | | |

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| | and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:<br>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the | | | |

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| | CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.<br>Based on record review and interview, the facility failed to ensure the emergency preparedness | E 0037 | 1.The administrator will ensure the emergency plan policies and | 08/18/2021 |

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| | program (EPP) training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., documentation of the required testing of employees on the Emergency Preparedness Plan was not available for review. The section of the EPP for training & Education had an outline or template only. Based on interview at the time of record review, the Area Supervisor acknowledged that he had no formal training in the emergency preparedness plan for this facility when he became the supervisor approximately three months ago.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | procedures initial training in emergency preparedness policies and procedures to all new and existing staff, annual emergency training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed in accordance with CFR 483.475(d) (1) and present in the EPP manual.<br>2.The area supervisor and program manager will provide initial training to all existing staff and new staff and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed.<br>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual<br><br>The persons responsible will be the, Program Manager, Area Supervisor, and Residential Manager | |
| E 0039<br><br>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), | | | |

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| | 15G127 | A. BUILDING -- B. WING | 07/19/2021 |

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| RES CARE COMMUNITY ALTERNATIVES SE IN | 1031 WEST ST NEW ALBANY, IN 47150 |

| (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 |
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| | 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)<br>EP Testing Requirements<br>§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).<br><br>*[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]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or | | | |

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| | (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.<br>(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.<br><br>*[For Hospices at 418.113(d):]<br>(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:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is | | | |

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| | 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.<br><br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise | | | |

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| | the hospice's emergency plan, as needed.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(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.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. | | | |

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| | *[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For LTC Facilities at §483.73(d):] | | | |

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| | (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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least | | | |

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| | twice per year. The ICF/IID must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a 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 every 2 years; or.<br>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.<br>(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:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(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.<br>(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.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(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 | | | |

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| | relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.<br>(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.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(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.<br>(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 an additional exercise to test the emergency plan at least once per year. The facility had no documentation of counting the COVID pandemic as an actual emergency that required activation of the existing EPP. The ICF/IID facility must do the following:<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>a. A second full-scale exercise that is | E 0039 | 1.The administrator will ensure the emergency plan policies and procedures includes the participation in a full-scale community based exercise and a table top exercise in accordance with CFR 483.475(d)(2) and present in the EPP manual.<br>2.The area supervisor and program manager will conduct the | 08/18/2021 |

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| | community-based or an individual, facility-based functional exercise.<br>b. A mock disaster drill; or<br>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.<br>(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.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., documentation of additional testing or activation of the Emergency Preparedness Plan was not available for review. Based on interview during record review, it was determined that the EPP did not include scheduled additional testing or an actual activation documentation. The Area Supervisor agreed with this assessment.<br><br>This deficiency was reviewed with the Area Supervisor after record review of the Emergency Preparedness Plan documentation on 07/19/2021. | | table top exercise and ensure documentation of the table top exercise and the community based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed.<br><br>1.The Program Manager will schedule a training event with community based services the Area Supervisor, and Residential Manager ensure the facility takes part in the training.<br>2.The Program Manager will contact local community based services to schedule a community based table top exercise before February 23, 2019.<br>3.Persons Responsible: Program Manager, Area Supervisor, and Residential Manager. | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). | K 0000 | | |

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| | Survey Date: 07/19/2021<br><br>Facility Number: 000664<br>Provider Number: 15G127<br>AIM Number: 100234310<br><br>At this Life Safety Code survey, Res Care Community Alternatives SE IN was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.<br><br>This two-story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in sleeping rooms and all living areas. The facility has a capacity of 8 and had a census of 6 at the time of this survey. The attic of the facility is not used for living purposes,storage, or fuel-fired equipment. The attic is protected using a heat detection system connected to the fire alarm system.<br><br>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 1.8.<br><br>Quality Review completed on 07/26/21 | | | |
| K S100<br><br>Bldg. 01 | NFPA 101<br>General Requirements - Other<br>General Requirements - Other<br>2012 EXISTING<br>List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided | | | |

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| RES CARE COMMUNITY ALTERNATIVES SE IN | 1031 WEST ST<br>NEW ALBANY, IN 47150 |

| (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 |
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| | 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.<br>1. Based on observation and interview, the facility failed to ensure 3 of 3 portable fire extinguisher located in the facility 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.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., all of the portable fire extinguishers had an affixed inspection and maintenance tag and lacked monthly inspections since their annual service in March 2021. Based on record review of the log | K S100 | 1. ResCare Maintenance will conduct monthly inspections of all facility fire extinguishers. Documented test dates will be kept onsite and with maintenance manager for review.<br>2. The AED met with ResCare Maintenance Manager on August 3, 2021 to ensure monthly checks are being performed.<br>3. The Facility will conduct random monthly inspections by the Residential Manager, Area Supervisor or Program Manager to ensure documentation of Fire Extinguisher Inspections are being completed as required and available for review. If documentation is not available the Program Manager, Area Supervisor or Residential Manager will contact Aramark (844)-RESCARE and create a service order and follow up to ensure completion within 5 days.<br>4. The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of inspecting Fire Extinguishers and maintaining proper documentation.<br>5. Random Monthly site visits will be conducted by the management team to verify the inspecting Fire Extinguishers and | 08/31/2021 |

