STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G175	A. BUILDING -- B. WING	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3607 MIDDLE RD JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 12/27/22 Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190 At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 7 certified beds. At the time of the survey, the census was 7. Quality Review completed on 12/30/22	E 0000		
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 12/27/22 Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190 At this Life Safety Code survey, Res Care Community Alternatives SE IN was found not in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick O'Heran	QIDP Manager	01/11/2023

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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RES CARE COMMUNITY ALTERNATIVES SE IN	3607 MIDDLE RD JEFFERSONVILLE, IN 47130

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	compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility with a basement was fully sprinkled, except for the garage, storage room within the garage, and the breezeway between the garage and house. The facility has a fire alarm system with smoke detection on both levels including the corridors and common living areas. It could not be determined if there was heat detection in the attic. The facility has a capacity of 7 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-score of 4.0. Quality Review completed on 12/30/22			
K S168 Bldg. 02	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING (Slow) In Slow Evacuation Capability facilities, the facility shall be housed in a building where the interior is fully sheathed with lath and plaster or other material providing a 15-minute thermal barrier, including all portions of bearing walls, bearing partitions, floor construction, and roofs. All columns, beams, girders, and trusses shall be similarly encased or otherwise shall provide not less than a 1/2-hour fire resistance rating, unless modified by the			

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	modified by the following: * Exposed steel or wood columns, girders, and beams (but not joists) located in the basement shall be permitted. * Buildings of Type I, Type II (222), Type II (111), Type III (211), Type IV, Type V (111) construction shall not be required to meet the requirements of 33.2.1.3.2 (See 8.2.1). * Areas protected by approved automatic sprinkler systems in accordance with 33.2.3.5. shall not be required to meet the requirements of 33.2.1.3.2. * Unfinished, unused, and essentially inaccessible loft, attic, or crawl space shall not be required to meet the requirements of 33.2.1.3.2. * Where the facility achieves an E-score of 3 or less using the board and care occupancies evacuation capability determination methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety. The requirements of 33.2.1.3.2 shall not apply. 33.2.1.3.2.1 through 33.2.1.3.2.7 Based on observation and interview, the facility failed to ensure the facility was fully sheathed to provide a 15-minute thermal barrier. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Qualified Intellectual Developmental Professional (QIDP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 12/27/22, the following was noted: a. two separate holes for the passage of gray data cables were noted in the ceiling of the office in the breezeway to the garage which exposed the attic above. b. a triangular hole was noted next to the ceiling	K S168	To correct the deficient practice the holes will be repaired to ensure the facility is fully sheathed. All staff responsible for maintenance of the home will be re-trained to ensure all repairs are reported and corrected in a timely manner. Additional monitoring will be achieved by the site lead completing weekly home inspections to ensure no maintenance issues have arisen. Ongoing monitoring will be achieved by the QIDP completing a monthly LSC inspection checklist.	01/27/2023

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	mounted horn strobe in TS's bedroom which exposed the attic above. Based on interview at the time of the observations, the QIDP agreed the aforementioned openings did not ensure the facility was fully sheathed to provide a 15-minute thermal barrier. This finding was reviewed with the QIDP during the exit conference.			
K S258 Bldg. 02	NFPA 101 Number of Exits - Patient Sleeping and Non-Sl Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Slow) In Slow Evacuation Capability facilities, the primary means of escape for each sleeping room shall not be exposed to living areas and kitchens, unless the building is protected by an approved automatic sprinkler system in accordance with 33.2.3.5 utilizing quick-response or residential sprinklers throughout. 33.2.2.2.3 Based on observation and interview, the facility failed to ensure 1 of 2 smoke barrier doors separating sleeping rooms from living areas and kitchens would resist the passage of smoke. 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 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section	K S258	To correct the deficient practice the clearance under the bottom of the door will be made to ¾ inch or less. All staff responsible for home maintenance will be re-trained to ensure all repairs are reported and corrected promptly. Additional monitoring will be achieved by the site lead completing weekly home inspections to ensure no maintenance issues have arisen. Ongoing monitoring will be achieved by the QIDP completing a monthly LSC inspection	01/27/2023

