STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING -- B. WING	02/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/01/21 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 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. At the time of the survey, the census was 7. Quality Review completed on 02/03/21	E 0000		
E 0036 Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency			

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

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	preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The			

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	dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated every two years in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants. Findings include: Based on record review on 02/01/21 at 11:27 a.m. with the HML, the facility did not have an emergency preparedness training and testing program available for review. Based on interview at the time of record review, the HML stated a written Emergency Training and testing Plan could not be provided for review. This was discussed with the HML during the exit conference.	E 0036	**E036: Local, State, Tribal Collaboration Process** **Corrective action:** ·All staff are trained annually on the Emergency Preparedness Plan. **(Attachment A)** ·All staff are tested annually on the Emergency Preparedness Plan. **(Attachment B)** ·The Mock Drill form will be used for all drills and or true emergency disaster situations **(Attachment C)** ·Area Supervisor has been trained to complete a full scale mock drill annually and a tabletop emergency disaster situation at least annually using a full scenario. **(Attachment D)** ·New hires are trained as part of their on the job training once they are assigned to the facility. **Monitoring of Corrective Action**: · Program Manager updates the Emergency Preparedness Plan	02/21/2021

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			annually and as needed. ·Area Supervisor trains all staff annually on the EPP and as needed. ·Area Supervisor ensures all new hires are trained upon placement as staff to the facility and annually thereafter. **Completion Date: 2-21-21**	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.			

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	*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all			

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	emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include			

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	instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain			

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	documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 02/01/21 at 11:19 a.m. with the HML, the emergency preparedness policy (EPP) did not include: 1. Training for new employees. 2. Biennial staff training. 3. Verification of knowledge (testing). 4. Staff is able to provide knowledge of testing program. Based on interview concurrent with record review with the HML it was stated items 1 through 4 could not be provided for review. This was discussed with the HML during the exit conference.	E 0037	**E037: EP Training Program`** **Corrective action:** ·All staff are trained annually on the Emergency Preparedness Plan. **(Attachment A)** ·All staff are tested annually on the Emergency Preparedness Plan. **(Attachment E)** ·The Mock Drill form will be used for all drills and or true emergency disaster situations **(Attachment C)** ·Area Supervisor has been trained to complete a full scale mock drill annually and a tabletop emergency disaster situation at least annually using a full scenario. **(Attachment D)** ·New hires are trained as part of their on the job training once they are assigned to the facility. **Monitoring of Corrective Action**: ·Copies of the completed drills will be sent to the Program Manager and will also remain in the EPP binder in the facility. ·Completed staff tests will be kept in the EPP binder and will be sent to Human Resource to remain in staff training file. ·Program Manager updates the	02/21/2021

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			Emergency Preparedness Plan annually and as needed. ·Area Supervisor trains all staff annually on the EPP and as needed. ·Area Supervisor ensures all new hires are trained upon placement as staff to the facility and annually thereafter. **Completion Date: 2-21-21**	
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 *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, 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			

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

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	(i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient 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			

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

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	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 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			

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	exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual 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 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			

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	tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset 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. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. 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	E 0039	**E039: EP Testing Requirements** **Corrective action:** ·The facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually and will use the Mock Drill Form **(Attachment F)** for completion and proof of the exercise. ·Staff training to ensure the facility will conduct at least two full scale or one full scale exercise and a table top exercise to test the emergency plan at least annually and will use the Mock Drill Form **(Attachment C)** for completion and proof of the exercise. ·Staff will be tested annual on the EPP. **(Attachment B)**	02/21/2021

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	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 on 02/01/21 at 11:13 a.m. with the HML, the facility did not document participation in any exercises using the Emergency Preparedness Policy (EPP) for the past year. Based on interview concurrent with record review with the HML it was stated the facility had not documented participation in any exercises which implement the EPP for the past twelve months. This was discussed with the HML during the exit conference.		**Monitoring of Corrective Action**: ·Copies of the completed drills will be sent to the Program Manager and will also remain in the EPP binder in the facility. ·Completed staff tests will be kept in the EPP binder and will be sent to Human Resource to remain in staff file. **Completion Date: 2-21-21**	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 02/01/21 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 At this Life Safety Code survey, Res Care Community Alternatives Se In was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.	K 0000		

