

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2019
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 01/28/2019	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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. --	<p>A Post Survey Revisit (PSR) to the Emergency Preparedness Survey (EP) PSR Survey conducted on 11/30/18 and EP Survey conducted on 10/04/18 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 01/28/19</p> <p>Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230</p> <p>At this PSR survey, Residential Care Community Alternatives SE IN Inc was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475.</p> <p>The facility has 6 certified beds. At the time of the survey, the census was 4.</p> <p>Quality Review completed on 01/30/19</p>			E 0000			
E 0007 Bldg. --	<p>Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice could affect all occupants.</p>			E 0007	<p>1.The emergency plan policies and procedures will be updated to include a) continuity of operations and b) Delegations of authority and succession plans.</p> <p>2.The area supervisor and program manager will train all staff on the policies and procedures updates and the updates will be</p>		02/27/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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E 0015 Bldg. --	<p>Findings include:</p> <p>Based on record review on 01/28/19 at 11:30 a.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not address:</p> <p>a) Continuity of operations.</p> <p>b) Delegations of authority and succession plans.</p> <p>Based on interview concurrent with record review it was acknowledged by the RM the EPP did not address items a and b above.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			E 0015	<p>placed in the Emergency Disaster Preparedness Manual for reference as needed.</p> <p>3.This information is located in section 21 of the Emergency Disaster Preparedness Manual</p> <p>4.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual</p> <p>5.The persons responsible will be the Executive Director, Associate Executive Director, Program Manager, Area Supervisor, and Residential Manager.</p>		02/27/2019
	<p>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. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview on 01/28/18</p>				<p>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.</p> <p>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.</p> <p>3.This information is located in section 21 of the Emergency</p>		

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E 0025 Bldg. --	<p>at 11:35 a.m. with the Residential Manager (RM) the emergency preparedness plan did not address</p> <ol style="list-style-type: none"> 1) alternative sources of energy. 2) emergency lighting, 3) fire detection, extinguishing and alarms. 4) proper disposal of sewage and waste. <p>Based on interview concurrent with record review with the RM it was stated this policy did not contain information concerning items 1,2,3 and 4.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Emergency Preparedness Plan with the Residential Manager (RM) on 01/28/19 at 11:40 a.m., there was no documentation of policy and procedures for the arrangement with other facilities to receive residents in the event of operations in the facility. This was confirmed by the RM at the time of record review.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			E 0025	<p>Disaster Preparedness Manual</p> <ol style="list-style-type: none"> 4. The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 5. The Executive Director 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. <p>1. The emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses arrangements with other ICF/IID facilities and/or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services.</p> <p>2. The area supervisor and program manager will train all staff on the updated policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed.</p> <p>3. This information is located in section 21 of the Emergency Disaster Preparedness Manual</p> <p>4. The corrective action will be</p>		02/27/2019

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E 0026 Bldg. --	<p>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on record review on 01/28/19 at 11:53 a.m. with the Residential Manager (RM) there was nothing in the emergency preparedness manual which addressed compliance with the 1135 waiver declared by the Secretary.</p> <p>Based on interview concurrent with record review with the RM it was stated she was not aware this waiver needed to be addressed and stated the policy would be updated to include the 1135 waiver.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		E 0026	<p>monitored and reviewed for effectiveness at a minimum bi-annual</p> <p>5.The persons responsible will be the Executive Director, Associate Executive Director, Program Manager, Area Supervisor, and Residential Manager.</p> <p>1.The administrator will ensure the table of contents for the emergency disaster preparedness manual is updated to include the location of the policy on the Roles of the facility Under a Waiver declared by Secretary is in the emergency preparedness manual.</p> <p>2.The area supervisor and program manager will train all staff on the table of contents, the policy and procedure, where to locate the policy, and the policy will be placed in the Emergency Disaster Preparedness Manual for reference as needed.</p> <p>3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual</p> <p>4.The Quality Assurance Manager will review the table of contents, the quality assurance manager and program manager will ensure the most current table of contents is in the Emergency</p>		02/27/2019	