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| | entitled "Monthly Fire and Safety System Checks" posted near the sprinkler riser during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the monthly fire extinguisher inspection was only documented until December 2019. The inspections for April, May, and June (of 2021) have not been documented on the tag or the "Monthly Fire and Safety System Log".. Based on interview at the time of observation, the D.S.P. indicated that monthly inspections were being done by individuals with the company but not recorded on the tags. No other form of a record of monthly inspections was provided for review.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>2. Based on record review and interview; the facility failed to ensure 2 of 2 battery operated emergency lights in the facility were 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.<br><br>Findings include:<br><br>Based on record review of the log entitled "Monthly Fire and Safety System Checks" posted near the sprinkler riser during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the | | maintaining proper documentation.<br>6. The Administrator will ensure the 3 of 3 portable fire extinguisher is inspected annual along with all portable fire extinguisher in the facility.<br>7. The Program Manager contacted Aramark scheduling a work order to have the portable fire extinguisher in the living room hung by a bracket supplied by the manufacturer approved for such purpose.<br>8. The Program Manager will insure all portable fire extinguishers are accessible at all times and random monthly inspections will be conducted by the management team to verify.<br>9. The Program Manager contacted Aramark to schedule the repair of the cross corridor door to repair the latching mechanism, upon repair random monthly inspection will be conducted by a member of the management team to insure proper functionality.<br>10. The Program Manager contacted Aramark to schedule the repair of 1 of 2 interior emergency lights, upon repair random monthly inspection will be conducted by a member of the management team to insure proper functionality.<br>11. Concerning annual maintenance of Fire Extinguisher The Associate Executive Director contacted Eric Grey with Koorsen | |

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| | D.S.P., the monthly battery operated emergency light inspection was only documented until December 2019. No documentation of testing from the last twelve months was available for review. Based on interview at the time of observation, the D.S.P. acknowledged lack of documentation but stated that someone came on a regular basis and checked the operation of the lights.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>3. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers in the living room was 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.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., a fire extinguisher located in the Cleaning Closet was sitting on the floor unsupported. Based on interview at the time of observation, the D.S.P. acknowledged that the portable fire extinguisher was on the floor and appeared to be forgotten. Based on interview at the time of observation, the D.S.P. stated that she did not know that the portable fire extinguisher was there.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>4. Based on observation and interview, the facility failed to ensure 1 of 3 fire extinguishers | | Fire and Security on August 3, 2021 to schedule annual maintenance for all the facilities Fire Extinguisher. The Scope of work has been updated to ensure the inclusion of annual maintenance for portable fire extinguishers and required documentation. The Program Manager, Area Supervisor and Direct Support Lead have been in-serviced on the requirement and if a deficiency is noted the Program Manager, Area Supervisor or Direct Support Lead will contact (844) ResCare to create a service order. The Associate Executive Director contacted Aramark Services on June 25, 2021 the Facilities maintenance vendor to ensure the scope of work for Koorsen Fire and Security included the annual maintenance of portable fire extinguishers and required documentation will be made available for review.<br>12. The Facility will ensure interior emergency lights are tested, maintained, and records of testing are maintained.<br>13. The Facility will ensure interior emergency lights are tested at a minimum of 3 weeks and a maximum of 5 weeks for no less than 30 seconds, records of test will be maintained by the facility.<br>14. The facility will ensure a functional test is conducted | |

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| | was accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, 6.1.3.1 states fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., one fire extinguisher in the home was obscured from view and obstructed by storage containers on the floor in front of the hanging fire extinguisher. Based on interview at the time of observation, the D.S.P. acknowledged that the fire extinguisher was not immediate available for use.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>5. Based on observation and interview, the facility failed to ensure 1 of 1 cross-corridor doors which appears to be a smoke barrier doors arranged to self close or automatic close with fire alarm system activation does not latch when released by the hold-open device. 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 doors held-open by devices connected to the fire alarm system, to be either maintained or removed. This deficient practice could affect all clients, staff and visitors.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the cross-corridor door did not latch into the strike to remain closed in the event of | | annually for a minimum of 1 ½ hour for all battery powered interior emergency lights, records of the test will be maintained by the facility.<br>15. The Program Manager will schedule a service order with Koorsen Fire and Security to repair or replace the emergency light<br><br>**Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP, Koorsen Fire and Security. | |

