STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G442	A. BUILDING -- B. WING	04/18/2024

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

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 12/20/2023 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 04/18/2024 Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760 At this Post Survey Revisit, Res Care Community Alternatives SE IN was found not 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 04/24/24 The requirement at 42 CFR, Subpart 483.475 is NOT MET.	E 0000		
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 §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Slaughter	AED	05/10/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	*[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. *[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			

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	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 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 PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing			

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	participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE 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 instruction in the location and use of alarm			

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	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 documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the			

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	CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure staff received training in regards to emergency preparedness policies and procedures. The ICF/IID facility 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 two years; (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 review of "Emergency/Disaster Preparedness Manual-Ewing Lane" documentation dated 05/18/22 with the QIDP on 04/18/2024 between 11:20 AM and 1:00 PM, documentation of staff training on the emergency preparedness plan within the most recent two year period was not available for review. Based on interview at the time of record review, the QIDP stated staff training documentation on emergency preparedness policies and procedures within the most recent two year period was not available for review at the time of the survey. These findings were reviewed with the QIDP during the exit conference. This deficiency was cited on 12/20/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0037	**E 037 EP Training Program:** 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 training, documentation of the training and staff demonstration of knowledge of the emergency procedures is completed in accordance with CFR 483.475(d)(1) and present in the EPP manual. 2.The area supervisor and program manager will provide initial training to all existing staff and new staff and the training and testing documentation will be present in the Emergency Disaster Preparedness Manual for reference as needed. 3.The corrective action will be monitored and reviewed for effectiveness at a minimum bi-annual 4.A copy of the AAR for an extreme weather event conducted on August 7, 2023 and a second event conducted as part of a state wide drill conducted on October 19, 2023 was place at the site by the Area Supervisor to be available for review upon request. 5.Two training events for 2024 have been scheduled and the Area Supervisor will verify After Action Reports are on site and available	05/10/2024

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			for review once completed. **Persons Responsible:** Program Manager, Area Supervisor, and DSL, DSP, ResCare Maintenance.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the survey which exited on 12/20/2023 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 04/18/2024 Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760 At this Life Safety Code survey, Res Care Community Alternatives SE IN was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was determined to be fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, common living areas and all client sleeping rooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the	K 0000		

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	facility Prompt with an E-Score of 0.3. Quality Review completed on 04/24/24			
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 1 of 2 smoke barrier doors which were arranged to self close or automatic close with fire alarm system activation would resist the passage of smoke. LSC Section 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC Section 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the QIDP during a tour of the facility from 11:20 AM to 1:00 PM on 04/18/2024, the smoke barrier door in the living room was held in the fully open position with a wall mounted magnetic hold open device set to release with fire alarm system activation and was equipped with a latching mechanism to latch the door into the door frame but the door failed to	K S100	1.The Area Supervisor will in-service the facility staff on ensuring smoke barrier doors remain free of and obstacle that will prevent the smoke barrier door from closing. 2.ResCare Maintenance will adjust closing and latching mechanism to ensure self-close door latches to door frame. 3.Random monthly site reviews will be conducted by a member of ResCare's Administrative Team to ensure smoke barrier doors remain free from obstacles that would prevent them from closing properly, and doors latch to frame as required. 4.The AED contacted C&S Services to adjust latch on 5/10/2024 work will be complete and verified no later than 5/17/2024 by ResCare Maintenance Manager. 5.The Area Supervisor will	05/17/2024

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	fully self close and latch into the door frame when tested to close multiple times. The latching mechanism failed to protrude into the latching plate on the door frame when tested to close multiple times. Based on interview at the time of the observations, the QIDP agreed the smoke barrier door failed to fully self close and latch into the door frame when tested to close multiple times. These findings were reviewed with the QIDP during the exit conference. This deficiency was cited on 12/20/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		in-service staff to ensure smoke barrier door positively latches during monthly fire drills, if a deficiency is noted staff will contact ResCare Maintenance for repair. **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP, ResCare Maintenance Manager	
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with			

