

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G239	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2015
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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 S 14TH ST NEW CASTLE, IN 47362
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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: 07/13/15</p> <p>Facility Number: 000762 Provider Number: 15G239 AIM Number: 100234890</p> <p>At this Life Safety Code survey, Rem Occazio Llc, 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>The one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and common living areas. The facility has a capacity of 8 and had a census of 7 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety,</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>Chapter 6, rated the facility Prompt with an E-Score of 0.2.</p> <p>Based on observation, record review, 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 1 of 2 portable fire extinguishers. 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. NFPA 10, Standard for Portable Fire Extinguishers, 4-3.1 requires 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.</p> <p>Findings include:</p> <p>Based on observation and record review of the fire extinguisher inspection/maintenance tag on the kitchen fire extinguisher with the</p>	K 0130	<p>K 130 NFPA 101 Misc LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly checks. The date and initials of person inspecting shall be recorded. 1. What corrective action will be accomplished? · Maintenance will inspect fire extinguishers monthly and record inspections on tag, per requirements. · Program Coordinator will evaluate home, monthly, to ensure group home extinguishers have been inspected and home meets safety standards. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. 2. 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. · Maintenance will inspect fire extinguishers monthly and record inspections on tag, per requirements. · Home</p>	08/12/2015

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K S056 Bldg. 01	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD PROMPT Program Coordinator on 07/13/15 at 12:57 p.m., there was no documentation on the tag to show the kitchen fire extinguisher had received a monthly inspection in January of 2015. The Program Coordinator acknowledged at the time of observation, the kitchen fire extinguisher had not received a monthly inspection since January 2015.		Manager will evaluate home, monthly, to ensure group home extinguishers have been inspected and home meets safety standards. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Maintenance will inspect fire extinguishers monthly and record inspections on tag, per requirements. · Program Coordinator will evaluate home, monthly, to ensure group home extinguishers have been inspected and home meets safety standards. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Program Coordinator will evaluate home, monthly, to ensure group home extinguishers have been inspected and home meets safety standards. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. 5. What is the date by which the systemic changes will be completed? 8/12/15	

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	<p>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 Residential Occupancies up to and 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 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> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing</p>				

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	<p>installations in accordance with 33.2.3.5.5.</p> <p>IMPRACTICAL</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 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>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 habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided</p>			

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	<p>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.</p> <p>1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system's maintenance records. 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, 1-8 requires records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. NFPA 25, 1-8.1 requires records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 1-8.2 requires records shall be maintained by the owner. Original records shall be retained for the life of the system. Subsequent records shall be retained for a period of one year after the next inspection, test, or maintenance required by the standard. This deficient practice</p>	K S056	<p>K0056 Life and 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.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Maintenance will replace sprinkler heads in both bathrooms due to corrosion. · Maintenance will schedule sprinkler inspection with Koorsen. · Staff will be retrained on reporting subpar equipment, including household fixtures. · Program Coordinator will be retrained on ensuring sprinkler inspections are completed and retention of records, per standards. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Program Coordinator will evaluate home, monthly to ensure group home meets safety standards and any maintenance issues will be reports to Maintenance. <p>2. How will we identify other residents having the potential</p>	08/12/2015

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	<p>could affect any client in the home.</p> <p>Findings include:</p> <p>Based on record review and interview on 07/13/15 at 1:31 p.m., the Program Coordinator was unable to provide documentation of a sprinkler inspection prior to the Koorsen Fire and Security Inspection dated 01/21/15.</p> <p>2. Based on observation and interview, the facility failed to replace corroded sprinklers in 2 of 3 bathrooms. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observation on 07/13/15 between 1:10 p.m. and 1:13 p.m., the Program Coordinator acknowledged the sprinkler head in the bathroom containing</p>		<p>to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Maintenance will replace sprinkler heads in both bathrooms due to corrosion. · Maintenance will schedule sprinkler inspection with Koorsen. · Staff will be retrained on reporting subpar equipment, including household fixtures. · Program Coordinator will be retrained on ensuring sprinkler inspections are completed and retention of records, per standards. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Program Coordinator will evaluate home, monthly to ensure group home meets safety standards and any maintenance issues will be reports to Maintenance. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Maintenance will replace sprinkler heads in both bathrooms due to corrosion. · Maintenance will schedule sprinkler inspection with Koorsen. · Staff will be retrained on reporting subpar equipment, including household fixtures. · Program Coordinator will be retrained on ensuring sprinkler inspections are completed and retention of records, per 				

