STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G697	A. BUILDING -- B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	4251 RIVER RD COLUMBUS, IN 47203

(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: 04/22/2024 Facility Number: 003184 Provider Number: 15G697 AIM Number: 200368720 At this Emergency Preparedness survey, Developmental Services Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. At the time of the survey, the census was 4. Quality Review completed on 04/26/24 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
Missy Rice	Regional Director	05/12/2024

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 complete a full-scale community-based annual exercise. 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. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 0039	**Corrective actions taken**: ·The facility has completed full scale community-based exercises. **Measures put in place:** Copies of the exercises will be placed in the drill book. **Monitoring of corrective action:** Program Coordinators will be trained on ensuring that the drills are placed in the drill books so they are readily available for review	05/15/2024

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	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 04/22/2024 between 11:00 AM and 12:45 PM and 1:20 PM and 1:40 PM, the facility did not have documentation of a full-scale community-based exercise for review. Based on interview at the time of record review, the Program Coordinator agreed there was not documentation for a full-scale community-based exercise available for review. This finding was reviewed with the Program Coordinator at the exit conference.			
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: 04/22/20204 Facility Number: 003184 Provider Number: 15G697 AIM Number: 200368720 At this Life Safety Code survey, Developmental Services Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.	K 0000		

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	This one-story facility was sprinkled. The facility has a monitored fire alarm system with smoke detection in the corridors and in all living areas. The attic has heat detection. The facility has a capacity of 6 and had a census of 4 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 1.9. Quality Review completed on 04/26/24			
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. 1. Based on observation and interview, the facility failed to document 1 of 1 portable fire extinguishers in the garage was subject to maintenance at intervals of not more than one year. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 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. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be subject to	K S100	**Corrective actions taken**: ·New tags have been issued for fire extinguishers that were not replaced previously. ·Staff will be retrained on checking tags/extinguishers monthly and signing off on tags. **Measures put in place:** Staff training sheet **Monitoring of corrective action:** ·Program Coordinator will preform monthly checks to ensure	05/15/2024

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	maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation during a tour of the facility with the Program Coordinator on 04/22/2024 between 1:40 PM and 2:00 PM, the portable fire extinguisher located in the garage had a tag which indicated it had not been serviced since 2021. Based on interview at the time of observation, the Program Coordinator agreed the tag indicated the extinguisher it had not been serviced since 2021. This finding was reviewed with the Program Coordinator at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the garage and 1 of 1 in the laundry rooms were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals.		that the tags are signed off properly and equipment is in proper working condition.	

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(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
	Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept demonstrating that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation during a tour of the facility on 04/22/2024 between 1:40 PM and 2:00 PM with the Program Coordinator, the portable fire extinguisher in the garage had a tag which indicated it had not had a monthly check since 2022 and the laundry room portable fire extinguisher tag indicated it had not had a monthly check in 2024. Based on interview at the time of observation, the Program Coordinator stated the facility does not keep any record of monthly fire extinguisher checks in any other location and the extinguishers in the garage and laundry room were forgotten. This finding was reviewed with the Program Coordinator at the exit conference.			
K S168 Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING (Slow) In Slow Evacuation Capability facilities, the facility shall be housed in a building where the interior is fully sheathed with lath and plaster or other material providing a 15-minute			

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	15G697	A. BUILDING 01 B. WING	04/22/2024

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	thermal barrier, including all portions of bearing walls, bearing partitions, floor construction, and roofs. All columns, beams, girders, and trusses shall be similarly encased or otherwise shall provide not less than a 1/2-hour fire resistance rating, unless modified by the modified by the following: * Exposed steel or wood columns, girders, and beams (but not joists) located in the basement shall be permitted. * Buildings of Type I, Type II (222), Type II (111), Type III (211), Type IV, Type V (111) construction shall not be required to meet the requirements of 33.2.1.3.2 (See 8.2.1). * Areas protected by approved automatic sprinkler systems in accordance with 33.2.3.5. shall not be required to meet the requirements of 33.2.1.3.2. * Unfinished, unused, and essentially inaccessible loft, attic, or crawl space shall not be required to meet the requirements of 33.2.1.3.2. * Where the facility achieves an E-score of 3 or less using the board and care occupancies evacuation capability determination methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety. The requirements of 33.2.1.3.2 shall not apply. 33.2.1.3.2.1 through 33.2.1.3.2.7 Based on observation and interview, the facility failed to ensure the facility was fully sheathed to provide a 15-minute thermal barrier. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation during a tour of the facility with the Program Coordinator on 04/22/2024	K S168	**Corrective actions taken**: Facility maintenance has repaired the wall by the breaker box and emergency food supply so that there is no penetration. **Measures put in place:** Repair	05/15/2024

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	15G697	A. BUILDING 01 B. WING	04/22/2024

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	between 1:40 PM and 2:00 PM, a 0.5 inch penetration was located in wall near the emergency food storage in the garage and a 1/3 inch penetration in the garage was located above the breaker box in the garage. Based on interview at the time of observation, the Program Coordinator agreed there were penetrations in the walls of the garage and provided the measurement. This finding was reviewed with the Program Coordinator at the exit conference.		**Monitoring of corrective action:** Facility Safety Manager will do quarterly walk through of the facility to ensure there are no deficiencies.	
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 observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 33.3.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation of the fire alarm control panel on 04/22/2024 at 1:56 PM during a tour of	K S345	**Corrective actions taken**: A service ticket has been issued to Koorsen to repair the incorrect time on the fire alarm panel. Staff will be trained to check the time on the fire alarm panel to ensure that it is correct. **Measures put in place:** Repair ticket Retraining sheet	05/15/2024

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	the facility with the Program Coordinator, the fire alarm control panel indicated the time was 2:06 PM. Based on interview at the time of the observation, the Program Coordinator agreed the fire alarm control panel was displaying the incorrect time. This finding was reviewed with the Program Supervisor at the exit conference.		**Monitoring of corrective action:** Facility Safety Manager will do quarterly walk through of the facility to ensure there are no deficiencies. Program Coordinator will retrain staff and do monthly checks of the facility to ensure training was implemented successfully.	
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.			

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	42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct 2 of 2 3rd quarter fire drills and 1 of 2 4th quarter fire drills. This deficient practice could affect all clients. Findings include: Based on a review of Fire Drill Reports on 04/22/2024 between 11:00 AM and 12:45 PM and 1:20 PM and 1:40 PM with the Program Coordinator, there was no documentation of any fire drills for the 3rd quarter of 2023 and no documentation of a 2nd shift fire drill for the 4th quarter. Based on interview with the Program Coordinator at the time of record review, the facility has 4 staff members, the facility does not have any staff working when the clients are at their day programs, and the staff who works during the week is the same staff that works on the weekend for 12 hour shifts. The Program Coordinator agreed there was no documentation of fire drills for the 3rd quarter of 2023 and no documentation for a 2nd shift fire drill for the 4th quarter. This finding was reviewed with the Program Coordinator at the exit conference.	K S712	**Corrective actions taken**: Staff will be retrained on conducting fire drills. **Measures put in place:** Retraining **Monitoring of corrective action:** Program Coordinator will monitor drills to ensure training was implemented successfully. Facility Safety Manager will track all drills.	05/15/2024