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	This one story facility was not sprinkled. The facility has a fire alarm system with smoke detection in the corridors common living areas, and hard wired smoke detectors in 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 Slow with an E-Score of 3.36. Quality Review completed on 02/03/21			
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 record review and interview; the facility failed to ensure 2 of 2 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could	K S100	**K0100:** General Requirements **Corrective Action:** ·The Program Manager submitted a work order to Aramark to have the maintenance tech perform testing on the emergency lights in the facility for 30 seconds monthly and 90 minutes annually. **(Attachment G)** ·Program Manager created a form for tracking the monthly and annual testing of the emergency lights. **(Attachment H)**	02/21/2021

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	affect all occupants. Findings include: Based on record review on 02/01/21 at 12:38 p.m., with the HML, there were two battery powered lights located throughout the facility and no documentation could be produced to indicate they had been tested for 30 seconds once a month or a 90 minute annual test. Based on interview at the time of record review, the HML was unaware the battery powered lights needed to be tested as described. This was discussed with the HML during the exit conference.		·Site Reviews are done monthly by Rescare Management, this includes all required testing including the emergency lights. **(Attachment I)** **Monitoring of Corrective Action:** ·Program Manager will contact Aramark for all issues with emergency lights and testing of the emergency lights. ·Site Reviews are entered into the CRM database and tracked by the Quality Assurance Manager to ensure completion and follow up on all issues with the Program Manager. **Completion Date: 2-21-21**	
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow			

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	opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii) Based on observation and interview, the facility failed to ensure 1 of 1 Staff bathroom door was arranged such that staff can rescue an occupant in an emergency if the bathroom door was locked from the inside. This deficient practice could affect any staff in the facility. Findings include: Based on observation on 02/01/21 at 12:15 p.m. with the HML, the Staff bathroom door had a doorknob with a lock and staff were unable to locate a key to unlock the door. Based on interview at the time of observation it was acknowledged by staff no keys were available to unlock the bathroom door. This was discussed with the HML at the exit conference.	K S222	**K0222: Egress Doors** **Corrective Action:** ·Program Manager completed a work order and sent to Aramark to have the bathroom door knob replaced with a locking knob with a key available to access the bathroom in an emergency if needed. **(Attachment J)** ·Rescare Management will complete environmental checks daily at this location until Aramark has completed the work order to have the new door and single lock installed. **(Attachment K)** ·Site Reviews are completed monthly at the facility by Rescare Management to monitor all environmental issues.	02/21/2021

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			(Attachment I) **Monitoring of Corrective Action:** ·Rescare Administration will complete monthly Site Reviews and send to the Program Director and Executive Director for monitoring of completion. ·Environmental checks completed daily at the facility will be sent to the Program Manager for monitoring of completion and review. ·Program Director will follow up on issues noted on the Site review and submit to the Program Manager for follow up on the issues. **Completion Date: 2-21-21**	
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 and interview, the	K S345	**K0345:** Testing and Maintenance	02/21/2021

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	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 in the facility. Findings include: Based on record review on 02/01/21 at 12:20 p.m. with the HML, the most recent two year smoke detector sensitivity test could not be provided upon request. Based on interview with the HML it was acknowledged the most recent two year smoke detector sensitivity test was not available for review. This was discussed with the HML during the exit conference. 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems could be reset promptly after activation in accordance with LSC 9.6. Section 9.6.1.5 refers to NFPA 72. NFPA 72-14.5.4 states all apparatus requiring resetting to maintain normal operation shall be reset as promptly as possible after each test and alarms. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review of fire drill reports on 02/01/21 at 12:06 p.m. with the HML, the fire drill		**Corrective Action:** ·Program Manager contacted Aramark to have documents of system inspections completed by Koorsen sent to Rescare to have them placed in the facility. **(Attachment L)** ·Program Manager contacted Aramark to have documents of sensitivity testing sent to be placed in the facility. **(Attachment M)** ·Area Supervisor trained all staff on activating the fire alarm during the monthly drills. **(Attachment N)** ·Residential Manager will participate in fire drills with each shift to ensure all staff understand the proper way to run the drill including activating the alarm.**(Attachment N)** **Monitoring of Corrective Action:** ·Program Manager will follow up with Aramark to ensure all documents are received as completed and all inspections are completed as scheduled. ·Residential Manager will submit the completed drill form with any additional training needed during the drill to the Area Supervisor and Program Manager for monitoring and to ensure completion.	