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	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 8 client bedroom doors were arranged such that staff can rescue clients in an emergency if the doors become locked. This deficient practice could affect 1 client. Findings include: Based on observations with the QIDP during a tour of the facility between 11:20 AM and 1:00 PM on 04/18/2024, 1 of 8 client bedroom doors had an operable lock on the door which required a key to unlock from the corridor side of the door. Each door had a thumb twist release device on the the room side of the door but no key was available to unlock the door from the corridor side of the door. Based on interview at the time of the observations, the QIDP agreed the key was not available to unlock the door from the corridor side of the door. These findings were reviewed with the QIDP during the exit conference. This deficiency was cited on 12/20/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S222	1.The Program Manager will ensure all bathroom and bedroom doors allow 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 May 17th, 2024. 2.Program manager will inspect installed door knobs to ensure the standard is met. Residential Manager with inspect operation of installed door knobs monthly to ensure correct operation. Area Supervisor and Program Manager will conduct periodic inspections. 3.The AED contacted C&S Services to replace door knob on client 1 of 8 bedroom door with a privacy locking door knob with keyless interior knob on 5/10/2024 work will be complete and verified no later than 5/17/2024 by ResCare Maintenance Manager. **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP. ResCare Maintenance Manager.	05/17/2024

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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 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, staff and visitors. Findings include: Based on record review with the QIDP between 11:20 AM and 1:00 PM on 04/18/2024, documentation of a visual semi-annual fire alarm system inspection within the most recent twelve	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 smoke sensitivity testing and documentation is available from fire alarm system inspection is completed Koorsen Fire and Security and that reports of the tests/inspections are available in the facility for review. Koorsen Fire and Security will also forward inspection reports to the QA Manager for monitoring of completion. 3.The AED scheduled a meeting with Kris Carney at Koorsen Fire and security to verify all inspection reports are available on the	05/17/2024

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	month period was not available for review. Based on interview at the time of record review, the QIDP stated fire alarm system inspection documentation was not available for review and agreed documentation for a semi-annual visual fire alarm system inspection within the most recent twelve month period was not available for review. These findings were reviewed with the QIDP during the exit conference. This deficiency was cited on 12/20/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		Koorsen Service Portal for online delivery. Reports will be printed and given to the area supervisor to place on site available for review. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager	
K S351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with Section 9.6, as modified below. The adequacy of the water supply shall be documented. In Prompt Evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities			

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	where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.1, 33.2.3.5.3.3, 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler	K S351	1.The administrator will ensure sprinkler head or sprinkler	05/31/2024

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	15G442	A. BUILDING 01 B. WING	04/18/2024

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	system was installed in accordance with NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 8.6.3.4, "Minimum Distance between Sprinklers", states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 4.6.7.5 requires existing life safety features that do not meet the requirements for new buildings, but exceed the requirements for existing buildings shall not be further diminished. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the QIDP during a tour of the facility between 11:20 AM and 1:00 PM on 04/18/2024, two of the two ceiling mounted sprinklers installed in 3 of the 8 client bedrooms were installed less than six feet apart. The two sprinklers in TD's bedroom were installed 37 inches apart. The two sprinklers installed in RR's bedroom were installed 53 inches apart. The two sprinklers installed in TT's bedroom were installed 48.5 inches apart. None of the sprinklers appear to have been moved. Based on interview at the time of the observations, the QIDP agreed the ceiling mounted sprinklers installed in the three client bedrooms were installed less than six feet of one another and did not appear to have been moved. These findings were reviewed with the QIDP during the exit conference. This deficiency was cited on 12/20/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		coverage is provided meets NFPA 13, Section 8.6.3.4, "Minimum Distance between Sprinklers", verifying sprinklers shall be spaced not less than 6 feet on center. 2.Work has been scheduled due to scheduling issues there was a delay in work order generation. The AED contacted Koorsen Fire and Security and received assurance all work will be complete no later than May 31, 2024. 3 The program Manager will verify work and report any issue to the AED immediately. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager	
K S353	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (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).			