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| | pressurization due to fire. The door was equipped with a magnetic hold open device arranged to self close or automatic close with fire alarm system activation. Based on interview at the time of observation, the D.S.P. acknowledged that the cross-corridor door provided some degree of protection in the event of an emergency and that the latch did not engage the strike on the frame.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>6. Based on observation and interview, the facility failed to ensure 1 of 2 interior emergency lights was in working order. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows:<br>(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds.<br>(2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction.<br>(3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered.<br>(4) The emergency lighting equipment shall be fully operational for the duration of the test.<br>(5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction.<br>This deficient practice could affect occupants on the second story if the facility were required to evacuate in an emergency during a loss of normal | | | |

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| | power.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., 1 of 2 of the battery operated emergency lights failed to light during testing. Based on interview at the time of observation, the D.S.P. stated that she was no aware how long the emergency light had not been working.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>7. Based on observation and interview, the facility failed to document 1 of 4 portable fire extinguishers located in the facility was subject to maintenance at intervals of not more than one year. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires 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, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance<br>was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all clients, staff and visitors. | | | |

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| | Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the portable fire extinguisher located in the Cleaning Closet had a maintenance tag or label documenting maintenance was performed more than one year ago. Based on interview at the time of observation, the D.S.P. stated the fire extinguisher in the closet was in storage and was not being used. She indicated that this fire extinguisher was no longer in service.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | | |
| K S211<br><br>Bldg. 01 | NFPA 101<br>Means of Egress - General<br>Means of Escape - General<br>2012 EXISTING<br>Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency.<br>33.2.2<br>1. Based on observation and interview, the facility failed to maintain 1 of 3 designated means of escape on the first story be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. This deficient practice could affect all consumers on the first story including 2 of 7 sleeping rooms the staff and visitors on the first story requiring means of escape through the Med. Room.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the | K S211 | 1.The administrator will ensure Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency.<br>2.The administrator will ensure the removal of boxes obstructing the exterior door of the med rooms. upon removal random monthly inspection will be conducted by a member of the management team to insure proper functionality. | 08/18/2021 |

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| | D.S.P., the exterior door from the Med. Room was obstructed by boxes of supplies waiting to be collected. The boxes obstructed the opening of the 36" wide exterior door by 14" and did not allow the door to open fully. The emergency evacuation route plan for the first story of the house illustrates the exterior door from the Office as a means of escape. Based on interview at the time of observation, the D.S.P., the supplies where only there for a short time until they are picked up. The supplies obstructed the operation of the door the entire time of the survey..<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br>]<br>2. Based on observation and interview, the facility failed to maintain 1 of 1 designated means of escape from the second story be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. The two side-by side stairs are classified as a single escape due to not having the required separation for two means of escape. This deficient practice could affect 5 consumers in their sleeping rooms on the second story and staff attending to them.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., two lawn chairs, used by the consumers who smoke, have been placed immediately outside the exterior doors from the interior stairs from the second story. The chairs obstruct the means of escape from the second story of the house. Based on interview at the time of the observation, the Area Supervisor acknowledged that the chairs blocked the path of escape. He also noted that the | | 3.Staff will be in-serviced on the daily inspection of all doors used for evacuation and if a deficiency is found they are to immediately report any issues to ResCare Maintenance.<br>4.The Residential Manager will check all doors used for evacuation weekly and if a deficiency is found they are to immediately report any issues to ResCare Maintenance.<br>5.The Management team will conduct monthly inspections for proper function of all doors used for evacuation and if a deficiency is found they are to immediately report any issues to ResCare Maintenance.<br>6.The Program Manager will in-service the staff on blocking exit doors with lawn chairs upon repair random monthly inspection will be conducted by a member of the management team to insure exit doors remain unobstructed.<br><br>Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP. Aramark, ResCare Maintenance. | |

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| | chairs are not always located in their current location.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | | |
| K S222<br><br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>2012 EXISTING (Prompt)<br>Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5.<br>Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited.<br>Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)<br>1. Based on observation and interview, the facility failed to maintain 1 of 3 designated means of egress on the first story be continuously | K S222 | 1.The administrator submitted a work order Aramark for the exterior | 08/31/2021 |