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	4.8.4.2 states the clearance under the bottom of a door shall be a maximum of 3/4 inch. This deficient practice could affect all clients and staff. Findings include: Based on observations with the Qualified Intellectual Developmental Professional (QIDP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 12/27/22, the smoke barrier door separating the kitchen and the living room from the north hallway which contained the laundry area was held in the fully open position with a wall mounted magnetic holding device set to release with fire alarm system activation. The clearance under the bottom of the door was measured to be 1 and 3/4 inches as measured with a measuring tape when the door was in the fully closed and latched position. Based on interview at the time of the observations, the QIDP agreed the clearance under the bottom of the door was greater than 3/4 inch. This finding was reviewed with the QIDP during the exit conference.		checklist.	
K S311 Bldg. 02	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING (Prompt) Vertical openings shall be protected so as not to expose a primary means of escape. Vertical openings shall be considered protected if separated by smoke partitions in accordance with 8.2.4 that resist the passage of smoke from one story to any primary means of escape on another story. Smoke partitions shall have a fire resistance rating on not less than 1/2 hour. Any doors or openings to the vertical opening shall be			

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	capable of resisting fire for not less than 20 minutes. Stairs shall be permitted to be open where complying with sections 33.2.2.4.6 or 33.2.2.7. 33.2.3.1.1 through 33.2.3.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 vertical openings was protected by smoke partitions that resist the passage of smoke and have a fire resistance rating of not less than 1/2 hour. 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. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Qualified Intellectual Developmental Professional (QIDP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 12/27/22, the clearance under the bottom of the smoke barrier door separating the kitchen from the basement stairwell was measured to be 1 and 1/2 inches as measured with a measuring tape when the door was in the fully closed and latched position. Based on interview at the time of the observations, the QIDP agreed the clearance under the bottom of the door was greater than 3/4 inch. This finding was reviewed with the QIDP during the exit conference.	K S311	To correct the deficient practice the clearance under the bottom of the door will be made to ¾ inch or less. All staff responsible for home maintenance will be re-trained to ensure all repairs are reported and corrected promptly. Additional monitoring will be achieved by the site lead completing weekly home inspections to ensure no maintenance issues have arisen. Ongoing monitoring will be achieved by the QIDP completing a monthly LSC inspection checklist.	01/27/2023
K S353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems			

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	All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2).			

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	11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by	K S353	To correct the practice the contractor will be contacted to provide documentation that the backflow preventer was inspected, and the deficiency found on 2-5-22 was repaired. Spare sidewall sprinkler heads will be provided and placed in the sprinkler cabinet. All staff responsible for home maintenance will be re-trained to ensure all repairs are reported and corrected promptly.	01/27/2023

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	this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all clients, staff, and visitors in the facility. Findings include: Based on record review with the Qualified Intellectual Developmental Professional (QIDP) from 10:40 a.m. to 12:20 p.m. on 12/27/22, sprinkler system backflow preventer inspection documentation within the most recent twelve month period was not available for review. Based on observations with the Qualified Intellectual Developmental Professional (QIDP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 12/27/22, the sprinkler system inspection contractor had affixed a hanging tag to the sprinkler system riser in the basement stating the backflow preventer device was listed as "Fail" for the "02/05/22" annual inspection. No additional backflow preventer inspection documentation within the most recent twelve month period was available for review. Based on interview at the time of the observations, the QIDP stated she believed the preventer had been repaired or replaced on or after 02/05/22 but agreed backflow preventer repair or replacement documentation on or after 02/05/22 was not available for review. This finding was reviewed with the QIDP during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were		Additional monitoring will be achieved by the site lead completing weekly home inspections to ensure no maintenance issues have arisen. Ongoing monitoring will be achieved by the QIDP completing a monthly LSC inspection checklist.	

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	provided with the minimum number of spare sprinklers in a spare sprinkler cabinet on the premises for the types and temperature ratings of the sprinklers on the property. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Qualified Intellectual Developmental Professional (QIDP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 12/27/22, sidewall sprinklers were installed throughout the basement. No sidewall spare sprinklers were stored in the spare sprinkler cabinet in the basement next to the sprinkler system riser or on the premises. Based on interview at the time of the observations, the QIDP agreed the spare sprinkler cabinet did not contain any sidewall spare sprinklers. This finding was reviewed with the QID during the exit conference.			
K S358	NFPA 101 Sprinkler System - Installation			

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Bldg. 02	Sprinkler System - Installation 2012 EXISTING (Slow) 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. 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. 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. 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. Initiation of the fire alarm system shall not be required for existing installations in			

