STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING -- B. WING	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/11/20 Facility Number: 000664 Provider Number: 15G127 AIM Number: 100234310 At this Emergency Preparedness survey, Res Care Community Alternatives SE IN was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 8 certified beds, with a current census of 7. Quality Review completed on 03/18/20	E 0000		
E 0030 Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1) Names and Contact Information [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following:			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING -- B. WING	03/11/2020

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

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	(i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.			

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	15G127	A. BUILDING -- B. WING	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

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	*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). 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)	E 0030	1.The administrator will ensure the emergency plan policies and procedures will be updated to include names and contact information for staff. 2.Due to screening and vetting of volunteers ResCare uses internal sources for assistance.	06/01/2020

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	(1). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency/Disaster Preparedness Manual on 03/11/20 between 12:15 p.m. and 1:45 p.m. with the Residential Manager Present, there was no documentation to indicate the names and contact information for staff and volunteers. Based on an interview at the time of record review, the Residential Manager agreed the Emergency/Disaster Preparedness Manual did not include a contact information list for staff and volunteers.		ResCare's ResCare -On-Call Team (ROC) pulling from 54,000 current employees nationwide was developed to aid operations that are in need of additional support and staffing that is activated by the Executive Director or subordinate Manager. All staff in the facility will be trained on the development of this program and its purpose. 3.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 required. 4.Emergency Disaster Preparedness Manual will be review Annually at a minimum by the Quality Assurance Manager to ensure all information remains up to date. **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP, Quality Assurance Department.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/11/20 Facility Number: 000664	K 0000		

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	15G127	A. BUILDING 01 B. WING	03/11/2020

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	Provider Number: 15G127 AIM Number: 100234310 At this Life Safety Code survey, Res Care Community Alternatives SW IN was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This was a two story fully sprinklered facility. The facility has a fire alarm system with hard wired smoke detectors in the corridors, common living areas, and all client sleeping rooms. The facility has a capacity of 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.45. Quality Review completed on 03/18/20			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided 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 2 of 2 interior emergency lights were tested, maintained, and the records of the	K S100	1.The facility will ensure emergency lighting will be tested monthly for a minimum of 30	06/01/2020

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	15G127	A. BUILDING 01 B. WING	03/11/2020

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	testing maintained. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. (2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the test. (5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction. This deficient practice could affect all clients and staff. Findings include: Based on observations on 03/11/20 between 12:15 p.m. and 1:45 p.m. during a tour of the facility with the Residential Manager, the facility had two battery powered emergency light units. Based on record review between 12:15 p.m. and 1:45 p.m., there was documentation to show the battery powered emergency lights were tested for 30 seconds monthly during the past 12 months, however, there was no documentation available for an annual 90 minute test during the past 12 months. Based on interview at the time of record review and observations, the Residential Manager		seconds and an annual test of 90 minutes for all units in the facility. The program manager met with Koorsen Fire and Security on May 15, 2020 to schedule annual 90 minute test of emergency lighting in the facility. Annual testing was completed in February 2020. **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP, Koorsen Fire and Security.	

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	said he could not find any documentation to show an annual 90 minute test during the past 12 months for the two battery powered emergency lights.			
K S311 Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING (Prompt) Vertical openings shall be protected so as not to expose a primary means of escape. Vertical openings shall be considered protected if separated by smoke partitions in accordance with 8.2.4 that resist the passage of smoke from one story to any primary means of escape on another story. Smoke partitions shall have a fire resistance rating on not less than 1/2 hour. Any doors or openings to the vertical opening shall be capable of resisting fire for not less than 20 minutes. Stairs shall be permitted to be open where complying with sections 33.2.2.4.6 or 33.2.2.7. 33.2.3.1.1 through 33.2.3.1.4 Based on observation and interview, the facility failed to ensure 1 of 2 interior stairway doors was not held open with an item that would resist the passage of smoke from the main level to the second floor, or for clients needing to exit from the second floor to the outside using this same stairway. This deficient practice could affect all occupants. Findings include: Based on an observation on 03/11/20 at 1:05 p.m. during a tour of the facility with the Residential Manager, the main level stairway door from the dining room was held wide open with a dining room chair. In the event of a fire on the main level this door would not automatically close and	K S311	1.The Program Manager will ensure interior stairway doors are not held open, random inspections will be conducted to verify the door is not being held open. 2.Staff trained on the standard on keeping the interior door closed to prevent the passage of smoke from the main level to the second floor Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP.	06/01/2020

