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	15G442	A. BUILDING -- B. WING	05/20/2021

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RES CARE COMMUNITY ALTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 05/20/2021 Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760 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 The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 06/02/21 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0015 Bldg. --	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), 485.625(b)(1) Subsistence Needs for Staff and Patients §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) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based			

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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	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: (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: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (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: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following:			

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	(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. 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: (i) Food, water, medical, and pharmaceutical supplies in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 05/20/2021 between 10:30 a.m. and 1:00 p.m. with the Associate Executive Director (AEO) the emergency preparedness plan did not adequately address the medical needs of the facility. Based on an interview at the time of review with the Residential Manager (RM) the emergency supplies in the first aid kit were inadequate and had not been replenished. The RM retrieved the kit and showed us the content. The AEO acknowledged that the supplies in the first aid kit did not match the policies and procedures for medical needs as written in the Emergency Preparedness Plan. This deficiency was reviewed with the AEO during the Exit Conference on 05/20/2021 at 2:30 p.m.	E 0015	1.The administrator will ensure the emergency plan policies and procedures includes the updated Shelter-In-Place policy which addresses 1) alternative sources of energy, 2) emergency lighting, 3) fire detection, extinguishing and alarms, and 4) proper disposal of sewage and waste. 2.The area supervisor and program manager will train all staff on the updated Shelter-In-Place policy and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3.The Administrator will update the emergency plan to include the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, to include sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). 4.The Administrator will update the emergency plan to include a plan for the temporary loss of or need during sheltering in place for sewage and waste disposal. 5.This information is located in section 21 of the Emergency Disaster Preparedness Manual 6.The corrective action will be	06/19/2021

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			monitored and reviewed for effectiveness at a minimum bi-annual 7.The Program Manager will purchase needed materials for the First Aid Kit staff will be in-serviced on the required items and during monthly management site review First Aid kit will be inspected for required items, replacement items will be order as needed by the Program Manager. 8.The Quality Assurance Manager will review and approve the shelter in place policy the quality assurance manager and program manager will ensure the most current Shelter in Place policy is in the Emergency Preparedness Manual. **Persons Responsible**: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative, Aramark	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).			

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*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:

(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:

(i) Participate in a full-scale exercise that is community-based every 2 years; or
(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or
(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.
(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and

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maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

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

(3) Testing for hospices that provide inpatient

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	care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital,			

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

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

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

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

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

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	of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. 1. Based on record review and interview, the facility failed to ensure its documentation of the COVID pandemic as an actual emergency that required activation of the existing Emergency Preparedness Plan (EPP) was complete. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.	E 0039	1.The administrator will ensure the participation in a full-scale community based exercise and a table top exercise is present in the EPP manual. 2.The area supervisor and program manager will ensure documentation of the table top exercise and the community based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review and update	06/19/2021

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	(ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 05/20/2021 between 10:30 a.m. and 1:00 p.m. with the Associate Executive Director (AED), the facility failed to maintain records of cleaning the facility as required by the policies and procedures for COVID-19 of the RES CARE Emergency/ Disaster Preparation Manual. Based on interview during record review, the AED indicated that the policy requiring morning and evening cleaning was no longer in effect. The AEO acknowledged that records of cleaning were not available for review. The AEO acknowledged that an assessment of the policy and procedure and documentation of the change to the policy were not available for review. The issue was reviewed with the AED during the Exit Conference on 5/20/2021 at 2:30 p.m.		annually as needed. 3.This information is located in section 22 of the Emergency Disaster Preparedness Manual 4.Dated Documentation will be provided showing the completion of a tabletop exercise 5.The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of conducting an annual community based exercise and maintaining documentation Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP.	

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2. Based on record review and interview, the facility failed to conduct an additional test of the emergency plan at least once per year. The ICF/IID facility must do the following:
(ii) Conduct an additional exercise that may include, but is not limited to the following:
a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.
b. A mock disaster drill; or
c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.

Findings include:

Based on record review of RES CARE Emergency/Disaster Preparation Manual documentation with the Associate Executive Director (AED) between 10:30 a.m. and 1:00 p.m., documentation of an additional or activation of the Emergency Preparedness Plan was not available for review. Based on interview during record review, in was determined that the EPP did not include scheduled testing or an actual activation documentation. The AED acknowledged that an additional exercise had not been completed.