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	reports did not indicate the fire alarm system had been activated monthly. House staff was asked to describe the procedure for testing the fire alarm system, but could not explain accurately how to reset the fire alarm system by opening the pull station and deactivating the device by flipping the switch up. Based on interview at the time of record review, the HML agreed that training on the activation and resetting of the fire alarm system would be helpful. This was discussed with the HML during the exit conference. 3. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system including the components was inspected annually to protect 7 of 7 clients. LSC 9.6.1.3 requires fire alarm systems to be installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, Table 14.4.5 requires functional testing to be conducted annually for initiating devices such as smoke detectors, release devices, and fire alarm boxes. This deficient practice affects all clients in the facility. Findings include: Based on record review on 02/01/21 at 11:20 a.m. with the HML, the most current annual fire alarm inspection was not complete. The report did not include details of fire alarm components and devices. Based on an interview at the time of record review with the HML, there was no other documentation available for review to indicate current annual functional test on the fire alarm system initiating devices. This was discussed with the HML during the exit conference.		**Completion Date: 2-21-21**	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

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	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 1 of 1 extension cord was not used as a substitute for fixed wiring according to 33.2.5.1. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect occupants in the TV room. Findings include: Based on observation with the HML on 02/01/21 at 12:12 p.m., there was an extension cord used to power a phone charger. Based on interview at the time of observation, the HML acknowledged an extension cord was used and agreed it would be removed. This was discussed with the HML during the exit conference.	K S511	**K0511: Utilities- Gas and Electric** **Corrective Action:** ·Area Supervisor trained all staff in the home that there is not to be extension cords used in the home at any time. **(Attachment N)** ·Area Supervisor completes weekly check and will ensure no extension cords are in use in the facility. **(Attachment O)** ·Rescare Administration conducts Site reviews monthly to ensure there are no extension cords in use in the facility. **(Attachment I)** **Monitoring of Corrective Action:** **·Area Supervisor will train monthly at house meetings to ensure staff are not using extension cords in the facility.** **·Area Supervisor will send completed weekly check to the Program Manager for review and monitoring of completion.** **·Site reviews will be sent to the Program Director for monitoring of noted issues and to ensure completion.** **Completion Date: 2-21-21**	02/21/2021

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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 record review and interview, the facility failed to provide a smoking policy for a facility allowing client and staff smoking. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review on 02/01/21 at 11:05 a.m. with the HML, documentation of a facility smoking policy was not available for review. Based on interview at the time of record review, the HML stated there were smokers in the facility, however, she could not locate the smoking policy. This was discussed with the HML during the exit conference.	K S741	**K0741: Smoking Regulations** **Corrective Action:** ·Area Supervisor will inservice all staff that smoking can only occur where a noncombustible receptacle is located for disposal of cigarette butts. **(Attachment N)** ·Program Manager completed a work order to Aramark to have them order a new noncombustible ashtray to be used at the facility. **(Attachment P)** ·Area Supervisor will inform all staff that they can only use the safety type ashtrays at the facility on the back area of the facility and not coffee cans or other non-safe containers monthly during staff meetings. **Monitoring of Corrective Action:** ·Area Supervisor will send the Program Manager all trainings or inservices completed on staff for	02/21/2021

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			proper disposal of their cigarette waste and monthly staff meetings. ·Site Reviews are completed monthly by Management staff to ensure safety at the facility. Management staff will note the use of proper disposal of cigarette waste is being used. **Completion Date: 2-21-21**	