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	10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for eleven months of the most recent twelve month period. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to	K S353	1 The Program Manager in-serviced ResCare Maintenance Manager on maintaining 12 months of documentation on sprinkler system gauge and valve inspections, and ensuring those reports are available onsite for review upon request. 2 The AED contacted Chris	05/31/2024

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	ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all clients, staff and visitors in the facility. Findings include: Based on record review with the QIDP between 11:20 AM and 1:00 PM on 04/18/2024, quarterly sprinkler inspection documentation performed by a sprinkler system inspection contractor for the most recent twelve month period was not available for review. In addition, monthly sprinkler system gauge and control valve inspection documentation for staff inspections for the most recent twelve month period was also not available for review. Based on interview at the time of record review, the QIDP agreed sprinkler system inspection and testing documentation for the most recent twelve month period was not available for review. Based on observations with the QIDP during a tour of the facility between 11:20 AM and 1:00 PM on 04/18/2024, the facility has a supervised wet sprinkler system. The sprinkler system inspection contractor affixed a hanging tag to the sprinkler system riser indicating sprinkler system gauge and valve inspections were conducted for one month of the most recent twelve month period in January 2024.		Carney with Koorsen Fire And Security for a copy of the sprinkler system annual antifreeze solution testing 1.The AED contacted Chris Carney with Koorsen Fire And Security for the installation of 2 missing escutcheon plates no later than May 31, 2024. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager	

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	These findings were reviewed with the QIDP during the exit conference. This deficiency was cited on 04/18/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 2. Based on record review, observation and interview; the facility failed to document annual testing of the sprinkler system antifreeze solution in accordance with NFPA 25 for the most recent twelve month period. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.4 states the freezing point of solutions in antifreeze systems shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Section 5.3.4.1 states solutions shall be in accordance with Table 5.3.4.1(a) and Table 5.3.4.1(b). Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review with the QIDP from 11:20 AM to 1:00 PM on 04/18/2024, annual antifreeze testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the QIDP agreed annual antifreeze testing documentation for the most recent twelve month period was not available for review. Based on observations with the QIDP during a tour of the facility between 11:20 AM and 1:00 PM on 04/18/2024, the facility			

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	has a supervised wet sprinkler system. Documentation affixed to the sprinkler system riser indicated the sprinkler system contained antifreeze. The sprinkler system inspection contractor affixed a hanging tag to the sprinkler system riser indicating sprinkler system water flow alarm, gauge and valve inspections were conducted for one month of the most recent twelve month period in January 2024 but annual antifreeze testing documentation for the most recent twelve month period was not available for review. These findings were reviewed with the QIDP during the exit conference. This deficiency was cited on 04/18/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3. Based on observation and interview, the facility failed to ensure 2 of over 10 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observations with the QIDP during a tour of the facility between 11:20 AM and 1:00 PM on 04/18/2024, the ceiling mounted sprinkler installed in the storage room was missing its escutcheon which left a two inch opening in the ceiling. Additionally, the sprinkler in the kitchen by the stove was missing it's escutcheon and showed evidence of corrosion/rusting. Based on			

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	interview at the time of the observations, the Program Director agreed the aforementioned sprinkler locations each had a missing escutcheon which left a two inch opening in the ceiling and the corrosion/rust on the sprinkler in the kitchen. These findings were reviewed with the QIDP during the exit conference. This deficiency was cited on 12/20/24. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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 outlets were protected in 1 of 8 client bedrooms according to Section 33.2.5.1. 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, staff and visitors. Findings include: Based on observations with the QIDP during a tour of the facility between 11:20 AM and 1:00 PM on 04/18/2024, the wall mounted outlet box for all electrical receptacles in TD's bedroom was missing its cover plate. Based on interview at the time of the observations, the QIDP agreed the	K S511	1 The Program Manager will ensure outlet box of receptacles have cover plates installed by ResCare Maintenance. 2 The Program Manager contacted ResCare Maintenance and schedule a service call to ensure cover plates are installed as required. 3 ResCare Maintenance installed outlet cover plates as required by NFPA 70, 10, 2024 on April 19, 2024. Persons Responsible: Program Manager, ResCare Maintenance.	04/18/2024

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	electrical outlet boxes in TD's bedroom was missing their cover plates. These findings were reviewed with the QIDP during the exit conference. This deficiency was cited on 12/20/24. The facility failed to implement a systemic plan of correction to prevent recurrence.			