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	The deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m.			
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 05/20/2021 Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760 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. This one story building was determined to be fully sprinklered. The attic is protected by heat detection connected to the fire alarm control panel. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.6. Quality Review completed on 06/02/21	K 0000		

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K S211 Bldg. 01	NFPA 101 Means of Egress - General Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 Based on observation and interview, the facility failed to maintain 1 of 2 primary means (1 of 5 exterior doors) of escape clear of obstructions and impediments to full instant use in the case of fire or emergency. This deficient practice could affect all occupants needing to use the primary means of escape from the Bedrooms #1-5. Findings include: Based on record review of RES CARE "Emergency Evacuation Drill" reports only two exterior doors are used to exit the house in the event of a fire emergency. Based on observation during the facility tour on 05/20/2021 between 1:00 p.m. and 2:00 p.m. with the Associate Executive Director (AED), Front Patio Door could not be opened because the door hardware was broken. Based on an interview at the time of record review the AED acknowledged that one means of escape appears to be drilled during the quarterly fire drills. Based on an interview at the time of observation the AED acknowledged that the door could not be opened. The AED made a telephone call immediately to have the hardware repaired. The deficiency and the need to practice multiple options was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m.	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. 2.The administrator submitted a work order Aramark for the exterior door used for the front patio door to be repair and or replaced. 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. 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. 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.	06/19/2021

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			Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP. Aramark, ResCare Maintenance.	
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) 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. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. 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)			
	Based on observation and interview, the facility failed to ensure 1 of 5 exterior exit doors were provided latching/security mechanism to release	K S222	1.The administrator submitted a work order Aramark for the exterior door used for the front patio door	06/19/2021

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	the door and open. 33.2.2 states designated means of escape shall be continuously maintained free of all obstruction or impediments to full instant use in the case of fire or emergency. This deficient practice could affect occupants in Bedrooms #1-5 in the facility. Findings include: Based record review of the Emergency Evacuation Drill reports on 05/20/2021 between 10:30 a.m. and 1:00 p.m. with the Associate Executive Director (AED), the "front patio" door is considered the primary exit from Bedrooms #1-5. Based on observation during the facility tour on 05/20/2021 between 1:00 p.m. and 2:00 p.m. with the AED, the "front patio" door could not be opened due to damaged or broken hardware. The AED was not aware of the fact that the door could not be opened in the direction of escape. The AED immediately called for service on the door hardware at the time of observation. The deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m.		to be repair and or replaced. 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. 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. 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. **Persons Responsible**: AED, Program Manager, Area Supervisor, and Residential Manager, DSP	
K S300 Bldg. 01	NFPA 101 Protection - Other Protection - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.2.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure the closing to latch of a door	K S300	1.The facility will ensure the door between the living room and	06/19/2021

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	equipped with spring-loaded hinges and a magnetic hold-open device activated by the fire alarm system. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observation with the Associate Executive Director on 05/20/2021 between 1:00 p.m. and 2:00 p.m., the door between the living room and the front hallway did not close and latch when released from the hold-open device. Based on an interview at the time of the observation, the AED did not know why the door was required or if the wall was a smoke barrier. No Life Safety Drawings illustrating wall fire rating requirements were available for document review. The AED acknowledged that the door did not fully close and latch when released from the hold-open device. The deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m.		front hallway that is equipped with a closing to latch of door equipped with spring-loaded hinges and a magnetic hold-open device activated by the fire alarm system. NFPA 101 in 4.6.12.3 required by the Code, shall be maintained following NFPA 72, 29.10 Maintenance and Tests. 2.The maintenance coordinator will ensure all doors will positively latch as required. 3.The Program Manager scheduled a service order with Aramark for the repair or preplacement of the door between the living room and front hallway and will be repaired by ResCare Maintenance before July 1, 2021. A delay in repair may occur due to scheduling limitations based on vendor supply. 4.The Residential Manager will inspect house weekly to latching doors operate properly Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure doors positively latch to frame as required and function as required. 5.Staff will notify ResCare Maintenance upon discovery of any deficiency that prevents Clients Bedroom Doors from positively latching to the frame as required by calling 844-ResCare. Persons Responsible: Program	

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			Manager, Area Supervisor, Residential Manager, DSP. Aramark, ResCare Maintenance.	
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, observation and interview; the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling 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 at 15(e) states the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with 14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit	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. 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. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. 3.The Program Manager will	06/19/2021

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	annually. Different detectors shall be tested each year. Records shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review on 05/20/2021 between 10:30 a.m. and 1:00 p.m. with the Associate Executive Director, documentation of heat detector testing for two devices located in the attic was not available for review. The most recent Inspection and Testing Report dated August 4, 2020 indicated that the two heat detectors in the attic were not included in the report. Survey of the attic was not possible because no ladder was available. Based on interview at the time of record review, the AED stated the fire alarm system inspection should now include the inspection and testing of heat detectors or the wiring connecting the devices to the faire alarm control panel. The deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m. 2. Based on record review and interview, the facility failed to ensure all facility 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 14.4.5.3.2 states every alternate year thereafter. After the second required		meet with a representative from Koorsen Fire and Security, a tentative date has been set for June 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. 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 July 1,2021. Access to the device will be made available and that device will be tested no later than July 1, 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 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	

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	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. (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 with the Associate Executive Director (AED) on 05/20/2021 between 10:30 a.m. and 1:00 p.m., documentation of smoke detector sensitivity testing within the most recent two year period was not available for review.		47150 within 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative.	