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E 0030 Bldg. --	<p>Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c) (1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 01/28/19 at 11 38 p.m. with the Residential Manager (RM) the Emergency Preparedness Plan (EPP) did not document a. contact information for other ICF's, or b. client physicians. Based on interview concurrent with record review with the RM it was confirmed the communication portion of the EPP did not include items a , or b.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>	E 0030	<p>Preparedness Manual.</p> <p>1.The administrator will ensure the emergency plan policies and procedures will be updated to include a continuity of operations plan which addresses a) contact information for other ICF's and b) client physicians.</p> <p>2.The area supervisor and program manager will train all staff on the policies and procedures updates and the updates will be placed in the Emergency Disaster Preparedness Manual for reference as needed.</p> <p>3.This information is located in section 3 of the Emergency Disaster Preparedness Manual</p> <p>4.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual</p> <p>5.The Executive Director will review and approve the continuity of operations plan the quality assurance manager and program manger will ensure the most current continuity of operations is in the Emergency Preparedness Manual.</p>	02/27/2019	
E 0031 Bldg. --	<p>Based on record review and interview, the facility failed to ensure the emergency preparedness</p>	E 0031	<p>1.The administrator will</p>	02/27/2019	

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E 0036 Bldg. --	<p>communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) Other sources of assistance (iii) The State Licensing and Certification Agency (iv) The State Protection and Advocacy Agency in accordance with 42 CFR 483.475(c)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 01/28/19 at 11:55 a.m. with the Residential Manager (RM) the emergency preparedness plan (EPP) did not include how to communicate with Indiana Protection and Advocacy Services (IPAS). Based on interview concurrent with record review with the AM it was acknowledged the EPP did not include the means to communicate with IPAS in the communication portion of the EPP.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		E 0036	<p>ensure the emergency plan policies and procedures will be updated to include a continuity of operations plan which includes how to communicate with Indiana Protection and Advocacy Services (IPAS).</p> <p>2.The area supervisor and program manager will train all staff on the continuity of operations plan and the plan will be present in the Emergency Disaster Preparedness Manual for reference as needed.</p> <p>3.This information is located in section 3 of the Emergency Disaster Preparedness Manual</p> <p>4.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual</p> <p>5.The Executive Director will review and approve the continuity of operations plan and how to communicate with Indiana Protection and Advocacy Services. The quality assurance manager and program manger will ensure the most current continuity of operations and how to communicate with Indiana Protection and Advocacy Services is in the Emergency Preparedness Manual.</p>		02/27/2019	
	Based on record review and interview, the facility			1.The administrator will			

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E 0037 Bldg. --	<p>failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 01/28/19 at 11:59 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include a training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.475(d). Based on interview concurrent with record review with the RM it was acknowledged the EPP did not include a training and testing program.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				<p>ensure the emergency plan policies and procedures annual emergency training and testing program is implemented in all locations and evidence of the annual training and testing is present in the EPP manual.</p> <p>2.The area supervisor and program manager will train all staff on the annual training and testing and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed. 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 annually as needed.</p> <p>3.This information is located in section 22 of the Emergency Disaster Preparedness Manual</p> <p>4.The program manager, area supervisor, residential manager will ensure initial training is conducted during on the job orientation and annual training is complete.</p>		
	<p>Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new</p>			E 0037	<p>1.The administrator will ensure the emergency plan policies and procedures initial training in emergency preparedness policies and procedures to all new and existing staff, annual emergency</p>		02/27/2019

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E 0039 Bldg. --	<p>and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview on 01/28/19 at 12:09 p.m. with the Residential Manager (RM) the emergency preparedness policy (EPP) did not include a. Initial training in emergency preparedness policies and procedures to all new and existing staff. b. Provide EPP training at least annually. c. Maintain documentation of the training. d. Demonstrate staff knowledge of emergency procedures. Based on interview concurrent with record review with the RM it was stated the EPP did not contain items a, b, c, and d described above.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			E 0039	<p>training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed and present in the EPP manual. The ResCare "On The Job" training checklist will be updated to include initial training in emergency preparedness of all new employees. The annual training requirements list will also be updated to include the training of all existing employees.</p> <p>2.The residential manager, area supervisor and program manager will provide initial training to all new staff and the ResCare trainer will provide annual training to existing staff. Testing results will be available to demonstrate staff knowledge of emergency procedures. The training and testing documentation will be present in the Emergency Disaster Preparedness Manual/HR personnel files 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 annually as needed.</p> <p>3.This information is located in section 22 of the Emergency Disaster Preparedness Manual</p>		02/27/2019
	Based on record review and interview, the facility				1.The administrator will ensure		

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	<p>failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d) (2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 01/28/19 at 12:00 p.m. with the Residential Manager (RM) the facility did not document in the emergency preparedness policy (EPP) the participation in a a. full scale community based exercise or b. an individual facility based exercise or c. table top for the past year. Nor had the facility experienced an actual natural or man made emergency which required</p>				<p>the participation in a full-scale community based exercise and a table top exercise is present in the EPP manual.</p> <p>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 annually as needed.</p> <p>3.This information is located in section 22 of the Emergency Disaster Preparedness Manual</p>		