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| | maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. Section 33.2.2.5.5 of the LSC states: no door in any means of escape, other than those meeting the requirement of 33.2.2.5.5.1 or 33.2.2.5.5.2, shall be locked against egress when the building is occupied. This deficient practice could affect all consumers on the first story including 3 of 7 sleeping rooms the staff and visitors on the first story.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the exterior door from the Office is equipped with a key-operated dead-bolt lock. The emergency evacuation route plan for the first story of the house illustrates the exterior door from the Office as a means of escape. This device is capable of locking the door in the means of escape. Based on interview at the time of observation, the D.S.P., a key for the dead-bolt lock was not available to verify the mechanical operation of the cylinder.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>2. Based on observation and interview, the facility failed to maintain 1 of 3 designated means of escape on the first story be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. Section 33.2.2.5.5 of the LSC states: no door in any means of escape, other than those meeting the requirement of 33.2.2.5.5.1 or 33.2.2.5.5.2, shall be locked against egress when the building is occupied. This deficient practice could affect all consumers on the first story including 3 of 7 | | office door for the removal of the dead bolt lock, upon repair random monthly inspection will be conducted by a member of the management team to insure proper functionality.<br>2.Staff will be in-serviced on the daily inspection of all doors used for evacuation and if a deficiency is found they are to immediately report any issues to ResCare Maintenance.<br>3.The Residential Manager will check all doors used for evacuation weekly and if a deficiency is found they are to immediately report any issues to ResCare Maintenance.<br>4.The Management team will conduct monthly inspections for proper function of all doors used for evacuation and if a deficiency is found they are to immediately report any issues to ResCare Maintenance.<br>5.The program manger contacted Aramark to remove the bathroom keyed lock and replace it with an easy access lock to ensure access will not be delayed, upon repair random monthly inspection will be conducted by a member of the management team to insure proper functionality.<br><br>**Persons Responsible**: AED, Program Manager, Area Supervisor, and Residential Manager, DSP | |

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| | sleeping rooms the staff and visitors on the first story.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the exterior door to the Med. Room from the hallway is equipped with a key-operated lockset. The emergency evacuation route plan for the first story of the house illustrates the interior door to the Med. Room on a means of escape route. This device is capable of locking the door in the means of escape. Based on interview at the time of observation, the D.S.P., a key for the lockset is carried by a staff person on duty at all times. In the event of an emergency when the staff is elsewhere in the house, access through the Med. Room is not available to the occupants of Bedroom #2 and #3 on the first story.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>3. Based on observation and interview, the facility failed to maintain the Med. Room bathroom door be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. Section 33.2.2.5.4 of the LSC states: every bathroom door shall be designed to allow opening from the outside during an emergency when locked. This deficient practice could affect consumers on the first story including 2 of 7 sleeping rooms the staff and visitors on the first story.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the | | | |

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| | D.S.P., the bathroom door to the Med. Room Bathroom has a privacy lockset that staff could not open from the outside during the tour. Based on interview at the time of observation, the D.S.P., made every attempt to open the door with the keys available.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | | |
| K S345<br><br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Fire Alarm System - Testing and Maintenance<br>2012 EXISTING (Prompt)<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, 14.2.1.2.1 states the requirements of Section 10.19 shall be applicable when a system is impaired. Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all clients, staff, and visitors.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the smoke detector in the Dining Room is hanging from the electrical box in the ceiling by | K S345 | 1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, heat detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review.<br>2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are | 08/31/2021 |

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| | the device wiring. Based on interview at the time of observation, the D.S.P. stated she did not know how long the smoke detector had been loose from the ceiling.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion.<br>3.The Program Manager will meet with a representative from Koorsen Fire and Security, a tentative date has been set for August 16, 2021 The Facility will require schedule required testing and request copies of inspections and testing mailed to the program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany IN 47150.<br>4.The Program Manager spoke with the Kris Carney from Koorsen Fire and Security effective immediately all sites will have an annual functional fire alarm inspection in the Month of February and a semiannual fire alarm visual inspection completed in August. Repair of the devices that failed the sensitivity test has been scheduled to be completed no later than August 31,2021.<br>Access to the device will be made available and that device will be tested no later than August 31, 2021. Koorsen Fire and Security was notified of ResCare's "In Scope Services Agreement" that automatically authorizes repair/service of fire systems. Koorsen will notify the Program Manger upon completion of all inspections to ensure any | |

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| | | | deficiencies are properly tracked and repaired. Koorsen will send documentation of all inspections, services and repair to ResCare main office at 4341 Security Parkway STE. 101 New Albany IN 47150 within 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required.<br>5.The Program Manager contacted Aramark to schedule the repair of the smoke detector in the dining room repair will be made no later than August 31, 2021.<br><br>Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative. | |
| K S353<br><br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>2012 EXISTING (Prompt)<br>NFPA 13 and 13R Systems<br>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. | | | |

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| | NFPA 13D Systems<br>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:<br>1. Control valves inspected monthly (NFPA 25, section 13.3.2).<br>2. Gauges inspected monthly (NFPA 25, section 13.2.71).<br>3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6).<br>4. Alarm devices tested semiannually (NFPA 25, section 5.3.3).<br>5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5).<br>6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1).<br>7. Visible pipe inspected annually (NFPA 25, section 5.2.2).<br>8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).<br>9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5).<br>10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2).<br>11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15).<br>12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4).<br>13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).<br>14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section | | | |

