STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G193	A. BUILDING -- B. WING	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13711 BENNETTSVILLE RD MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/21/24 Facility Number: 000723 Provider Number: 15G193 AIM Number: 100234760 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 7 certified beds. At the time of the survey, the census was 7. Quality Review completed on 02/23/24	E 0000		
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Slaughter	AED	03/04/2024

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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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.			

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	(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This	E 0018	1.and clients, whether they evacuate or shelter in place. Including the consideration of care and treatment needs of evacuees, staff responsibilities; transportation; identification of evacuation locations; and primary and means of communication with external assistance. 2.The area supervisor and	03/05/2024

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	deficient practice could affect all occupants. Findings include: During record review on 02/21/2024 from 10:00 AM to 1:40 PM, no documentation could be located ensuring the facility's emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location. Based on interview at the time of record review, the Maintenance Manager and House Supervisor acknowledged the lack of policy and was unable to provide any further evidence or additional information contrary to this deficient finding. This finding was reviewed with the Maintenance Manager and House Supervisor during the exit conference.		program manager will train all staff on the policies and procedures and the program overview will be placed in the Emergency Disaster Preparedness Manual for reference as needed. 3 A member of the Administrative team will conduct a monthly site reviews for all clients in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the facility. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP, DSL, Quality Assurance.	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at			

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	§491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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			

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

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural			

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	or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (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			

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	requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (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,			

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	facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2			

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	years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next 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			

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	the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional 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 an individual, facility-based functional exercise. b. A mock disaster drill; or	E 0039	**1** The administrator will ensure the participation in a full-scale community based exercise and a table top exercise is present in the EPP manual. **2** A full scale community based drill The Great Shake out on Thursday the 19th of October 2023 a second tabletop exercise was complete on January 30, 2024. **3** The area supervisor and program manager will ensure documentation of the table top exercise and the community based exercise are present in the Emergency Disaster Preparedness Manual for reference as needed. The associate executive director will review the training documentation to ensure it has been completed	03/05/2024

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	c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 02/21/2024 from 10:00 AM to 1:40 PM with the Maintenance Manager and House Supervisor, the facility failed to provide documentation of annual exercises in the form of a full-scale community-based exercise and a second full-scale exercise, mock disaster drill, or tabletop or workshop. Based on interview at the time of record review, the House Supervisor stated they did not have emergency preparedness exercises. This finding was reviewed with the Maintenance Manager and House Supervisor during the exit conference.		and is present. The safety committee will review and update annually as needed. **4** This information is located in section 22 of the Emergency Disaster Preparedness Manual **5** Dated Documentation will be provided showing the completion of a tabletop exercise **6** The AED will in service the Program Manager, Area Supervisor and Residential Manager on the requirement of conducting an annual community based exercise and maintaining documentation. **7** All supervisory staff responsible for maintaining drills will be retrained to ensure each group home is completing the drills per LSC. Ongoing monitoring will be achieved by the Quality Assurance Department maintaining a tracking spreadsheet to ensure all drills are completed per the calendar. Persons Responsible: AED, Program Manager, Area Supervisor, and Residential Manager, DSP Quality Assurance.	
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).	K 0000		

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	Survey Date: 02/21/2024 Facility Number: 000732 Provider Number: 15G193 AIM Number: 100234760 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 fully sprinklered. The facility has a fire alarm system with manual fire alarm boxes, sprinkler system flow switches and alarms hard wired to the fire alarm system. The facility has interconnected smoke detectors powered from the building electrical system installed in corridors and in all common living areas. The facility has heat detectors in the kitchen and attic. The facility has a capacity of 7 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 1.6. Quality Review completed on 02/23/24			
K S338 Bldg. 02	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING (Slow) In Slow Evacuation Capability facilities, interior wall and ceiling finish materials in accordance with 10.2. Class A or Class B is			

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	permitted. There are no requirements for interior floor finish. 33.2.3.3.2, 33.2.3.3.3 Based on observation and interview, the facility failed to ensure the interior finish in 1 of 1 living room and 2 of 2 bathrooms was rated in accordance with 33.2.3.3.2. LSC 33.2.3.3.2 requires interior wall and ceiling finish materials comply with Section 10.2 providing a Class A or Class B flame spread rating for this slow facility. This deficient practice could affect all clients and staff. Findings include: Based on observation with the Maintenance Manager during a tour of the home on 02/21/2024 between 1:40 PM and 2:00 PM, wood paneling covered the bottom half of the walls in the living room and plastic paneling covered the bottom half of the walls in both bathrooms. Based on interview at the time of observation, the Maintenance Manager acknowledged the aforementioned condition and confirmed there was no documentation available to show the finish on the wood paneling or plastic paneling provided a Class A or B flame spread rating. This finding was reviewed with the Maintenance Manager and House Supervisor during the exit conference.	K S338	The administrator will ensure interior wall and ceiling finish materials comply with Section 10.2 providing a Class A or Class B materials in accordance with 33.2.3.3.2. LSC 33.2.3.3.2 The Maintenance Manager will verify compliance of interior wall and ceiling finish materials with manufacture for living room and bathrooms to obtain verification of compliance. If wall and ceiling material compliance cannot be verified and documented existing wall and ceiling material will be removed and replaced with Class A or Class B materials in accordance with 33.2.3.3.2. LSC 33.2.3.3.2. no later than 15MAR2024. Verification of Class A or Class B materials in accordance with 33.2.3.3.2. LSC 33.2.3.3.2 will be verified by the Program Manager. A member of the Administrative team will conduct a monthly site reviews for all clients in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the facility. Persons Responsible: AED, Maintenance Manager, Program	03/15/2024

