STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G442	A. BUILDING -- B. WING	08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 05/20/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 08/03/2021 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 08/05/21 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	(2), §491.12(d)(2), §494.62(d)(2). *[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.			

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	(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 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.			

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	(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (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			

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	plan twice per year. The [PRTF, Hospital, 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			

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	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 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			

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	(A) When a community-based exercise is not 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.			

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	(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (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			

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	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 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			

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	required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct 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.	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	10/21/2021

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	(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) on 08/03/2021 between 3:15 p.m. and 4:00 p.m., documentation of an additional or activation of the Emergency Preparedness Plan was not available for review. Based on interview during record review, it was determined that the EPP did not include scheduled testing or an actual activation documentation. The AED stated that a tabletop exercise of the Emergency Preparedness plan has been scheduled on 10/21/2021. The deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		to ensure it has been completed and is present. The safety committee will review and update 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 on October 21, 2021 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 6. The management team will hold an annual planning meeting to be held in the first quarter of the year to plan for the upcoming years training events. The Quality Manager will verify all facilities in the New Albany Operation are scheduled for required training. The Program Manager will ensure all facilities in the New Albany Operation take part in required training. Area Supervisors will ensure Facilitates in their case load take part in the training document the event. Documentation will be maintained in the Emergency Preparedness Plan stored onsite available for	

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			review.	
			Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP. Quality Assurance Manager, Area Supervisor, Associate Executive Director.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 05/20/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/03/2021 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	K 0000		

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	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 08/05/21			
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	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	09/17/2021

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	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 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 08/03/2021 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 AED stated that testing would be accomplished in August at the next regularly scheduled inspection and service appointment.		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 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 on August 6, 2021 to include a sensitivity test. Repair of the devices that failed the	

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	The deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 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 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		sensitivity test has been scheduled to be completed no later than September 16, 2021. Access to the heat detectors will be made available and that device will be tested no later than September 16, 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 47150 within 30 days of completed service. The Program Manager will follow up to ensure work is completed and documented as required. 5. The Associate Executive Director Contacted Eric Gray with Koorsen Fire and Security on August 17, 2021 to schedule the inspection of the Heat Detectors the devices will be tested no later than September 16, 2021. The Associate Executive Director scheduled a meeting with David Danzo on with Aramark, ResCare maintenance provider to on August 30, 2021 to cover inspection and testing requirements of fire systems.	

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	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 08/03/2021 between 3:15 p.m. and 4:00 p.m., documentation of smoke detector sensitivity testing within the most recent two year period was not available for review. 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 AED stated that testing would be accomplished in August at the next regularly scheduled inspection and service appointment. The deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		**Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative. Aramark**	
K S351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation			

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	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 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.			

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	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. Findings include: Based on observation with the Associate Executive Director on 08/03/2021 during a tour of the facility between 3:15 p.m. and 4:00 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	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 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.	12/31/2021

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	was higher than normal and that the sprinkler does not appear to adequately protect the area. The AED stated that modifying the sprinklers was one of the tasks to be performed on a work order that must be competitively bid and they are having a difficult time finding contractors. This deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 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 08/03/2021 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 had not been completed to verify that the existing sprinkler design was adequate for the combustible load in the room. The AED stated that modifying the sprinklers was one of the tasks to be performed on a work order that must be competitively bid and they are having a difficult time finding contractors.		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 May 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 December 31, 2021 documentation will be made available for review. 9) The Associate Executive Director scheduled a meeting with David Danzo on with Aramark,	

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	This deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 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 08/03/2021 during a tour of the facility between 3:15 p.m. and 4:00 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. The AED stated that modifying the sprinklers was one of the tasks to be performed on a work order that must be competitively bid and they are having a difficult time finding contractors. This deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		ResCare maintenance provider to on August 30, 2021 to cover installation and maintenance requirements of fire systems. Updated bids will be collected no later than September 30, 2021 and contract work will be completed no later than December 31, 2021 to build in time based on the reemergence of COVID. Work may be completed sooner based on contractor material and labor availability. 10) The Associate Executive Director scheduled a meeting with the Regional Director of Facility Maintenance Joe Moore to streamline the bid process to ensure required work outside of the agreed upon scope of work for maintenance and repair for Auguest 19, 2021. **Persons Responsible: Koorsen Fire and Security, Aramark Maintenance Manager, Program Manager, Area Supervisor, and Residential Manager, DSP , Aramark**	

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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.

Findings include:

Based on observation with the Associate Executive Director (AED) on 08/03/2021 during a tour of the facility between 3:15 p.m. and 4:00 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. The AED stated that modifying the sprinklers was one of the tasks to be performed on a work order that must be competitively bid and they are having a difficult time finding contractors.

This deficiency was reviewed with the AED during the Exit Conference.

This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence.

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

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	Executive Director (AED) on 08/03/2021 during a tour of the facility between 3:15 p.m. and 4:00 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. The AED stated that modifying the sprinklers as necessary was one of the tasks to be performed on a work order that must be competitively bid and they are having a difficult time finding contractors. This deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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			

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	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 (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			

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	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, 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 3:15 p.m. to 4:00 p.m. on 08/03/2021, 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. The AED stated that replacing the escutcheon was one of the tasks to be performed on a work order that must be	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 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	08/27/2021

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

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	competitively bid and they are having a difficult time finding contractors. This deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 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 08/03/2021 between 3:15 p.m. and 4:00 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. The AED stated that the sealing of the pipe had been missed. This deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 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		Supervisor or Direct Support Lead will contact (844) ResCare to create a service order. 4. The Associate Executive Director contacted Joe Moore the regional director with Aramark Services on August 17, 2021 the Facilities maintenance vendor to ensure the scope of work for Koorsen Fire and Security coveres the installation of the missing escutcheon plate, sealing the unsealed pipe in the closet of bedroom #8, and replacement of dirty sprinkler head are included in the scope of work for maintenance are repair. This work does not required the maintenance vender to go through the bid process and is to be completed as soon a scheduling permits after the receipt of a work order request. Upon completion no later than December 31, 2021 documentation will be made available for review. 1.The Associate Executive Director scheduled a meeting with David Danzo New Albany ResCare Maintenance Manager with Aramark, ResCare maintenance provider to on August 30, 2021 to cover work authorized by the maintenance and repair scope of work for all fire systems. An emergency work order has been created and the installation of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G442	A. BUILDING 01 B. WING	08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130

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	clients, as well as staff and visitors in the facility. Findings include: Based on observation during the facility tour on 08/03/2021 between 3:15 p.m. and 4:00 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. The AED stated that cleaning the sprinkler was one of the tasks to be performed on a work order that must be competitively bid and they are having a difficult time finding contractors. This deficiency was reviewed with the AED during the Exit Conference. This deficiency was cited on 05/20/21. The facility failed to implement a systemic plan of correction to prevent recurrence.		missing escutcheon plate, sealing the unsealed pipe in the closet of bedroom #8 and replacement of dirty sprinkler head will be completed within 10 days not later than August 27, 2021. 2.The Associate Executive Director scheduled a meeting with the Regional Director of Facility Maintenance Joe Moore to streamline the bid process to ensure required work outside of the agreed upon scope of work for maintenance and repair for Auguest 19, 2021. **Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative, Aramark**	