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| | 13.3.4).<br>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).<br>A. Date sprinkler system last checked and necessary maintenance provided.<br>_____<br>B. Show who provided the service.<br>_____<br>C. Note the source of the water supply for the automatic sprinkler system.<br>_____<br>(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.)<br>33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 | | | |
| | 1. Based on record review and interview, the facility failed to document annual, semiannual, and quarterly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect all clients in the facility.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., there was no documentation of inspections and testing at the house for review. The Work Order for the "wet system - quarterly" service accomplished on 05/06/2021 indicates that the report of the inspection and testing is sent directly to an individual within the organization that could not be reached on the day of the survey. Based on observation during the facility tour on 07/19/2021 | K S353 | 1.Sprinkler head location on the pantry will be relocated by Koorsen Fire and Security Before October 31, 2022.<br>2.Sprinkler head location in Bedroom #1 will be relocated by Koorsen Fire and Security Before October 31, 2022.<br>3.The Program Manager, Area Supervisor and Direct Support Lead have been in-serviced on the requirement of monthly visual inspections for all Fire alarm and Sprinkler components and if a deficiency is noted the Program Manager, Area Supervisor or Direct Support Lead will contact (844) ResCare to create a service order.<br>4.The Associate Executive Director contacted Joe Moore with Aramark Services on June 11, | 10/31/2021 |

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| | between 2:30 p.m. to 3:30 p.m. with the D.S.P., tags were found at the sprinkler riser indicating that service work was performed on 05/06/2021. Based on interview at the time of observation, the D.S.P. and the Area Supervisor made attempts to reach the recipient of the reports but were unable to provide documentation for review.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>2. Based on record review, observation and interview, the facility failed to document monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states an inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. This deficient practice could affect all clients in the facility.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., no documentation was available for review. Based on record review during the facility tour on 07/19/2021 between 2:30 | | 2021 the Facilities maintenance vendor to ensure the scope of work for Koorsen Fire and Security for the installation of the missing escutcheon plate and replacement of dirty sprinkler head is included. Upon completion no later than July 1, 2021 documentation will be made available for review.<br>5.An Additional Meeting with Aramark we held on Thursday August 19, 2021 to discuss the streamlining of bid and contracting process, in conjunction with Koorsen Fire and security. The requirements for collecting 3 competitive bids has been removed and the approval for payment has been submitted. Work will be completed no later than October 31, 2021 however the expectation is for work to be complete as soon as possible. Upon completions all documentation will be made available for review.<br><br>**Persons Responsible**: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative | |

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| | p.m. to 3:30 p.m. with the D.S.P., a log entitled "Monthly Fire and Safety System Checks" indicated that sprinkler valve and gauge inspections were made until December of 2019. No documentation of monthly inspections after December 20219 were made available for record review. Based on interview at the time of observation, the D.S.P. stated that someone from the organization did inspect the system on a regular basis without providing documentation of their service.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>3. Based on observation and interview, the facility failed to ensure the spray pattern for a sprinkler head were not obstructed in the Pantry in accordance with 33.2.3.5. NFPA 13, 2010 edition, Section 8.7.3.3.1 Sprinklers shall be located a minimum of 4 in. (102 mm) from an end wall.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the sidewall sprinkler has been obstructed by the construction of the front wall of the pantry. The front wall of the pantry is only 1.5 inches from the centerline of the deflector. Based on interview at the time of observation, the D.S.P. acknowledged the sprinkler was less than 4" from the front wall of the pantry. The D.S.P. stated that the wall and Pantry had been as is since before she began working at the house more than two years ago.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | | |

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| | 4. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in the first story Bedroom #1 in accordance with 33.2.3.5. NFPA 13, 2010 edition, Section 8.5.5.1, states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect all clients.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., a closet has been constructed in the room which obstructs the spray pattern from the sidewall sprinkler located in the room from reaching the far corner. Based on interview at the time of observation, the D.S.P. stated that closet had been as is since before she began working at the house more than two years ago.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | | |
| K S356<br><br>Bldg. 01 | NFPA 101<br>Sprinkler System - Supervisory Signals<br>Sprinkler System - Supervisory Signals<br>2012 EXISTING (Slow)<br>In Slow Evacuation Capability facilities where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 9.6, as modified below. The adequacy of the water supply shall be documented.<br>In Slow Evacuation Capability facilities, an | | | |

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| | automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier.<br>In Slow Evacuation Capability facilities, where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier.<br>In Slow Evacuation Capability facilities, in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted.<br>Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6.<br>Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following:<br>1. Protected by heat detection system to activate the fire alarm system according to 9.6.<br>2. Protected by automatic sprinkler system | | | |

