

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G745	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/18/2015
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16611 SIMA GRAY RD HENRYVILLE, IN 47126
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K 0000 Bldg. 01	<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: 06/18/2015</p> <p>Facility Number: 011663 Provider Number: 15G745 AIM Number: 200902020</p> <p>At this Life Safety Code survey, Res Care Southeast Indiana 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 32, New Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in common living areas, and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 4 and had a census of 4 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K 0000		
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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.

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K 0130 Bldg. 01	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.36.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1) Based on observation and interview, the facility failed to ensure monthly fire extinguisher inspections were documented, including the date and initials of the person performing the inspections for 3 of 3 portable fire extinguishers. LSC 101, 4.5.7 states any device, equipment or system required for compliance with this Code shall thereafter is maintained unless the Code exempts such maintenance. NFPA 10, Standard for Portable Fire Extinguishers, 4-3.1 requires that extinguishers shall be inspected monthly. NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. NFPA 10, 4-3.4.2 requires at least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include: During observation on 06/18/2015</p>	K 0130	<p>K130: Other LSC deficiency not on 2786</p> <p>Corrective Action:(specific): Maintenance personnel will ensure that all monthly fireextinguisher inspections are completed each month and will include the date andinitials of the person inspecting. Maintenance personnel will also ensure that an annual 90 minute test andmonthly visual inspections will occur on the interior emergency lights. Allfire extinguishers that are not visible will have proper signage indicatingwhere they are located.</p> <p>How others will beidentified: (Systemic): Maintenancepersonnel will inspect and ensure that proper documentation is in place eachmonth or as required.</p> <p>Measures to be put inplace: Maintenance personnel will ensure that all monthly fire extinguisherinspections are completed each month and will include the date and initials ofthe person inspecting.</p>	07/18/2015

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	<p>between 2:30 P.M. and 3:10 P.M. with Direct Care Staff #1, the fire extinguisher inspection/maintenance tags on 3 of 3 fire extinguishers in the home failed to have any evidence of a monthly inspection being conducted since the extinguisher's annual inspection in February 2015. During an interview on 06/19/2015 at the time of the observation, Direct Care staff #1 indicated there was no other evidence the portable fire extinguishers had been inspected monthly since the annual inspection.</p> <p>2) Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers was located in areas where they were readily accessible. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1-6.3 requires extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from an area. This deficient practice affects all clients,</p>		<p>Maintenance personnel will also ensure that an annual 90 minute test and monthly visual inspections will occur on the interior emergency lights. All fire extinguishers that are not visible will have proper signage indicating where they are located.</p> <p>Monitoring of Corrective Action: Maintenance personnel will inspect and ensure that proper documentation is in place each month or as required.</p> <p>Completed date: 7.18.15</p>	

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	<p>visitors and staff.</p> <p>Findings include:</p> <p>During observation on 06/18/2015 between 2:30 P.M. and 3:10 P.M. with Direct Care Staff #2, one of three fire extinguishers in the home was found behind a cabinet door underneath the kitchen sink. Interview with Direct Care Staff #2 at the time of the observation indicated he was unaware that an extinguisher was stored beneath the sink. Interview with Direct Care Staff #1 at 3:10 P.M. on 6/18/2015 indicated it was stored underneath the sink to protect it from damage. There was no indication on the outside of the cabinet that a fire extinguisher was stored inside the cabinet.</p> <p>3) Based on observation, record review and interview, the facility failed to have annual or monthly tests for interior emergency lights were conducted. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires a functional test be conducted at 30 day intervals and an annual test be conducted on every</p>						

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K S056	<p>required battery powered emergency lighting system for not less than 1 1/2 hours. 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 occupants if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>During observation on 06/18/2015 between 2:30 P.M. and 3:10 P.M. with Direct Care Staff #1, wall mounted emergency lights were found in the home. During review of facility records on 6/18/2015 at 3:10 P.M. there was no evidence that emergency lighting installed in the home had an annual 90 minute test or monthly visual inspections during the previous 12 months. Interview with Direct Care Staff #1 at 1:45 P.M. indicated there was no documentation available to her which indicated any of the testing of the emergency lights had been completed.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p>			

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Bldg. 01	<p>PROMPT</p> <p>Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and initiates the fire alarm system in accordance with 32.2.3.4.1, 32.2.3.5.2. 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. Facilities with more than eight residents are permitted. Facilities with more than eight residents are treated as two-family dwellings with regard to water supply. Additionally, entrance foyers are sprinklered.</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 an Including Four Stories in Height, are permitted.</p>			

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	<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 initiates the fire alarm system in accordance with 32.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</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. Facilities with more than eight residents are treated as two family dwellings with regard to water supply.</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</p>			

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	<p>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> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 32.2.3.5.5.</p> <p>MPRACTICAL Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 32.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction. 32.2.3.5.2.</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 system in One and Two Family Dwellings and Manufactured Homes, with a 30 minute water supply, is permitted. All habitable areas and closets are sprinklered. Facilities with more than eight residents are treated as two family dwellings with regard to water supply.</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 stores in height, systems in accordance with</p>			