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	<p>33.2.2.5.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 bathroom doors could be opened from the outside during an emergency when locked. This deficient practice could affect any client who might lock themselves in the staff bathroom.</p> <p>Finding includes:</p> <p>Based on observation with the Program Coordinator on 07/13/15 at 1:00 p.m., the staff bathroom door could be locked from the inside. Based on an interview with the Program Coordinator at the time of observation, she was unaware of the location of the key or special tool needed to unlock to bathroom door.</p>	K S123	<p>K0123 LIFE SAFETY CODE STANDARD Every bathroom door is designed to allow opening from the outside during an emergency when locked. 1. What corrective action will be accomplished? · Maintenance will ensure that the staff bathroom can be opened from the outside when locked. · Staff and Program Coordinator will be retrained on how to open the staff bathroom door, when locked, in case of emergency. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Program Coordinator will evaluate home, monthly to ensure group home meets safety standards and any maintenance issues will be reports to Maintenance. 2. 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. · Maintenance will ensure that the staff bathroom can be opened from the outside when locked. · Staff and Program Coordinator will be retrained on how to open the staff bathroom door, when locked, in case of emergency. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Program Coordinator will evaluate</p>	08/12/2015	

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			<p>home, monthly to ensure group home meets safety standards and any maintenance issues will be reports to Maintenance. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Maintenance will ensure that the staff bathroom can be opened from the outside when locked. · Staff and Program Coordinator will be retrained on how to open the staff bathroom door, when locked, in case of emergency. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Program Coordinator will evaluate home, monthly to ensure group home meets safety standards and any maintenance issues will be reports to Maintenance. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Maintenance will ensure that the staff bathroom can be opened from the outside when locked. · Staff and Program Coordinator will be retrained on how to open the staff bathroom door, when locked, in case of emergency. · Quarterly Health and Safety Assessments will be conducted to ensure group home meets safety standards. · Program Coordinator will evaluate home, monthly to ensure group home meets safety standards</p>	

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K S147 Bldg. 01	<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 persons 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 not 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</p> <p>Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under 1 of 1 written fire safety plans. Such instruction is reviewed by the staff not less than every 2 months. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p>	K S147	<p>and any maintenance issues will be reports to Maintenance. 5. What is the date by which the systemic changes will be completed? 8/12/15</p> <p>K0147 LIFE SAFETY CODE STANDARD Every resident has in effect and available to staff written copies of a plan for protecting all persons in the event of a fire, keeping persons in place, evacuating to areas of refuge and evacuating the building. 1. What corrective action will be accomplished? · Staff and Program Coordinator will be retrained on safety plans for all clients in the home. · Program Director will monitor and</p>	08/12/2015

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	Based on record review with the Program Coordinator on 07/13/15 at 12:30 p.m., the facility failed to provide training records to show first shift employees have been instructed of their duties and responsibilities, at least every two months, according to the written fire safety plan. Based on interview with the Program Coordinator at the time of record review, the facility did not conduct a first shift fire drill for the first quarter of 2015.		ensure that safety plans are reviewed with and training is documented for all staff at monthly staff meetings. 2. 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. · Staff and Program Coordinator will be retrained on safety plans for all clients in the home. · Program Director will monitor and ensure that safety plans are reviewed with and training is documented for all staff at monthly staff meetings. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Staff and Program Coordinator will be retrained on safety plans for all clients in the home. · Program Director will monitor and ensure that safety plans are reviewed with and training is documented for all staff at monthly staff meetings. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Staff and Program Coordinator will be retrained on safety plans for all clients in the home. · Program Director will monitor and ensure that safety plans are reviewed with and training is documented for all staff at monthly staff				

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K S148 Bldg. 01	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1 Based on observation and interview, the facility failed to enforce 1 of 1 smoking policy. This deficient practice could affect any of the 7 clients.</p> <p>Findings include:</p> <p>Based on observation with the Program Coordinator on 07/13/15 at 12:35 p.m., a client came to this surveyor with a pipe full of tobacco in his mouth and a lighter in his hand requesting that I take him out to smoke. At the time of observation, the Program Coordinator stated when the clients make a request to smoke then facility staff are to take the client outside and light his pipe for him. His lighter is to be handled by the facility staff.</p>	K S148	<p>meetings. 5. What is the date by which the systemic changes will be completed? 8/12/15</p> <p>K0148 LIFE SAFTEY CODE STANDARD Smoking regulations are adopted by the administrations board and care occupancies. 1. What corrective action will be accomplished? · Staff and Program Coordinator will be retrained on smoking policy and protocol for all clients in the home. · Program Director will monitor and ensure that safety plans are reviewed with and training is documented for all staff at monthly staff meetings. 2. 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. · Staff and Program Coordinator will be retrained on smoking policy and protocol for all clients in the home. · Program Director will monitor and ensure that safety plans are reviewed with and training is documented for all staff at monthly staff meetings. 3. What measures will be put into place or what systemic</p>	08/12/2015

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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 S 14TH ST NEW CASTLE, IN 47362		
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K S152 Bldg. 01	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. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the		changes will be made to ensure that the deficient practice does not recur: · Staff and Program Coordinator will be retrained on smoking policy and protocol for all clients in the home. · Program Director will monitor and ensure that safety plans are reviewed with and training is documented for all staff at monthly staff meetings. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Staff and Program Coordinator will be retrained on smoking policy and protocol for all clients in the home. · Program Director will monitor and ensure that safety plans are reviewed with and training is documented for all staff at monthly staff meetings. 5. What is the date by which the systemic changes will be completed? 8/12/15		