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| | according to 9.7.<br>3. Constructed of noncombustible or limited-combustible construction; or<br>4. Constructed of fire-retardant-treated wood according to NFPA 703.<br>33.2.3.5.3, 33.2.3.5.3.2 through 33.2.3.5.3.4, 33.2.3.5.3.6<br><br>Based on record review and interview, the facility failed to document the adequacy of the water supply shall be documented to the authority having jurisdiction. Section 33.2.3.5.3 of the LSC states: where an automatic sprinkler system is installed, for either total or partial building coverage the adequacy of the water supply shall be documented to the authority having jurisdiction. Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect all clients in the facility.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., there was no documentation of the adequacy of the water supply. Based on record review during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., documentation of the pressure only was recorded on the log entitled "Monthly Fire and Safety System Checks" and only until December 2019. Based on interview at the time of observation, the D.S.P. and the Area Supervisor made attempts to reach the recipient of the sprinkler system reports but were unable to provide documentation for review.<br><br>This deficiency was not reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | K S356 | **1.** ResCare Maintenance will conduct monthly inspections of the facility sprinkler system. Documented test dates will be kept onsite and with maintenance manager for review.<br>2. The AED met with ResCare Maintenance Manager on August 3, 2021 to ensure monthly checks are being performed.<br>3. The Facility will conduct random monthly inspections by the Residential Manager, Area Supervisor or Program Manager to ensure documentation of Fire Extinguisher Inspections are being completed as required and available for review. If documentation is not available the Program Manager, Area Supervisor or Residential Manager will contact Aramark (844)-RESCARE and create a service order and follow up to ensure completion within 5 days.<br>4. The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of inspecting Fire Extinguishers and maintaining proper documentation.<br>**Persons Responsible**: AED, Program Manager, Area | 08/31/2021 |

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| | | | Supervisor, and Residential Manager, DSP | |
| K S358<br><br>Bldg. 01 | NFPA 101<br>Sprinkler System - Installation<br>Sprinkler System - Installation<br>2012 EXISTING (Slow)<br>In Slow Evacuation Capability facilities where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 9.6, as modified below. The adequacy of the water supply shall be documented.<br>In Slow Evacuation Capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier.<br>In Slow Evacuation Capability facilities, where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier.<br>In Slow Evacuation Capability facilities, in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler | | | |

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| | Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted.<br>Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6.<br>Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected.<br>Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following:<br>1. Protected by heat detection system to activate the fire alarm system according to 9.6.<br>2. Protected by automatic sprinkler system according to 9.7.<br>3. Constructed of noncombustible or limited-combustible construction; or<br>4. Constructed of fire-retardant-treated wood according to NFPA 703.<br>33.2.3.5.3, 33.2.3.5.3.2 through 33.2.3.5.3.4, 33.2.3.5.3.6 | | | |
| | Based on record review and interview, the facility failed to document the adequacy of the water supply shall be documented to the authority having jurisdiction. Section 33.2.3.5.3 of the LSC states: where an automatic sprinkler system is installed, for either total or partial building coverage the adequacy of the water supply shall be documented to the authority having jurisdiction. Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect all clients in the facility.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the | K S358 | **1.** ResCare Maintenance will conduct monthly inspections of the facility sprinkler system. Documented test dates will be kept onsite and with maintenance manager for review.<br>2. The AED met with ResCare Maintenance Manager on August 3, 2021 to ensure monthly checks are being performed.<br>3. The Facility will conduct random monthly inspections by the Residential Manager, Area Supervisor or Program Manager to ensure documentation of Fire Extinguisher Inspections are being completed as required and | 08/18/2021 |

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| | Area Supervisor and D.S.P., there was no documentation of the adequacy of the water supply. Based on record review during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., documentation of the pressure only was recorded on the log entitled "Monthly Fire and Safety System Checks" and only until December 2019. Based on interview at the time of observation, the D.S.P. and the Area Supervisor made attempts to reach the recipient of the sprinkler system reports but were unable to provide documentation for review.<br><br>This deficiency was not reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | available for review. If documentation is not available the Program Manager, Area Supervisor or Residential Manager will contact Aramark (844)-RESCARE and create a service order and follow up to ensure completion within 5 days.<br>4. The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of inspecting Fire Extinguishers and maintaining proper documentation.<br><br>**Persons Responsible**: AED, Program Manager, Area Supervisor, and Residential Manager, DSP | |
| K S362<br><br>Bldg. 01 | NFPA 101<br>Corridors - Construction of Walls<br>Corridors - Construction of Walls<br>2012 EXISTING (Prompt)<br>Unless otherwise indicated below, corridor walls shall meet all of the following:<br>* Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier.<br>* Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity.<br>* Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are | | | |

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| | wired glass not exceeding 9 square feet each in area and installed in approved frames.<br>This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels.<br>In Prompt Evacuation facilities, all sleeping rooms shall be separated from the escape route by smoke partitions in accordance with 8.2.4.<br>Sleeping arrangements that are not located in sleeping rooms shall be permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.<br>In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms shall be separated from escape routes by walls and doors that are smoke resistant.<br>33.2.3.6 | | | |
| | 1. Based on observation and interview, the facility failed to ensure 1 of 7 sleeping room doors were smoke-resistant construction. This deficient practice could affect all clients, staff and visitors.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the door to the second story Bedroom #2 was missing its latch/lockset which left a 3" hole through the otherwise smoke-resistant door.<br>Based on interview at the time of observation, the | K S362 | 1.The AED met with ResCare Maintenance Manager on August 3, 2021 to ensure all doors in the facility meet or exceed LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, | 10/31/2021 |