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	accordance with 33.2.3.5.6. 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: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 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, observation and interview; the facility failed to ensure 1 of 1 attics was fully sprinklered or met 1 or more of 4 exceptions per LSC 33.2.3.5.7.2. This deficient practice could affect all clients, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Alarm System Inspection" documentation dated 02/18/22, 08/12/22 and 09/02/22 with the Qualified Intellectual Developmental Professional (QIDP) during record review from 10:40 a.m. to 12:20 p.m. on 12/27/22, no attic heat detectors were listed as inspected or tested within the most recent twelve month period. The aforementioned three inspection reports listed three heat detector locations in the facility which were inspected or tested but did not identify heat detectors as being located in the attic. Based on observations with the Qualified Intellectual Developmental	K S358	To correct the deficient practice, the contractor will be contacted to inspect and test the attic heat detectors and provide documentation. All staff responsible for maintenance of the home will be re-trained to ensure all repairs are reported and corrected promptly. Additional monitoring will be achieved by the site lead completing weekly home inspections to ensure no maintenance issues have arisen. Ongoing monitoring will be achieved by the QIDP completing a monthly LSC inspection checklist.	01/27/2023

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	Professional (QIDP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 12/27/22, access to the attic was not available. As a result, it could not be determined if the attic was fully sprinklered or met 1 or more of 4 exceptions to the LSC. Based on interview at the time of record review and of the observations, the QIPD agreed it could not be determined if the attic was fully sprinklered or met an exception per the LSC. This finding was reviewed with the QIDP during the exit conference.			
K S511 Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring according to 33.2.5.1. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observations with the Qualified Intellectual Developmental Professional (QIDP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 12/27/22, the refrigerator in the garage was plugged into an extension cord which was plugged into a power strip on the floor of the	K S511	To correct the deficient practice the refrigerator and freezer in the garage will be plugged into a fixed fixture. The ceiling mounted electrical wiring will be placed in a junction box and covered. All staff will be trained not to utilize extension cords for major appliances. All staff responsible for maintenance of the home will be re-trained to ensure all repairs are reported and corrected promptly. Additional monitoring will be achieved by the site lead completing weekly home inspections to ensure no maintenance issues have arisen. Ongoing monitoring will be	01/27/2023

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	15G175	A. BUILDING 02 B. WING	12/27/2022

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	garage. In addition, the freezer in the garage was plugged into the same power strip the refrigerator was plugged into on the floor of the garage. Based on interview at the time of the observations, the QIDP agreed a power strip and an extension cord were being used as a substitute for fixed wiring in the garage. This finding was reviewed with the QIDP during the exit conference. 2. Based on observation and interview, the facility failed to ensure all electrical wiring in the facility was maintained in safe operating condition. LSC 33.2.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3)(c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Qualified Intellectual Developmental Professional (QIDP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 12/27/22, spliced electrical wiring was not completely confined within a ceiling mounted electrical wiring junction box in the pantry in the garage. The junction box was also not provided with a cover compatible with the box. Based on interview at the time of the observations, the QIDP agreed spliced electrical wiring for the aforementioned junction box was not completely confined within the junction box and the junction box was not provided with a cover compatible		achieved by the QIDP completing a monthly LSC inspection checklist	

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	with the box. This finding was reviewed with the QIDP during the exit conference.			
K S712 Bldg. 02	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) 1. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second shift for 1 of 4 quarters. This deficient practice affects all clients, staff and visitors.	K S712	To correct the deficient practice, a drill calendar was created for quarterly drills and varied times. All staff will be trained in completing evacuation drills per	01/27/2023

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	Findings include: Based on review of "Emergency Evacuations Drill: Fire" documentation with the Qualified Intellectual Developmental Professional (QIDP) during record review from 10:40 a.m. to 12:20 p.m. on 12/27/22, documentation of a fire drill conducted on the second shift in the first quarter (January, February, March) 2022 was not available for review. Based on interview at the time of record review, the QIPD stated the facility operates three shifts per day and agreed fire drill documentation for the second shift in the first quarter 2022 was not available for review. This finding was reviewed with the QIDP during the exit conference. 2. Based on record review and interview, the facility failed to conduct fire drills under varied conditions on the third shift for 3 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Emergency Evacuations Drill: Fire" documentation with the Qualified Intellectual Developmental Professional (QIDP) during record review from 10:40 a.m. to 12:20 p.m. on 12/27/22, three of four third shift fire drills conducted within the most recent twelve month period on 03/07/22, 09/15/22 and 12/21/22 were conducted at, respectively, 3:00 a.m., 3:30 a.m. and 3:30 a.m. Based on interview at the time of record review, the QIPD stated the facility operates three shifts per day and agreed the aforementioned third shift fire drills were not conducted under varied conditions.		the established drill calendar.¿ Additional monitoring will be achieved by the AS reviewing the completed drills compared to the drill calendar twice monthly. Ongoing monitoring will be achieved by the Lead and RM completing a monthly LSC inspection form to ensure all LSC requirements are met.¿	

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	This finding was reviewed with the QIPD during the exit conference.			