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	Based on interview at the time of record review, the Area Director acknowledged documentation of smoke detector sensitivity testing within the most recent two year period was not available for review and that no other documentation that could indicate that sensitivity testing and results were available. The deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m.			
K S351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 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 Section 9.6, as modified below. The adequacy of the water supply shall be documented. In Prompt Evacuation 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 Prompt Evacuation Capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall			

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	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 Prompt 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 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 by July 5, 2019. 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, 33.2.3.5.3.1, 33.2.3.5.3.3, 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7			
	1. Based on observation and interview, the facility failed to place sprinkler protection adequate for the layout of Bedroom #5 in a fully sprinklered group home. This deficient practice could affect all residents, staff, and visitors within the facility.	K S351	1.The Facility will ensure the installation an additional automatic sprinkle head to adequately protect the bedroom #5. 2.The Facility will ensure the installation an additional automatic	06/19/2021

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	Findings include: Based on observation with the Associate Executive Director on 05/20/2021 during a tour of the facility between 1:00 p.m. and 2:00 p.m., the construction of the enclosure for a pantry has obstructed the spray pattern of the existing sprinkler in Bedroom #5 including the floor area within and in front of the closet. Based on an interview with the AED at the time of observation, the AED stated that the pantry was not new construction. The AED acknowledged that the quantity of combustibles in and near the closet was higher than normal and that the sprinkler does not appear to adequately protect the area. This deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m. 2. Based on observation and interview, the facility failed to place sprinkler protection adequate for the fuel load in Bedroom #4 in a fully sprinklered group home. This deficient practice could affect all clients, staff, and visitors within the facility. Findings include: Based on observation with the Associate Executive Director on 05/20/2021 during a tour of the facility between 1:00 p.m. and 2:00 p.m., the quantity of combustibles in Bedroom #4 exceeds that for a typical bedroom. Stuffed animals filled the entire floor, bed, and flat surfaces of dressers in the room. Based on an interview with the AED at the time of observation, the AED acknowledged that the quantity was higher than normal and that an assessment by the sprinkler system designer		sprinkle head to adequately protect the bedroom #4. 3.The Facility will ensure the installation an additional automatic sprinkle head to adequately protect the Pantry. 4.The Facility will ensure the installation an additional automatic sprinkle head to adequately protect the bathroom #1. 5.The Facility will ensure the installation an additional automatic sprinkle head to adequately protect the bathroom #2. 6.Koorsen Fire and Security was notified by the Program Manager on Mat 20, 2021 to schedule the installation of an additional automatic sprinkler in the bathroom and are added to the inspection and testing of the Sprinkler System. 7.The Program Manager contacted Aramark on May 20, 2021 and submitted a work order to have ResCare Maintenance verify install the installation required by LSC and add the inspection and testing to Koorsen's scope of work. 8.The Associate Executive Director contacted Joe Moore with Aramark Services on June 11, 2021 the Facilities maintenance vendor to ensure the scope of work for Koorsen Fire and Security for the installation of additional sprinkler heads are included. Upon completion no later than July 1, 2021 documentation will be made	

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	had not been completed to verify that the existing sprinkler design was adequate for the combustible load in the room. This deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m. 3. Based on observation and interview, the facility failed to place sprinklers in 1 of 1 Pantry in a fully sprinklered group home. This deficient practice could affect all residents and staff within the facility. Findings include: Based on observation with the Associate Executive Director (AED) on 05/20/2021 during a tour of the facility between 1:00 p.m. and 2:00 p.m., there was no sprinkler located in the Pantry. The Pantry enclosure appears to have been created from space formerly part of Bedroom #5. When the room was created, sprinkler protection was not modified to protect the Pantry. The quantity of combustibles and packaging in the Pantry appears to be greater than normally found in a residence. The lack of sprinklers in the Pantry was acknowledged by the AED at the times of the observations. This deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m. 4. Based on observation and interview, the facility failed to place sprinklers in 1 of 2 bathrooms with floor areas greater than 55 square feet in a fully sprinklered group home. This deficient practice could affect all residents and staff within the facility.		available for review. **Persons Responsible**: Koorsen Fire and Security, Aramark Maintenance Manager, Program Manager, Area Supervisor, and Residential Manager, DSP.	