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| | D.S.P. stated the door had been recently replaced because of damage caused by the consumer. The door was replaced more than a week ago.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>2. Based on observation and interview, the facility failed to ensure 1 of 7 sleeping room doors were smoke-resistant construction. This deficient practice could affect all clients, staff and visitors.<br><br>Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the door to the second story Bedroom #1 had a gap larger than 1/8" at the top of the opening. Based on interview at the time of observation, the D.S.P. acknowledged the gap was larger than 1/8".<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 4.8.4.2 states the clearance under the bottom of a door shall be a maximum of 3/4 inch.<br>2.The AED met with ResCare Maintenance Manager on August 3, 2021 to schedule the repair of the latch lock set for bedroom #2. Upon repair random monthly inspections for a member of ResCare Management team will be conducted to ensure proper functionality.<br>3.The AED contacted Aramark on 8/03/2021 and submitted a work order to have ResCare Maintenance noncompliant doors will be removed and compliant door will be installed by October 31, 2021.<br>4.The AED will meet with ResCare Maintenance Manager on August 3, 2021 to schedule the replacement of sleeping room doors. Aramark Maintenance has collected measurements for sleeping room doors. An order has been placed and the vendor has given a tentative delivery date between 6 and 12 weeks due to supply chain issues. Upon delivery door will be installed with in 2 | |

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| | | | weeks. Estimated install date will be no later than October 31, 2021.<br>5.The program manager will verify the installation upon completion<br><br>**Persons Responsible**: AED, Aramark Program Manager, Area Supervisor, and Residential Manager, DSP | |
| K S363<br><br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors shall meet all of the following requirements:<br>1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed.<br>2. No doors shall be arranged to prevent the occupant from closing the door.<br>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.<br>33.2.3.6.4, 33.7.7<br>Based on observation and interview, the facility failed to ensure 1 of 7 sleeping room doors were capable of resisting smoke and provided with mechanisms suitable for keeping the doors closed. This deficient practice affects 5 of 6 clients who reside on the second story.<br><br>Findings include: | K S363 | 1.The Program Manager will ensure clients bedroom doors positively latch to the frame.<br>2.The maintenance coordinator will ensure all clients bedroom doors will positively latch as required.<br>3.The #2 Second Story Bedroom Door will be repaired by | 08/18/2021 |

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| | Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the corridor doors to consumer sleeping room, Second Story Bedroom #2, was not equipped with latching hardware. Based on interview at the time of observation, the D.S.P. stated the door had been recently replaced because of damage caused by the consumer. The door was replaced more than a week ago.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | ResCare Maintenance before August 31, 2021.<br>4.The Residential Manager will inspect house weekly to ensure bedroom Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure bedroom doors positively latch to frame as required.<br>5.Staff will notify ResCare Maintenance upon discovery of any damage that prevents Clients Bedroom Doors from positively latching to the frame as required by calling 844-ResCare.<br><br>Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP. | |
| K S364<br><br>Bldg. 01 | NFPA 101<br>Corridor - Openings<br>Corridor - Openings<br>2012 EXISTING (Prompt)<br>No louvers or operable transoms or other air passages shall penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles shall be prohibited.<br>33.2.3.6.3<br>Based on observation and interview, the facility failed to ensure 3 of 11 (corridor) doors were capable of resisting smoke within the means of escape inside the home. This deficient practice affects 2 of 6 consumers who reside on the first story. | K S364 | 1.The AED met with ResCare Maintenance Manager on August 3, 2021 to ensure all doors in the facility meet or exceed LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by | 01/01/2022 |

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| | Findings include:<br><br>Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., two furnace closet (corridor) doors are equipped with louvers and the Pantry door is a louver-style door. The louvers appear to be installed to provide combustion air to the HVAC units. The presence of the louvers creates a condition in which air is drawn through the corridors. Based on interview at the time of observation, the D.S.P. stated the doors had been as is since she arrived at the home more than two years ago.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 4.8.4.2 states the clearance under the bottom of a door shall be a maximum of 3/4 inch.<br>2.The AED met with ResCare Maintenance Manager on August 3, 2021 to schedule the removal and replacement of two closet doors. Upon repair random monthly inspections for a member of ResCare Management team will be conducted to ensure proper functionality.<br>3.The Residential Manager will inspect house weekly to ensure bedroom Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure bedroom doors positively latch to frame as required.<br>4.The January 1st date was incorrectly selected the corrected estimated date is the same as the sleeping room doors. All door for the facility have been ordered at | |