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	resist the passage of smoke to the second floor due to being held wide open with a chair. Based on interview at the time of observation, the Residential Manager acknowledged the stairway door being held wide open with a chair.			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. This deficient practice could affect all clients and staff. Findings include: Based on record review on 03/11/20 between 12:15 p.m. and 1:45 p.m. with the Residential Manager present, there was no documentation for an annual fire alarm system test/inspection during the past 12 months available for review. There was however a tag on the fire alarm control panel	K S345	1.The administrator will ensure annual functional testing for initiating devices such as smoke detectors, release devices, and fire alarm boxes is performed by Koorsen Fire and Security on the fire alarm system and that reports of the tests/inspections are available in the facility for review. 2.The administrator will ensure sensitivity testing of the fire alarm system is completed by Koorsen Fire and Security every alternate year after install and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion.	06/01/2020

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	which indicated the fire alarm system had been inspected in February of 2020. Based on interview at the time of record review, the Program Manager acknowledged there was no documentation for an annual fire alarm system test/inspection during the past 12 months available for review other than the tag on the fire alarm control panel. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients and staff. Findings include: Based on record review on 03/11/20 between 12:15 p.m. and 1:45 p.m. with the Residential Manager present, no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months, furthermore, there was no documentation of an annual fire alarm system inspection during the past 12 months other than the tag on the fire alarm		3.The Program Manager will meet with a representative from Koorsen Fire and Security, on May 15, 2020. 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. Persons Responsible: Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative.	

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	control panel dated February of 2020. Based on interview at the time of record review, the Program Manager acknowledged there was no documentation for a semi-annual visual fire alarm system test/inspection during the past 12 months available for review. 3. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all clients and staff. Findings include: Based on record review on 03/11/20 between 12:15 p.m. and 1:45 p.m. with the Residential Manager present, there was no documentation available for a smoke detector sensitivity test for the past 24 month period. Based on interview at the time of record review, the Residential Manager acknowledged the lack of a smoke detector sensitivity test during the past 24 month period.			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems			

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

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	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			
	Based on record review and interview, the facility failed to ensure there was documentation available the sprinkler system was tested/inspected during 4 of the past 4 quarters in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a	K S353	1.The administrator will ensure Koorsen Fire and Security conducts quarterly sprinkler inspections and that the reports of the inspections are available in the facility for review and forwarded to the Program Manager for monitoring. 1.The administrator will ensure monthly sprinkler gauge inspections and monthly control valve inspections are conducted by the ResCare maintenance coordinator, documentation will be maintained on site and a copy	06/01/2020

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	component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff in the facility. Findings include: Based on record review on 03/11/20 between 12:15 p.m. and 1:45 p.m., with the Residential Manager present, there were no quarterly sprinkler inspections available for the past 12 months to review. Based on interview at the time of record review, the Residential Manager said he was unable to find any documentation of quarterly sprinkler inspections for the past four quarters.		kept with ResCare Maintenance Manager. 1.The program manager will conduct random monthly inspections to ensure monthly and quarterly inspections are being preformed as required. 1.The Program Manager will meet with a representative from Koorsen Fire and Security, on May 15, 2020. 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. **Persons Responsible:** Program Manager, Area Supervisor, and Residential Manager, DSP Koorsen Fire and Security Representative.	
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			

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	15G127	A. BUILDING 01 B. WING	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

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	33.2.3.5. 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 7 client sleeping room doors would latch into the door frame. This deficient practice could affect all clients. Findings include: Based on observation on 03/11/20 at 1:10 p.m. during a tour of the facility with the Residential Manager, client sleeping room door #2 (first floor, second sleeping room door on west side of house) had a loose and hanging door knob and did not latch properly when closed. Based on interview at the time of observation, the Residential Manager acknowledged that the door knob was loose and hanging for client sleeping room #2 and did not latch properly.	K S363	1.The Program Manager will ensure clients bedroom doors positively latch to the frame. 2.The maintenance coordinator will ensure all clients bedroom doors will positively latch as required. 3.Bedroom #2 door will be repaired by ResCare Maintenance on March 25, 2020. 4.The Residential Manager will inspect house weekly to ensure bedroom Area Manager will preform random monthly inspections and Program Manager will provide quarterly inspections to ensure bedroom doors positively latch to frame as required. 5.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.	03/25/2020
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical receptacles were	K S511	1. The Program Manager will ensure protection receptacle	05/19/2020

