STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING -- B. WING	12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL DR JEFFERSONVILLE, IN 47130

(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: 12/20/23 Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810 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 8. Quality Review completed on 01/02/24 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
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).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Slaughter	AED	01/15/2024

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 ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §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			

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	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: (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			

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	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 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:			

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	(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 [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			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural 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,			

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	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 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			

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	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 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,			

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	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 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.			

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	(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. *[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 at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of 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	E 0039	**E 039 EP Training Requirements:** **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 will be completed 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	01/31/2024

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	community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or 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 review of "Emergency/Disaster Preparedness Manual-Cornwell Drive" documentation dated 03/22/22 with the Program Director and the Home Manager during record review from 10:35 a.m. to 12:30 p.m. on 12/20/23, documentation for at least two exercises conducted within the most recent twelve month period to test the emergency plan using the emergency procedures was not available for review. Based on interview at the time of record review, the Program Director stated the facility just completed an emergency preparedness exercise but agreed the facility has not documented a community based disaster drill, mock drill, workshop or conducted a tabletop exercise within the most recent twelve month period and agreed testing documentation was not available for review at the time of the survey. These findings were reviewed with the Program Director during the exit conference.		Emergency Disaster Preparedness Manual for reference as needed. The associate executive director will review the training documentation to ensure it has been completed and is present. The safety committee will review and update annually as needed. **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.	

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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: 12/20/23 Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810 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 building with a basement was non sprinklered. The facility has a fire alarm system with smoke detection on all levels in corridors and all in all living areas. The facility has battery operated smoke detectors installed in 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 facility Prompt with an E-Score of 1.3. Quality Review completed on 01/02/24	K 0000		
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other			

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	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.			
	1. 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 Program Director during a tour of the facility from 12:30 p.m. to 1:00 p.m. on 12/20/23, 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 but the door was blocked from swinging to self close and latch into the door frame because a wheeled three tier shelf was stored up against the door to prevent it from self closing. The door self closed and latched into the door frame when the shelving was removed and the door was tested to close. Based on interview at the time of the observations, the Program Director agreed the smoke barrier door would fail to self close and	K S100	**K0100 General Requirements - Other:** 1.The facility will ensure emergency lighting will be tested monthly for a minimum of 30 seconds and an annual test of 90 minutes for all units in the facility. 2.The Program Manager will in-service the Maintenance Manager on the inspection and documentation of monthly 30 second duration test. 3.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. 4.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. **Persons Responsible**: Program Manager, Area Supervisor, and Residential Manager, DSP, Koorsen Fire and Security.	01/31/2024

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RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL DR JEFFERSONVILLE, IN 47130

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	latch into the door frame with the tiered shelf stored up against the door. These findings were reviewed with the Program Director during the exit conference. 2. Based on record review, observation and interview; the facility failed to ensure 3 of 3 battery operated emergency lights in the facility was 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 affect all clients, staff and visitors. Findings include: Based on record review with the Program Director and the House Manager from 10:35 a.m. to 12:30 p.m. on 12/20/23, monthly battery operated emergency light documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Program Director agreed monthly battery operated emergency light documentation for the most recent twelve month period was not available for review. Based on observations with the Program Director during a tour of the facility from 12:30 p.m. to 1:00 p.m. on 12/20/23, a total of three battery operated emergency lights were noted in the facility and each battery operated light illuminated when its respective test button was pushed. The battery light inspection			

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	contractor had affixed a sticker to each light documenting the annual 90 minute testing was performed on 02/03/23 but the contractor did not document monthly 30 second duration testing. These findings were reviewed with the Program Director during the exit conference.			
K S253 Bldg. 01	NFPA 101 Number of Exits - Patient Sleeping and Non-Sl Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Prompt) Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, each sleeping room shall have a second means of escape that consists of one of the following: 1. It shall be a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape. 2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape. 3. It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 square feet. The width shall be not less than 20			

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	inches. The height shall be not less than 24 inches. The bottom of the opening shall be not more than 44 inches above the floor. Such means of escape shall be acceptable where one of the following criteria are met: a. The window shall be within 20 feet of finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an exterior balcony. 4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following: 1. The ladder or steps do not extend more than 6 inches into the well. 2. The ladder or steps are not obstructed by the window. 5. If the sleeping room has a door leading directly to the outside of the building with access to finished ground level or to a stairway that meets the requirements of exterior stairs in 33.2.2.2.2, that means of escape shall be considered as meeting all the escape requirements for the sleeping room. a. A second means of escape from each sleeping room shall not be required where the facility is protected throughout by approved			