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	<p>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 conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all clients.</p> <p>Findings include: Based on record review and interview of the fire drill reports titled "ISP Data Collection" on 07/13/15 at 12:30 p.m., the Program Coordinator acknowledged a first shift fire drill for the first quarter of 2015 was not conducted.</p>	K S152	<p>K0152 LIFE STAFEY CODE STANDARD The facility holds evacuation drills at least quarterly for each shift of staff and under varies conditions. 1. What corrective action will be accomplished? · Staff and Program Coordinator will be retrained on running monthly drills. · Program Director will monitor and ensure that drills are being run and documented appropriately, monthly. 2. 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. · Staff and Program Coordinator will be retrained on running monthly drills. · Program Director will monitor and ensure that drills are being run and documented appropriately, monthly. 3. What measures will be put into place or what</p>	08/12/2015	

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K S154 Bldg. 01	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 7 of 8 clients by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance</p>	K S154	<p>systemic changes will be made to ensure that the deficient practice does not recur: · Staff and Program Coordinator will be retrained on running monthly drills. · Program Director will monitor and ensure that drills are being run and documented appropriately, monthly. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Staff and Program Coordinator will be retrained on running monthly drills. · Program Director will monitor and ensure that drills are being run and documented appropriately, monthly. 5. What is the date by which the systemic changes will be completed? 8/12/15</p> <p>K0154 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24 hours period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided until</p>	08/12/2015

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	<p>with LSC, Section 9.7.6.1. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on record review process on 07/13/15 at 3:03 p.m., the Program Coordinator acknowledged the procedure did not indicate the individual conducting the fire watch shall be trained in the duties and responsibilities of a fire watch and the individual shall be assigned no other duties or responsibilities while conducting the fire watch.</p>		<p>the sprinkler is returned to service. 1. What corrective action will be accomplished? · Staff and Program Coordinator will be retrained on policy regarding procedures to be followed in the event that an automatic sprinkler system is out of service for more than 4 hours in a 24 hour period. · Program Director will monitor and ensure that training is completed and documented appropriately, with all new and existing staff. 2. 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. · Staff and Program Coordinator will be retrained on policy regarding procedures to be followed in the event that an automatic sprinkler system is out of service for more than 4 hours in a 24 hour period. · Program Director will monitor and ensure that training is completed and documented appropriately, with all new and existing staff. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Staff and Program Coordinator will be retrained on policy regarding procedures to be followed in the event that an automatic sprinkler system is out</p>		

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K S155 Bldg. 01	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to protect 7 of 8 clients by providing a written policy containing procedures to be followed in the event the fire alarm system has to be placed out	K S155	of service for more than 4 hours in a 24 hour period. . . Program Director will monitor and ensure that training is completed and documented appropriately, with all new and existing staff. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? . . Staff and Program Coordinator will be retrained on policy regarding procedures to be followed in the event that an automatic sprinkler system is out of service for more than 4 hours in a 24 hour period. . . Program Director will monitor and ensure that training is completed and documented appropriately, with all new and existing staff. 5. What is the date by which the systemic changes will be completed? 8/12/15 K0155 LIFE SAFTEY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24 hours period, the authority having jurisdiction shall be notified, and the building shall be evacuated or	08/12/2015

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	<p>of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on interview during the record review process on 07/13/15 at 3:03 p.m., the Program Coordinator acknowledged the procedure did not indicate the individual conducting the fire watch shall be trained in the duties and responsibilities of a fire watch and the individual shall be assigned no other duties or responsibilities while conducting the fire watch.</p>		<p>an approved fire watch system be provided until the system is returned to service. 1. What corrective action will be accomplished? · Staff and Program Coordinator will be retrained on policy regarding procedures to be followed in the event that the fire alarm system is out of service for more than 4 hours in a 24 hour period. · Program Director will monitor and ensure that training is completed and documented appropriately, with all new and existing staff. 2. 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. · Staff and Program Coordinator will be retrained on policy regarding procedures to be followed in the event that the fire alarm system is out of service for more than 4 hours in a 24 hour period. · Program Director will monitor and ensure that training is completed and documented appropriately, with all new and existing staff. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · Staff and Program Coordinator will be retrained on policy regarding procedures to be followed in the event that the fire alarm system is</p>	

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			<p>out of service for more than 4 hours in a 24 hour period. · Program Director will monitor and ensure that training is completed and documented appropriately, with all new and existing staff. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Staff and Program Coordinator will be retrained on policy regarding procedures to be followed in the event that the fire alarm system is out of service for more than 4 hours in a 24 hour period. · Program Director will monitor and ensure that training is completed and documented appropriately, with all new and existing staff. 5. What is the date by which the systemic changes will be completed? 8/12/15</p>		