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	Findings include: Based on observation with the Associate Executive Director (AED) on 05/20/2021 during a tour of the facility between 1:00 p.m. and 2:00 p.m., there was no sprinkler located in Bathroom #1. The floor area of the bathroom is approximately 82 square feet. The lack of sprinklers in Bathroom #1 and the area of the bathroom being greater than 55 square feet was acknowledged by the AED at the times of the observations. This deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m. 5. Based on observation and interview, the facility failed to place sprinklers in 1 of more than 10 spaces without obstructions to the spray pattern. This deficient practice could affect all clients and staff within the facility. Findings include: Based on observation with the Associate Executive Director (AED) on 05/20/2021 during a tour of the facility between 1:00 p.m. and 2:00 p.m., the sprinkler in Bathroom #2 located in the in front of the bath/shower is obstructed by the beam at the ceiling. The beam extends 2.5 inches below the deflector and prevents water from reaching the water closet and vanity area of the bathroom. Bathroom #2 has a floor area of approximately 95 square feet. The obstruction of the beam was acknowledged by the AED at the times of the observations. This deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30			

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	p.m.			
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 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			

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	(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 (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. ____________________ B. Show who provided the service. ____________________ C. Note the source of the water supply for the automatic sprinkler system. ____________________ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on observation and interview, the facility failed to ensure 1 of more than 10 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.1 states plates,	K S353	1.The Facility will ensure the installation of an escutcheon plate in the office for the automatic sprinkler head in accordance with NFPA 13, Standard for the	06/19/2021

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	escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation with the Associate Executive Director (AED) during a tour of the facility from 1:00 p.m. to 2:30 p.m. on 05/20/2021, the sprinkler is missing its escutcheon plate at the ceiling in the office. Based on interview at the time of observation, the AED stated that he has noticed the missing escutcheon earlier the same day. The AED acknowledged the sprinkler was missing an escutcheon plate. This deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of more than 10 automatic sprinklers would activate properly due to a build up of hot gases at the ceiling. This deficient practice could affect all clients, as well as staff and visitors in the facility. Findings include: Based on observation during the facility tour on 05/20/2021 between 1:00 p.m. and 2:00 p.m. with the Associate Executive Director, there was an unsealed pipe penetration of the ceiling in the closet (sprinkler riser location) in Bedroom #8. The AED acknowledged that the ceiling penetration was unsealed. This deficiency was reviewed with the AED		Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.1. 2.Sprinkler head location on the ceiling in bedroom #8 will be inspected by Koorsen Fire and Security Before July 1, 2021. If needed the Sprinkler Head will be cleaned or replaced. 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. 4.The Associate Executive Director contacted Joe Moore with Aramark Services on June 11, 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. **Persons Responsible**: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative	

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	during the Exit Conference on 05/20/2021 at 2:30 p.m. 3. Based on observation and interview, the facility failed to ensure 1 of more than 10 automatic sprinklers clean and free of foreign material that might affect the operation of the sprinkler. This deficient practice could affect all clients, as well as staff and visitors in the facility. Findings include: Based on observation during the facility tour on 05/20/2021 between 1: p.m. and 2:00 p.m. with the Associate Executive Director (AED), the sprinkler in Bedroom #8 was covered with dust and dirt that might affect the proper activation of the sprinkler in the event of a fire. The AED acknowledged the build-up of material on the bulb of the sprinkler at the time of observation. This deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5.			

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	Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure 1 of 8 resident rooms doors had no impediment to the occupant from closing the door. This deficient practice could affect one client. Findings include: Based on observation during a facility tour with the Associate Executive Director (AED) on 05/20/2021 between 1:00 p.m. and 2:00 p.m., a door stop was found placed under the door to Bedroom #8. Based on interview at the time of observation, the AED stated that the door stop was there to prevent the door from pinching closing the oxygen tube that the resident of Bedroom #8 uses continuously and is connected to the oxygen concentrator in Bedroom #8. The AED acknowledged that the door stop would prevent the occupant from closing the door and readily closing the door in the event of a fire emergency. The deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m.	K S363	1.The Program Manager will ensure clients bedroom doors positively latch to the frame. 2.Bedroom #8 door stop was removed by the Program Manager and staff has been in-serviced about not leaving doors propped open. DSP's will check all doors to ensure no client doors are propped open. 3.The Residential Manager will inspect house weekly to ensure bedroom doors are not propped open. Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure bedroom doors positively latch to frame as required. 4.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. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP.	06/19/2021
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			

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	under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)			
	Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters and 1 of 3 shifts over the past year. This deficient practice could affect all clients. Findings include: Based on a review of Emergency Evacuation Drill Reports on 05/20/2021 between 10:30 a.m. and 1:00 p.m. with the Associate Executive Director (AED), there was no record of a fire drill conducted on first shift for the second quarter of 2020. Based on an interview with the AED at the time of record review, there was no other documentation	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. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date.	06/19/2021

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	available for review to indicate the missed drill had been conducted. This deficiency was reviewed with the AED during the Exit Conference on 05/20/2021 at 2:30 p.m.		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. 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. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP	