STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING -- B. WING	01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/16/19 Facility Number: 000664 Provider Number: 15G127 AIM Number: 100234310 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 483.73 The facility has 8 certified beds, with a current census of 7. Quality Review completed on 01/18/19 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0032 Bldg. --	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.	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.	02/15/2019

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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	Finding include: Based on review of emergency preparedness documentation on 01/16/19 between 11:15 a.m. to 2:00 p.m. with the Program Manager present, the emergency preparedness communication plan failed to include a primary and an alternate means for communication. Based on interview at the time of record review, the Program Manager said the emergency preparedness plan does not include a plan for primary and alternative means for communication.		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. 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. 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. 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	

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			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 Bldg. --	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 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. Findings include: Based on review of emergency preparedness documentation on 01/16/19 between 11:15 a.m. to 2:00 p.m. with the Program Manager present, the emergency preparedness plan failed to include a communication plan that included 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. Based on interview at the time of record review, the Program Manager said no further documentation was available for review.	E 0033	1.The facility will maintain emergency plan policies and procedures 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 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). 1.The Quality Assurance Department will ensure the EPP is reviewed and updated annually in accordance with Federal, State and local laws outlining a method for sharing information and medical documentation for patients under the facility's care; a means of 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	02/25/2019

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			CFR 164.510(b)(1)(ii). 1.The Program Manager, and Area Supervisor will ensure 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. 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 0035 Bldg. --	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	E 0035	1.The administrator will ensure the emergency plan policies and procedures will be shared with patient's and guardians during annual meetings. The Emergency Plan will be made available for review at request of	02/15/2019

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	could affect all occupants. Findings include: Based on review of emergency preparedness documentation on 01/16/19 between 11:15 a.m. to 2:00 p.m. with the Program Manager present, the facility failed to ensure there was an emergency preparedness communication plan that included a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives. Based on interview at the time of the record review, the Program Manager said the emergency preparedness plan failed to ensure there was a plan to include a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives.		patients and guardians. 1.The QIDP, Area Supervisor and Program Manager will ensure the emergency plan policies and procedures is shared with patient's and guardians during annual meetings. 1.The Program Manager, and Area Supervisor will ensure a copy of the Emergency Preparedness Manual is available onsite and at ResCare Jeffersonville main office for patient and guardian review. The Area Supervisor will ensure staff have knowledge of where the Emergency Preparedness Manual is kept in the home and all its content updated. 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. 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	

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			necessary to correct all issues.	
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness 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 annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of emergency preparedness documentation on 01/16/19 between 11:15 a.m. to 2:00 p.m. with the Program Manager present, emergency preparedness program training documentation within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Program Manager said there has not been any training conducted on the emergency preparedness plan for all staff that he was aware of.	E 0037	1.The administrator will ensure the emergency plan policies and 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. 1.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. 1.The Area Supervisor will ensure all new staff are trained on emergency plan policies and procedures initial training in emergency preparedness policies and procedures. Test will be given by Area Supervisor for all new staff and annually to existing staff that demonstrate proficiency with the emergency plan policies and procedures in emergency preparedness policies.	02/15/2019

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			1.The Program Manager, and Area Supervisor will ensure all staff is trained on emergency plan policies and procedures initial training in emergency preparedness policies. 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. 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 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based	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	02/15/2019

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	exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of emergency preparedness documentation on 01/16/19 between 11:15 a.m. to 2:00 p.m. with the Program Manager present, the facility was unable to provide documentation that two annual exercises were conducted during the past 12 months. Based on interview at the time of review, the Program Manager said the facility has not conducted two emergency preparedness exercises during the past 12 months that he was aware of.		present in the EPP manual. 1.To meet the requirements for the Emergency/Disaster Preparedness training, the facility must conduct mock drills twice a year. These should be conducted the same months other simulated drills are completed (January and July). **1.The Program Manager and Area Supervisor will ensure the facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually** **1.Area Supervisor will ensure Mock drill form is sent to the Program Manager for review and follow-up. Program Manager will forward Mock Drill to the QA department for review and filing.**	
K 0000 Bldg. 01				

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	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 01/16/19 Facility Number: 000664 Provider Number: 15G127 AIM Number: 100234310 At this Life Safety Code survey, Res Care Community Alternatives SW 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. This was a two story fully sprinklered facility. The facility has a fire alarm system with hard wired smoke detectors in the corridors, common living areas, and all client sleeping rooms. The facility has a capacity of eight and had a census of seven 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 2.3. Quality Review completed on 01/18/19	K 0000		
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided			

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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. 1. Based on record review, observation and interview; the facility failed to ensure 2 of 2 interior emergency lights were tested, maintained, and the records of the testing maintained. 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: (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. (2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the test. (5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 01/16/19 between 11:15 a.m. and 2:00 p.m. with the Program Manager present, there was documentation to show the battery powered emergency lights were tested for 30 seconds monthly, however, there was no	K S100	1.The maintenance coordinators will be trained by the program managers to ensure the Portable Fire Extinguishers are secured on hangers in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4. and documented monthly inspections of fire extinguishers is complete. 2.The program manager met with Koorsen Fire and Security on February 4, 2019 to schedule annual inspections of all fire extinguishers in the facility. Annual Inspections of the fire extinguishers will be completed by February 25, 2019. 3.The facility will ensure emergency lighting will be tested monthly for a minimum of 30 seconds and an annual test of 90 minutes for all units in the facility. The program manager met with Koorsen Fire and Security on February 4, 2019 to schedule annual 90 minute test of emergency lighting in the facility. Annual testing will be completed by February 25, 2019. 4.ResCare Maintenance will conduct monthly inspections of all facility fire extinguishers and monthly 30 second function test of emergency lighting. Documented test dates will be keep onsite and with maintenance manager for	02/25/2019