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			Manager, Area Supervisor, and Residential Manager, DSP, DSL, Quality Assurance.	
K S346 Bldg. 02	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 1. Based on record review and interview, the facility failed to provide a complete written fire watch policy for when the fire alarm system is out of service for more than 4 hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Maintenance Manager on 02/21/2024 10:00 AM and 1:40 PM, 2 fire watch policies were reviewed. One fire watch policy was located in an orange binder and one was located in a black binder. The fire watch policies did not match in the information they provided. The policy in the black binder did not state how often fire watch rounds should be conducted. The policy in the orange binder stated fire watch rounds should be completed every 15 minutes. Based on interview at the time of record review, the Maintenance Manager acknowledged the 2 fire watch policies did not match.	K S346	The administrator will ensure when the fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service The Fire Watch Policy will be updated to include how often fire watch walk should be conducted and if it should be continuous. Staff will be retrained by the Area Supervisor on updated Fire Watch Policy. A member of the Administrative team will conduct a monthly site reviews for all clients	03/05/2024

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	2. Based on record review and interview, the facility failed to provide a complete written fire watch policy for when the fire alarm system is out of service for more than 4 hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Maintenance Manager on 02/21/2024 between 10:00 AM and 1:40 PM, the fire watch policy in the black binder did not note how often a fire watch walk should be conducted or if it should be continuous Based on interview at the time of record review, the Maintenance Manager acknowledged the fire watch policy in the black binder did not indicate how often a fire watch walk should occur. This finding was reviewed with the Maintenance Manager and House Supervisor during the exit conference.		in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the facility. Persons Responsible: AED, Maintenance Manager, Program Manager, Area Supervisor, and Residential Manager, DSP, DSL, Quality Assurance.	
K S353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance			

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	with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into			

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	unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to ensure 1 of over 10 sprinkler heads in the facility were maintained. NFPA 13 and 13R Systems states 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. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation with the Maintenance Manager during a tour of the facility from 1:40 PM to 2:00 PM on 02/21/2024, the sprinkler in the right bathroom had rust or corrosion on the escutcheion and sprinkler head. Based on interview at the time of observation, the Maintenance Manager acknowledged the	K S353	1 The administrator will ensure monthly sprinkler gauge inspections and monthly control valve inspections are conducted by the ResCare maintenance coordinator and is clearly documented on the control valve and gauge inspection tags. Proof of the inspections will be available in the facility for review. 2 The Maintenance Manager contacted Koorsen Fire and Security to have the right bathroom sprinkler and escutcheon plate replaced. 3 The sprinkler head and escutcheon plate will be replaced no later than April 1, 2024. 4 The program manager will inspect work and report any issues or delay to the Associate Executive Director immediately. 1.A random monthly site review will be completed by a member of	04/01/2024

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	aforementioned sprinkler rust and corrosion and stated he would put in a work order to get it addressed. This finding was reviewed with the Maintenance Manager and House Supervisor during the exit conference.		ResCare's Administrative team to ensure compliance. Persons Responsible: AED, Maintenance Manager, Program Manager, ResCare Maintenance. Area Supervisor, DSL, DSP	
K S354 Bldg. 02	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) 1. Based on record review and interview, the facility failed to provide a written fire watch policy for when the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Maintenance Manager on 02/21/2024 10:00 AM and 1:40 PM, 2 fire watch policies were reviewed. One fire watch policy was located in an orange binder and one was located in a black binder. The fire watch policies did not match in the information they provided. The policy in the black binder did not state how often fire watch rounds should be conducted. The policy in the orange binder stated	K S354	The Fire Watch Policy will be updated to include how often fire watch walk should be conducted and if it should be continuous. Staff will be retrained by the Area Supervisor on updated Fire Watch Policy. A member of the Administrative team will conduct a monthly site reviews for all clients in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the facility Persons Responsible: AED, Maintenance Manager, Program	03/05/2024

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	fire watch rounds should be completed every 15 minutes. Based on interview at the time of record review, the Maintenance Manager acknowledged the 2 fire watch policies did not match. 2. Based on record review and interview, the facility failed to provide a written fire watch policy for when the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Maintenance Manager on 02/21/2024 between 10:00 AM and 1:40 PM, the fire watch policy in the black binder did not note how often a fire watch walkthrough should be conducted or if it should be continuous Based on interview at the time of record review, the Maintenance Manager acknowledged the fire watch policy in the black binder did not indicate how often a fire watch walk should occur. This finding was reviewed with the Maintenance Manager and House Supervisor during the exit conference.		Manager, Area Supervisor, and Residential Manager, DSP, DSL, Quality Assurance.	