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| | | | the same time. Replacement is expected sooner than projected date, but supply chain issues and labor shortages has extended expected completion date. The AED will meet with ResCare Maintenance Manager on August 3, 2021 to schedule the replacement of sleeping room doors. Aramark Maintenance has collected measurements for sleeping room doors. An order has been placed and the vendor has given a tentative delivery date between 6 and 12 weeks due to supply chain issues. Upon delivery door will be installed with in 2 weeks. Estimated install date will be no later than October 31, 2021.<br><br>Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP. | |
| K S712<br><br>Bldg. 01 | NFPA 101<br>Fire Drills<br>Fire Drills<br>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:<br>a. Ensure that all personnel on all shifts are trained to perform assigned tasks;<br>b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.<br>2. The facility must:<br>a. Actually evacuate clients during at least | | | |

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| | one drill each year on each shift;<br>b. Make special provisions for the evacuation of clients with physical disabilities;<br>c. File a report and evaluation on each drill;<br>d. Investigate all problems with evacuation drills, including accidents and take corrective action; and<br>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.<br>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.<br>42 CFR 483.470(i)<br>Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 4 of the last 12 calendar quarters and 3 shifts over the past year. This deficient practice could affect all consumers.<br><br>Findings include:<br><br>Based on record review of the "Emergency Evacuation Drill - Fire" documentation and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., there was no record of a fire drill conducted on second shift for the second and third quarters of the year 2020 and there was no record of a fire drill conducted on third shift for the third and fourth quarters of the year 2020. Based on interview at the time of observation, the D.S.P. stated there was no other documentation available for review to indicate the missed drill had been conducted. The Area Supervisor stated there was no documentation of non-drill type training.<br><br>This deficiency was reviewed with the D.S.P. | K S712 | 1.All staff at the Facility will be re-trained on conducting fire drills quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff.<br><br>1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date.<br><br>1.The Residential Manager will submit monthly drills to the QA Department upon completion. The QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required. | 08/18/2021 |

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| | during the Exit Conference held on 07/07/2021. | | 1.The Area supervisor will ensure drills are completed as required.<br><br>1.The program manager will conduct random monthly inspections to ensure drills are being completed as required.<br><br>**Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP | |
| K S741<br><br>Bldg. 01 | NFPA 101<br>Smoking Regulations<br>Smoking Regulations<br>Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations.<br>32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2<br>Based on record review, observation and interview; the facility failed to provide a smoking policy for a facility allowing client and staff smoking. The facility failed to provide cigarette butt waste containers at the smoking area. This deficient practice affects all clients, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., documentation of a facility smoking policy was not available for review. Based on interview at the time of record review, the D.S.P. stated that two consumers smoked cigarettes. Efforts to obtain a copy of the | K S741 | 1.All staff at the home will be re-trained the Facilities smoking policy, and use of the designated smoking area.<br>2.The Facility will in service staff on the use of the smoking tower used to dispensing cigarette butts.<br>3.All staff in the facility will be inserviced on ensure smoking materials are deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design<br>4.The Facility will ensure the smoking area is cleaned and all | 08/18/2021 |

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| | policy were not successful. Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., cigarette butts were found at the front door landing in a plastic container with other trash. Based on interview at the time of the observations, the D.S.P. acknowledged a non-combustible safety container was not provided at the landing for smokers and that cigarette butts were mixed with trash in the plastic container.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021. | | cigarette butts are removed from the ground and disposed of properly<br>5.The Program Manager, Area Supervisor, and Residential Manager will randomly inspect the facility monthly to ensure the proper use of the smoking tower and that cigarette butts are not being thrown on the ground.<br><br>**Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance Manager. | |
| K S761<br><br>Bldg. 01 | Based on observation and interview, the facility failed to maintain annual testing of 2 of 2 fire doors in accordance of NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants in the dining room. | K S761 | 1.The administrator will ensure annual functional testing and inspections for fire doors is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review.<br>**2.The Program Manager will meet with a representative from Koorsen Fire and Security, a tentative date has been set for August 23, 2021 The Facility will require schedule required testing and request copies of inspections and testing mailed to the** | 08/31/2021 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G127 | A. BUILDING 01<br>B. WING | 07/19/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RES CARE COMMUNITY ALTERNATIVES SE IN | 1031 WEST ST<br>NEW ALBANY, IN 47150 |

| (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 |
|---|---|---|---|---|
| | Findings include:<br><br>Based on record review and interview on 07/19/2021 between 11:20 a.m. to 2:30 p.m. with the Area Supervisor and D.S.P., no documentation of fire door annual inspections was provided for review. Based on observation during the facility tour on 07/19/2021 between 2:30 p.m. to 3:30 p.m. with the D.S.P., the tag on the doors to the interior stair enclosure indicates that the two doors are fire-rated assemblies listed for 90-minutes. Based on interview at the time of observation, the D.S.P. the fire-rated door assemblies had not been inspected in the last year or since their installation.<br><br>This deficiency was reviewed with the D.S.P. during the Exit Conference held on 07/07/2021.<br><br>3.1-19(b) | | **program manager upon completion to the Program Manager at 4341 Security PKWY Suite 101 New Albany IN 47150.**<br><br>Persons Responsible: Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative. | |