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	automatic sprinkler system in accordance with 33.2.3.5. b. Existing approved means of escape shall be permitted to continue to be used. 33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through 33.2.2.3.4 Based on observation and interview, the facility failed to ensure 3 of 5 client sleeping rooms were provided with a secondary means of escape in accordance with 33.2.2.3. LSC Section 33.2.2.3 requires a secondary egress from each sleeping room with multiple provisions. This deficient practice could affect at least 3 clients. Findings include: Based on observations with the Program Director during a tour of the facility from 12:30 p.m. to 1:00 p.m. on 12/20/23, the one window in the Bedroom #1 opened to a height of 24 inches and a width of 31 inches for a minimum clear width of 5.1 square feet. The one window in Bedroom #2 opened to a height of 24.25 inches and a width of 31 inches for a minimum clear width of 5.1 square feet. The one window in Bedroom #3 opened to a height of 22.25 inches and a width of 34 inches for a minimum clear width of 5.2 square feet. Each window served as the secondary means of egress for the room. All measurements were made with a measuring tape. Based on interview at the time of the observations, the Program Director agreed the aforementioned secondary means of egress did not provide a clear opening of not less than 5.7 square feet with the windows in the fully open position. These findings were reviewed with the Program Director during the exit conference.	K S253	**K0253: Number of Exits -Patient Sleeping and Non-Sleeping Rooms.** 1.The administrator will ensure client sleeping rooms maintain a secondary escape with multiple provisions including windows providing a clear with of eleven inches when open and an unobstructed secondary means of escape in accordance with 33.2.2.3. 2.The Program Director will schedule repair/replacement of the window with the ResCare maintenance coordinator. The ResCare maintenance coordinator will inspect all windows to ensure they meet all criteria for means of escape. The facility manager will ensure secondary means of escape are not blocked with furniture. 3.Bedroom window 1,2, and 3 will be replaced to ensure an approved means of escape. Competitive bids will be accepted until February 15, 2024 and contractor selected by February 29, 2024. The replacement windows will be installed before May 31, 2024. 4.The facility will perform function check of windows during	05/31/2024

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			monthly drills to ensure windows are operating properly and report any defect through the maintenance request form when discovered. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager	
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.)	K S345	**K0345: Fire Alarm System – Testing and Maintenance** 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 visual semi-annual fire alarm system inspection is completed	01/31/2024

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	d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Alarm System Inspection" documentation dated 01/25/23 with the Program Director and the House Manager from 10:35 a.m. to 12:30 p.m. on 12/20/23, documentation of a visual semi-annual fire alarm system inspection six months after 01/25/23 was not available for review. Based on interview at the time of record review, the Program Director stated additional fire alarm system inspection documentation was not available for review and agreed documentation for a semi-annual visual fire alarm system inspection six months after 01/25/23 was not available for review. These findings were reviewed with the Program Director during the exit conference.		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. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Maintenance Manager	
K S347 Bldg. 01	NFPA 101 Smoke Detection Smoke Alarms 2012 EXISTING (Prompt) Approved smoke alarms shall be provided in accordance with 9.6.2.10, unless either of the following exist: 1. Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system, or			

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	2. Buildings are protected throughout by an approved automatic sprinkler system, in accordance with 33.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms. Smoke alarms shall be installed on all levels, including basement but excluding crawl spaces and unfinished attics. Additional smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. These alarms shall be powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas. 33.2.3.4.3.			
	Based on observation and interview, 5 of 5 client sleeping rooms were not provided with an approved smoke alarm in accordance with LSC 9.6.2.10. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Program Director during a tour of the facility from 12:30 p.m. to 1:00 p.m. on 12/20/23, each of the five client sleeping rooms in the facility did not have an approved smoke alarm installed in the room. Each resident sleeping room had a single station battery operated smoke alarm installed on the ceiling in the room. Each smoke alarm was not powered by the building electrical system. Each battery operated smoke alarm installed in the bedrooms were not interconnected to all other bedroom	K S347	**K0347 Smoke Detectors:** 1.The administrator will ensure the installation of smoke alarms are powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas. 2.The Maintenance Manager will request bids and select a vendor for installation of approved smoke detectors NLT February 15, 2024. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP	02/15/2024

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	smoke alarms. Based on interview at the time of the observations, the Program Director agreed each of the client sleeping rooms was not provided with a smoke alarm which was powered by the building electrical system. These findings were reviewed with the Program Director during the exit conference.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure the corridor door to 2 of 5 client bedrooms had no impediment to closing and latched into the door frame. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Program Director during a tour of the facility from 12:30 p.m. to 1:00 p.m. on 12/20/23, the corridor door to Bedroom #1 and Bedroom #2 were equipped with a self closing	K S363	1.The Area Supervisor will in-service the facility staff on ensuring smoke barrier doors and bedroom doors remain free of and obstacle that will prevent the smoke barrier door from closing. 2.Random monthly site reviews will be conducted by a member of ResCare's Administrative Team to ensure smoke barrier and bedroom doors remain free from obstacles that would prevent them	01/31/2024

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	device but each door was propped in the fully open position with a wedge placed under the door. Based on interview at the time of the observations, the Program Director agreed each of the two bedroom doors had an impediment to closing and latching into the door frame. These findings were reviewed with the Program Director during the exit conference.		from closing properly. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)			

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	Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the first shift for 2 of 4 quarters, on the second shift for 1 of 4 quarters and on the third shift for 2 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Emergency Drill Report: Fire" and "Emergency Evacuations Drills" documentation with the Program Director and the Home Manager during record review from 10:35 a.m. to 12:30 p.m. on 12/20/23, documentation of a fire drill conducted on the first shift in the second quarter (April, May, June) 2023 and in the third quarter (July, August, September) 2023 was not available for review. In addition, documentation of a fire drill conducted on the second shift in the first quarter (January, February, March) 2023 and on the third shift in the first and third quarters in 2023 was also not available for review. Based on interview at the time of record review, the Home Manager stated the facility operates three shifts per day, additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the first, second and third shifts in the aforementioned calendar quarters in 2023 was not available for review. These findings were reviewed with the Program Director and the Home Manager during the exit conference.	K S712	**K0712 Fire Drills:** 1.All staff at the Facility will be re-trained on conducting fire drills quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home and up to date. 1.The Residential Manager will submit monthly drills to the QA Department upon completion. The QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required. 1.The Area supervisor will ensure drills are completed as required. 1.The program manager will conduct random monthly inspections to ensure drills are being completed as required. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, DSP	01/31/2024