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	documentation of an annual 90 minute test. Based on interview at the time of record review, the Program Manager said there was no documentation available to show an annual 90 minute test during the past 12 months. Furthermore, based on observation during a tour of the facility with the Program Manager, the battery powered light set at the top of the west stairway did not illuminate when tested several times. This was acknowledged by the Program Manager at the time of observation. 2. Based on observation and interview, the facility failed to ensure 4 of 4 portable fire extinguishers were 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 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. Findings include: Based on observation on 01/16/19 between 11:15		review. 5.The Program Manager will conduct random monthly inspections to ensure testing has been completed.	

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	a.m. and 2:00 p.m. during a tour of the facility with the Program Manager, four portable fire extinguishers had an annual inspection tag dated February 2017. Based on interview at the time of observation, the Program Manager agreed that the date listed was prior to the most recent 12 month time period. Furthermore, he stated no other documentation for annual fire extinguisher maintenance was available for review.			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure documentation for 1 of 1 fire alarm system was complete in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 states all initiating devices shall be functional tested annually. This deficient practice could affect all clients, staff and visitors. Findings include:	K S345	1.The administrator will ensure annual functional testing for initiating devices such as smoke 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. 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 available in the facility for review.	02/25/2019

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

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	Based on record review on 01/16/19 between 11:15 a.m. and 2:00 p.m. with the Program Manager present, there was documentation of an annual fire alarm system inspection, however, the report dated 03/30/18 was only a cover page with a blanketed statement of how many devices are connected to the fire alarm system. There was no itemized list of devices showing the location of the device and the results of the visual and functional testing results. This was acknowledged by the Program Manager who also said this was the only report available. 2. Based on record review and interview, the facility failed to ensure documentation was available to show 13 of 13 smoke detectors were within their listed and marked sensitivity range. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method.		Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. 1.The Program Manager met with Koorsen Fire and Security on February 4, 2019 to ensure completion of required annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes was performed by Koorsen Fire and Security. 1.Eric Gray with Koorsen Fire and Security will email reports of the tests/inspections to the Program manager by February 25, 2019.	

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	15G127	A. BUILDING 01 B. WING	01/16/2019

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	(2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review on 01/16/19 between 11:15 a.m. and 2:00 p.m. with the Program Manager present, there was no documentation available to show the facility's smoke detectors have been tested for sensitivity. Based on interview at the time of record review, the Program Manager said there was no documentation available to show sensitivity testing was performed for the facility's 13 smoke detectors.			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in			

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	Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually			

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	(NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review, observation and interview; the facility failed to document complete sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler system. 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 normal water pressures are being maintained. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its 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.	K S353	The administrator will ensure Koorsen Fire and Security conducts quarterly sprinkler inspections and that the reports of the inspections are available in the facility for review and forwarded to the Program Manager for monitoring. The administrator will ensure monthly sprinkler gauge inspections and monthly control valve inspections are conducted	02/25/2019

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	Findings include: Based on record review on 01/16/19 between 11:15 a.m. and 2:00 p.m. with the Program Manager present, monthly wet sprinkler system gauge inspection documentation for 12 of the most recent 12 month period was available for review on a tag attached to the sprinkler riser, however, the documentation was only a date of inspection, not the pressure readings for the two attached sprinkler gauges. Based on interview at the time of record review, the Program Manager acknowledged the documentation on the tag attached to the sprinkler riser only provided the date of inspection and not the sprinkler gauge pressure for each gauge.		by the ResCare maintenance coordinator, documentation will be maintained on site and a copy kept with ResCare Maintenance Manager. The program manager will conduct random monthly inspections to ensure monthly and quarterly inspections are being preformed as required. The Program Manager met with Koorsen Fire and Security on February 4, 2019 to ensure completion of required quarterly and annual sprinkler inspections are being completed as required. Eric Gray with Koorsen Fire and Security will email reports of the tests/inspections to the Program manager by February 25, 2019.	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are			

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	familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 1 of 3 shifts during 2 of 4 quarters during the past 12 months. This deficient practice could affect all clients. Findings include: Based on review of the facility's fire drill reports on 01/16/19 between 11:15 a.m. and 2:00 p.m. with the Program Manager present, there were no fire drill reports available for the third (night) shift of the second quarter (April, May, and June), and fourth quarter (October, November, and December) of 2018. Based on interview at the time of record review, the Program Manager confirmed the lack of fire drills during the previously mentioned shift and quarters of 2018.	K S712	1.All staff at the home 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. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date. 1.The Residential Manager will submit monthly drills to the QA Department upon completion. The	02/25/2019

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			QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required. 1.The Area supervisor will ensure drills are completed as required. 1.The program manager will conduct random monthly inspections to ensure drills are being completed as required. 2.The Program Manager will conduct training at the Monthly Residential Managers Meeting on March 5, 2019 covering the standards and requirements of drills.	