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	<p>NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stores in Height, are permitted. All habitable areas and closets are sprinklered.</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 observation and interview, the facility failed to ensure a sprinkler in the garage, was installed correctly and maintained free of debris. LSC 32.2.3.5.2 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 2-2.1.1 requires sprinklers shall be free of corrosion, foreign materials and paint. Any sprinkler shall be replaced which is painted, corroded, damaged or loaded. This deficient practice could affect any clients in the living room, family room, kitchen or hallway between the family room and kitchen.</p> <p>Findings include:</p> <p>During observation in the home on 6/18/2015 between 2:30 P.M. and 3:10 P.M. with Direct Care Staff #2, a sprinkler head located in the garage was missing a cover and/or escutcheon plate. The sprinkler installed were the type that recessed into the ceiling with a cover.</p>	K S056	<p>K0056:</p> <p>Corrective Action:(specific): Maintenance personnel will ensure that all sprinkler head will have a cover and/or escutcheon plate and be free from any debris that may cause malfunction.</p> <p>How others will be identified: (Systemic): Maintenance personnel will inspect all sprinkler heads each month to ensure they are free from corrosion, foreign materials and paint.</p> <p>Measures to be put in place: Maintenance personnel will ensure that all sprinkler head will have a cover and/or escutcheon plate and be free from any debris that may cause malfunction.</p> <p>Monitoring of Corrective Action: Maintenance personnel will inspect all sprinkler heads each month to ensure they are free from corrosion, foreign materials and paint.</p> <p>Completed date: 7.18.15</p>	07/18/2015

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K S147 Bldg. 01	<p>However the sprinkler head in the garage was missing the cover and the head was visible through a 2 to 3 inch hole in the ceiling of the garage. Additionally, the deflector on the visible sprinkler head had been covered with a fuzzy material. Interview with Direct Care Staff #2, at the time of the observation, and while removing the debris from the deflector, indicated the debris appeared to be fragments of insulation from above the ceiling.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff no less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1 Based on record review and interview, the administration failed to ensure all</p>	K S147	<p>K0147: Corrective Action:(specific): The</p>	07/18/2015

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	<p>employees were periodically instructed and kept informed with respect to their duties and responsibilities under a plan for special staff response, including fire protection procedures needed to ensure the safety of 4 of 4 clients. Such instruction is reviewed by the staff not less than every two months.</p> <p>Findings include:</p> <p>During review of the facility's fire evacuation drill records on 06/18/2015 at 1:30 P.M. the facility lacked documentation a fire drill was conducted during the evening shift (2:30 P.M.-to 10:00 P.M.) of the fourth quarter (October, November, and December) of 2014. A memorandum located in the Emergency Evacuation Drill Record binder listed the shifts for the home as 7:00 A.M. to 3:30 P.M. (first shift), 3:30 P.M. to 11:00 P.M. (second shift) and 11:00 P.M. to 7:00 A.M. (third shift). Review of fourth quarter fire drills indicated drills were ran as follows:</p> <p>10/10/2014 at 1:00 P.M. 11/10/2014 at 10:00 P.M. 12/9/2014 at 8:00 A.M.</p> <p>Initially no record was found for a third shift fire drill. Direct Care staff #1 indicated during interview at 3:10 P.M.</p>		<p>Residential Manager and staff will be in-serviced on the emergency drill schedule for the home which includes evacuation drills to be conducted on each shift. The Clinical Supervisor will review the emergency drill paperwork to ensure these are completed monthly, as required, per the drill schedule. Monthly staff meetings will be held to ensure all staff are aware of fire protection procedures needed to ensure the safety of all residents in the home.</p> <p>How others will be identified: (Systemic): The Residential Manager will be in-serviced on the monthly emergency drill schedule. The Clinical Supervisor will be in-serviced on reviewing the emergency drill paperwork to ensure the drills are completed monthly, as required, per the drill schedule.</p> <p>Measures to be put in place: The Residential Manager and staff will be in-serviced on the emergency drill schedule for the home which includes evacuation drills to be conducted on each shift. The Clinical Supervisor will review the emergency drill paperwork to ensure these are completed monthly, as required, per the drill schedule. Monthly staff meetings will be held to ensure all staff are aware of fire protection procedures needed to ensure the safety of all residents in the home.</p>		

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K S150 Bldg. 01	<p>there was no other evidence available with regard to additional drills. However immediately after the interview, Direct Care staff #1, while conversing with her supervisor by phone, clarified that the policy on shift times had changed and indicated that shifts were moved to one hour earlier within the past year, making the third shift 10:00 P.M. until 6:00 A.M. Direct Care staff, and her supervisor by phone indicated the 11/10/2014 drill should be counted as the third shift drill. Therefore, with this change, there was no evidence a second shift drill had been conducted during the 4th quarter. The most recent second shift drill occurred 8/14/2014 and there was no other evidence presented which indicated periodic instruction of fire drill procedures not less than every two months.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with the provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p> <p>Based on interview and observation, the facility failed to have evidence draperies and curtains were flame resistant. LSC Section 10.3.1 requires that draperies, curtains, and other similar loosely hanging furnishings and decorations shall</p>	K S150	<p>Monitoring of Corrective Action: The Residential Manager will be in-serviced on the monthly emergency drill schedule. The Clinical Supervisor will be in-serviced on reviewing the emergency drill paperwork to ensure the drills are completed monthly, as required, per the drill schedule.</p> <p>Completed date: 7.18.15</p> <p>K0150: Corrective Action:(specific): All window coverings will be inspected to ensure that they are flame resistant and the flammability rating will be documented.</p>	07/18/2015