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K 0000 Bldg. 02	<p>the activation of the EPP. Based on interview concurrent with record review with the RM it was stated the facility had not participated or experienced items a-c for the past year.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code (LSC) PSR Survey conducted on 11/30/18 and the LSC Recertification Survey conducted on 10/04/18 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 01/28/19</p> <p>Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230</p> <p>At this PSR 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.</p> <p>This one story facility was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 6 and had a census of 4 at the time of this survey.</p>		K 0000				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/28/2019	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143			
(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
K S222 Bldg. 02	<p>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 0.08.</p> <p>Quality Review completed on 01/30/19</p> <p>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</p>			K S222	1.All bathroom doors allow		02/27/2019

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K S341 Bldg. 02	<p>failed to ensure 1 of 2 bathroom doors with locks on the inside were arranged such that staff can rescue clients in an emergency if the bathroom door becomes locked from the inside. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation on 01/28/19 at 12:05 p.m. with the Residential Manager (RM), the client bathroom door could be locked from the inside and when the RM was asked to provide a key to unlock the bathroom door a key to do so could not be located. Based on interview at the time of observation, the RM lacked the knowledge to unlock the client bathroom door.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm panels were installed and maintained with a primary and secondary source of reliable power. LSC Section 9.6.2.10 requires compliance with NFPA 72, National Fire Alarm Code, 2010 Edition. NFPA 72 at 10.5.3.2 requires fire alarm systems shall be</p>			K S341	<p>opening from the outside during an emergency when locked. New door knobs that do not require a special tool or key will be installed by ResCare Maintenance by February 13, 2019.</p> <p>2. Program manager will inspect installed door knobs to ensure the standard is met. Residential Manager will inspect operation of installed door knobs monthly to ensure correct operation. Area Supervisor and Program Manager will conduct periodic inspections.</p> <p>1. The program manager will ensure proof that the fire alarm system is provided with at least two independent and reliable power supplies, one primary and one secondary (Standby) is present in the facility.</p>		02/27/2019

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K S711 Bldg. 02	<p>provided with at least two independent and reliable power supplies, one primary and one secondary (Standby), each of which shall be of adequate capacity for the application. This deficient practice could affect all clients, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 01/28/19 12:05 p.m. with the Residential Manager (RM) it was observed the fire alarm control panel (FACP) did not have a secondary power supply to ensure the facility would be protected in the event of a primary power outage. Based on interview concurrent with the observation, the RM was asked why the FACP did not have a secondary power supply such as DC batteries and the answer was the FACP never had them to her knowledge.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan The administration of every resident board and care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All</p>				<p>2.The program manager will contact Koorsen Fire and Security to provide proof that a secondary power supply is present in the facility and the facility is protected in the event of a primary power outage. The written documentation will be present in the facility for reference as needed.</p> <p>3.Koorsen Fire and Security will send all FACP inspections to the program manager inspections will include primary and secondary power source testing.</p> <p>4.The program manager will review all reports and ensure all deficiencies are corrected.</p>		

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	<p>employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility.</p> <p>All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk.</p> <p>32.7.1, 32.7.2, 33.7.1, 33.7.2</p> <p>Based on record review, observation and interview, the facility failed to ensure there was a complete fire safety plan in place which addressed the use of the pull stations to ensure the safety of 4 of 4 clients. This deficient practice could affect all clients, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review on 01/28/19 at 12:30 p.m. with the Residential Manager (RM), the facility's Fire Emergency plan did not address the use of pull stations to activate the alarm to notify all occupants in the event of a fire. Based on observation and interview at 12:20 p.m. the RM was asked how to operate the fire alarm system and she replied the pull station required a key. She was asked to produce the key and after approximately five minutes a key could not be</p>			K S711	<p>1.The Quality Assurance Manager will ensure the Fire Safety Plan which includes use of the pull stations is in the home for review as needed.</p> <p>2.The area supervisor will train all staff on the Fire Safety Plan, the use of pull stations, and the location of pull station keys. The area supervisor will ensure all staff know the location of the plan and keys for reference when needed. The residential manager will ensure the pull station keys are available for use at all times.</p> <p>3.Program manager, area supervisor will preform periodic inspections to ensure pull stations keys are available. Area</p>		02/27/2019

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	<p>produced.</p> <p>This deficiency was cited on 10/04/18 and 11/30/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>				<p>Supervisor and Residential Manager will ensue staff is trained on pull station use.</p>		