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	protected in 1 of 7 client sleeping rooms according to 33.2.5.1. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect one client. Findings include: Based on observation on 03/11/20 at 1:12 p.m. during a tour of the facility with the Residential Manager, two electrical receptacles in client sleeping room #1 (first floor, first room on west side of house) had missing cover plates, furthermore, one electrical receptacle had a cracked and chipped cover plate. Based on interview at the time of observation, the Residential Manager acknowledged the missing electrical receptacle cover plates and cracked cover plate and said he would have new cover plates put on as soon as possible.		faceplates are installed and damage free. 2. The Program Manager contacted ResCare Maintenance and schedule a service call to ensure receptacle faceplates are installed in Client Sleeping room #1 as required by NFPA 101. 3. ResCare Maintenance installed receptacle faceplates for outlets in Client Sleeping room #1 on March 17, 2020. Persons Responsible: Program Manager, ResCare Maintenance.	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must:			

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	a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 3 of 3 shifts during 2 of 4 quarters during the past 12 months. This deficient practice could affect all clients. Findings include: Based on review of the facility's fire drill reports on 03/11/20 between 12:15 p.m. and 1:45 p.m. with the Residential Manager present, there were no fire drill reports available for the following shifts and quarters: a. First shift (day) of the fourth quarter (October, November, and December) of 2019 b. Second shift (evening) of the first quarter (January, February, and March) of 2019 or so far in 2020 c. Third shift (night) of the fourth quarter (October, November, and December) of 2019 Based on interview at the time of record review, the Residential Manager confirmed the lack of fire drills during all three shifts of the first and	K S712	1.All staff at the home will be re-trained on conducting fire drills quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date. 1.The Residential Manager will submit monthly drills to the QA Department upon completion. The QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required.	06/01/2020

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	fourth quarters of 2019 and 2020.		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	
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on observation and interview, the facility failed to ensure the facility's smoking policy was properly followed, furthermore, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 area where cigarettes are smoked. This deficient practice could affect all clients, as well as staff and visitors when entering or exiting the east side door. Findings include: Based on observations on 03/11/20 between 12:15 p.m. and 1:45 p.m. during a tour of the facility with the Residential Manager, the following was noted: a. There were cigarette butts and ashes in a waste basket and also on a small table where cigarettes were being made in client sleeping room	K S741	1.All staff at the home will be re-trained the Facilities smoking policy, and use of the designated smoking area. 2.The Program Manager contacted Aramark had “Lifesaver Cigarette/Cigar/Pipe Battery Operated No-Smoking Alarm” installed. This device detects cigarette, cigar & pipe smoke is NOT A FIRE SMOKE ALARM. This will be used to detect client smoking in bedroom and alert staff to use appropriate redirection. 3.Lifesaver ‘No Smoking’ Smoke Alarm is effective at detecting cigarette, cigar and pipe smoke at an early stage. It is	06/01/2020

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	#2 (first floor, second room on west side of house). When asked, client #2 said he didn't smoke in his room and didn't know how the cigarette butts and ashes got in the waste basket or on the table where he was making his cigarettes. Based on interview at the time of exit conference, the Residential Manager said client #2 has been caught smoking in his room and that is one of his behaviors he is working on. b. There were at least 25 to 50 cigarette butts on the ground outside the east side entrance/exit door where smoking is allowed by staff and clients. This was acknowledged by the Residential Manager the time of observation.		designed to alarm at the slight presence of cigarette or cigar smoke. The 'No Smoking' alarm is a highly sensitive alarm based on advanced photoelectric technology. It warns by emitting a buzzer and flashing red light on the unit. The suggested installation range is within 2.4 meters of floor height, and the area is about 7-8 square meters. Vents or Fans and other similar equipment may affect smoke entry into the device. This product is not to be used for any fire protection system application or general smoke alarm application and is not connected in any way to the Facilities Fire Detection System. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP, ARAMARK, Maintenance Manager.	