

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 11/07/13</p> <p>Facility Number: 000840 Provider Number: 15G322 AIM Number: 100244010</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Occazio Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>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</p>	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>in all common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> <p>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 0.3.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K01S056	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD PROMPT Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7, 33.2.3.5.2 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p> <p>Exception No. 1: In prompt evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, is permitted. Automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 2: Not applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Residential Occupancies up to and Including Four Stories in Height, are permitted.</p> <p>Exception No. 5: Not applicable</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>SLOW Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p> <p>Exception No. 1: Not Applicable</p> <p>Exception No. 2: Not Applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted.</p> <p>Exception No. 5: Not Applicable</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p><b>IMPRACTICAL</b> Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction. 33.2.3.5.2.</p> <p>Exception No. 1: Not Applicable.</p> <p>Exception No. 2: In slow and impractical evacuation capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and Two Family Dwellings and Manufactured Homes, with a 30 minute water supply, is permitted. All habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 3: Not Applicable.</p> <p>Exception No. 4: Not Applicable.</p> <p>Exception No. 5: In impractical evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted. All</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5. Based on record review and interview, the facility failed to ensure sprinkler waterflow alarm devices were tested for 3 of 4 quarters. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires waterflow alarm devices, including but not limited to, mechanical water motor gongs, and pressure switches that provide audible or visual signals be tested quarterly. Vane-type waterflow devices may be tested semiannually. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire &amp; Security "Systems Service" documentation with the Home Manager during record review from 10:20 a.m. to 11:20 a.m. on 11/07/13, the most recent documentation of quarterly sprinkler system inspections of waterflow alarm</p>	K01S056	<p>K 0056 Life Safety Code Standard Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7, 33.2.3.5.2 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction. What corrective action will be accomplished?The sprinkler water flow alarm devices will be tested on a quarterly basis.Koorsen's will complete a water flow alarm test by December 7th, 2013. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by the same deficient practice.The Maintenance Coordinator will ensure that the water flow alarm devices are tested on a quarterly basis. The test documentation will be kept by the Site Manager in the site's life safety book. The original documentation will be filed at the</p>	12/07/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2013
NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	devices was for the first quarter of 2013 on 01/16/13. No other written documentation of sprinkler system inspections of waterflow alarm devices performed in the most recent twelve month period was available for review. In addition, the aforementioned documentation stated "Annual Sprinkler Inspection" was performed. Based on interview at the time of record review, the Home Manager stated additional sprinkler system inspections of waterflow alarm devices was not available for review and acknowledged the only documented sprinkler system inspection of waterflow alarm devices available for review was performed on 01/16/13.		corporate office. The Residential Coordinator and Area Residential Coordinator will review the life safety book on a quarterly basis to ensure all of the inspection reports have been received and concerns are addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Coordinator will ensure that the water flow alarm devices are tested on a quarterly basis. The test documentation will be kept by the Site Manager in the site's life safety book. The original documentation will be filed at the corporate office. The Residential Coordinator and Area Residential Coordinator will review the life safety book on a quarterly basis to ensure all of the inspection reports have been received and concerns are addressed. How will the corrective action be monitored to ensure the deficient practice will not recur? Maintenance Coordinator will continue to monitor as he is in the home. Residential Coordinator will continue to monitor as she is in the home. Koorsen Fire and Security will monitor quarterly. The test documentation will be kept by the Site Manager in the site's life safety book. The original documentation will be filed at the corporate office. The Residential Coordinator and Area Residential Coordinator will review the life		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2013
NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
			safety book on a quarterly basis to ensure all of the inspection reports have been received and concerns are addressed. What is the date by which the systemic changes will be completed? December 7th, 2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2013	
NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC				STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K01S152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) 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.</p> <p>(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. Based on record review and interview, the facility failed to provide documentation of fire drills conducted on the first shift for 1 of 4 quarters. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include:  Based on review of "ISP Data Collection" fire drill documentation with the Home</p>	K01S152	K 0152 Life Safety Code Standard The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to- (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.The facility must-	12/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/07/2013
NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	Manager during record review from 10:20 a.m. to 11:20 a.m. on 11/07/13, documentation of a fire drill being conducted on the first shift in the first quarter (January, February, March) of 2013 was not available for review. Based on interview at the time of record review, the Home Manager acknowledged documentation of a fire drill being conducted on the first shift in the first quarter of 2013 was not available for review.		(i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) 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. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. What corrective action will be accomplished?SMs trained on regulations regarding evacuation drills.The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff, Site Manager and RC during their team meetings.A drill tracking sheet will be utilized by the RC and Site Manager to ensure that drills for each shift of personnel are being conducted. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by the same deficient practice.The importance of ensuring that evacuation drills are ran at least quarterly for each		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC	STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			<p>shift of personnel will be reviewed with the staff, Site Manager and RC during their team meetings.A drill tracking sheet will be utilized by the RC and Site Manager to ensure that drills for each shift of personnel are being conducted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:The importance of ensuring that evacuation drills are ran at least quarterly for each shift of personnel will be reviewed with the staff, Site Manager and RC during their team meetings.A drill tracking sheet will be utilized by the RC and Site Manager to ensure that drills for each shift of personnel are being conducted. How will the corrective action be monitored to ensure the deficient practice will not recur?Area Residential Coordinator and Residential Coordinator will review drills monthly to ensure drills are being properly run. What is the date by which the systemic changes will be completed? December 7th, 2013</p>	