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	<p>be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>During observation in the home on 06/18/2015 between 2:30 P.M. and 3:10 P.M. Towels, blankets and curtains were used throughout the home as window coverings. In the southwest bedroom a blanket with a sports team emblem covered one window while a large towel hung over another window. Interview with Direct Care staff #1 during the observation indicated the resident of that room had just put up the window coverings in the past week. In the north bedroom a large red towel was used as a window covering. The south bedroom, the southeast bedroom and the family room had curtains. Interview on the same day at 3:10 P.M. with direct care staff #1, who had contacted her supervisor by phone, indicated she had been informed by her supervisor that the curtains were sprayed periodically with a fire retardant, but it was not known when the last time it had been applied and acknowledged that the curtains had been laundered. It was further indicated that there was no</p>		<p>How others will be identified: (Systemic): Maintenance personnel will inspect window covering and ensure that proper documentation is in place each month or as required.</p> <p>Measures to be put in place: All window coverings will be inspected to ensure that they are flameresistant and the flammability rating will be documented.</p> <p>Monitoring of Corrective Action: Maintenance personnel will inspect window covering and ensure that proper documentation is in place each month or as required.</p> <p>Completed date: 7.18.15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G745	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/18/2015
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16611 SIMA GRAY RD HENRYVILLE, IN 47126
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K S152 Bldg. 01	<p>documentation available to indicate the flammability rating of any of the window coverings.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>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>Facilities meet the requirements of paragraphs (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 hold an evacuation drill during 2nd shift in the fourth quarter</p>	K S152	<p>K0152:</p> <p>Corrective Action:(specific): The Residential Manager and staff will</p>	07/18/2015

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	<p>of 2014. This finding could affect 4 of 4 residents in the home.</p> <p>Findings include:</p> <p>During review of the facility's fire evacuation drill records on 06/18/2015 at 1:30 P.M. the facility lacked documentation a fire drill was conducted during the evening shift (2:30 P.M.-to 10:00 P.M.) of the fourth quarter (October, November, and December) of 2014. A memorandum located in the Emergency Evacuation Drill Record binder listed the shifts for the home as 7:00 A.M. to 3:30 P.M. (first shift), 3:30 P.M. to 11:00 P.M. (second shift) and 11:00 P.M. to 7:00 A.M. (third shift). Review of fourth quarter fire drills indicated drills were ran as follows:</p> <p>10/10/2014 at 1:00 P.M. 11/10/2014 at 10:00 P.M. 12/9/2014 at 8:00 A.M.</p> <p>Initially no record was found for a third shift fire drill. Direct Care staff #1 indicated during interview at 3:10 P.M. there was no other evidence available with regard to additional drills. However immediately after the interview, Direct Care staff #1, while conversing with her supervisor by phone, clarified that the policy on shift times had changed and</p>		<p>be in-serviced on the emergency drill schedule for the home which includes evacuation drills to be conducted on each shift. The Clinical Supervisor will review the emergency drill paperwork to ensure these are completed monthly, as required, per the drill schedule. Monthly staff meetings will be held to ensure all staff are aware of fire protection procedures needed to ensure the safety of all residents in the home.</p> <p>How others will be identified: (Systemic): The Residential Manager will be in-serviced on the monthly emergency drill schedule. The Clinical Supervisor will be in-serviced on reviewing the emergency drill paperwork to ensure the drills are completed monthly, as required, per the drill schedule.</p> <p>Measures to be put in place: The Residential Manager and staff will be in-serviced on the emergency drill schedule for the home which includes evacuation drills to be conducted on each shift. The Clinical Supervisor will review the emergency drill paperwork to ensure these are completed monthly, as required, per the drill schedule. Monthly staff meetings will be held to ensure all staff are aware of fire protection procedures needed to ensure the safety of all residents in the home.</p>	

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	indicated that shifts were moved to one hour earlier within the past year, making the third shift 10:00 P.M. until 6:00 A.M. Direct Care staff, and her supervisor by phone indicated the 11/10/2014 drill should be counted as the third shift drill. Therefore, with this change, there was no evidence a second shift drill had been conducted during the 4th quarter. The most recent second shift drill occurred 8/14/2014 and there was no other evidence presented which indicated periodic instruction of fire drill procedures not less than every two months.		Monitoring of Corrective Action: The Residential Manager will be in-serviced on the monthly emergency drill schedule. The Clinical Supervisor will be in-serviced on reviewing the emergency drill paperwork to ensure the drills are completed monthly, as required, per the drill schedule. Completed date: 7.18.15		