

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G137	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2021
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP COD 8616 NORTHFIELD DR EVANSVILLE, IN 47713
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 07/14/21</p> <p>Facility Number: 000674 Provider Number: 15G137 AIM Number: 100234390</p> <p>At this Emergency Preparedness survey, Normal Life of Indiana was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 8 certified beds. At the time of this survey, the census was 8.</p> <p>Quality Review completed on 07/20/21</p>	E 0000		
E 0039 Bldg. --	<p>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)</p> <p>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).</p> <p>*[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]:</p>			

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 other safeguards 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 disclosed 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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	<p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>*[For Hospices at 418.113(d):]</p>			

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	<p>(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:</p> <p>(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.</p> <p>(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.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct 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</p>				

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	<p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual,</p>			

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	<p>facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires</p>				

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	<p>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.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the</p>			

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	<p>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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires 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</p>			
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	<p>onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(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, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or</p>			

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	<p>functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(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.</p> <p>(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</p>			

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	<p>needed.</p> <p>*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. 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 in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a</p>	E 0039	<p>To Correct tag E039</p> <p>Area Supervisor will be in-serviced on completing and documenting all quarterly tabletop exercises in lieu of a full-scale community based or facility-based functional exercise. The tabletop exercise led by an Area Supervisor that includes a group discussion with clients and staff assigning job responsibilities and using a narrated, clinically-relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan.</p> <p>Program will ensure through monthly visits to home that all Emergency Preparedness</p>	08/13/2021	

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K 0000 Bldg. 02	<p>facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency/Disaster Preparedness Manual on 07/14/21 between 10:15 a.m. and 11:45 a.m. with the Program Manager present, the facility provided emergency preparedness documentation, however it was incomplete. There was documentation provided of the facility's response to the COVID-19 Public Health Emergency, however, the facility was unable to provide documentation of an additional exercise to test the emergency preparedness plan. Based on interview at the time of record review, the Program Manager acknowledged she was unable to provide documentation of an additional exercise.</p> <p>This finding was reviewed with the Program Manager during the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p>	K 0000	<p>guidelines are completed, documented, and placed in the Emergency Preparedness Manual.</p> <p>Persons Responsible: Area Supervisor, Program Manager and Executive Director</p>	

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K S100 Bldg. 02	<p>Survey Date: 07/14/21</p> <p>Facility Number: 000674 Provider Number: 15G137 AIM Number: 100234390</p> <p>At this Life Safety Code survey, Normal Life of Indiana 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.</p> <p>This one story facility was not sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, sleeping rooms, and common living areas, plus heat detection in the attic connected to the fire alarm system. 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 0.32.</p> <p>Quality Review completed on 07/20/21</p> <p>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</p>			

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	<p>NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on record review, observation, and interview; the facility failed to ensure 2 of 2 interior emergency lights were tested, maintained, and the records of the testing maintained. LSC 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds.</p> <p>(2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction.</p> <p>(3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered.</p> <p>(4) The emergency lighting equipment shall be fully operational for the duration of the test.</p> <p>(5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction.</p> <p>This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on observations on 07/14/21 between 10:15 a.m. and 11:45 a.m. during a tour of the facility with the Program Manager, the facility had two battery powered emergency light units. Based on record review between 10:15 a.m. and 11:45 a.m., there was no documentation to show the battery powered emergency lights were tested for 30</p>	K S100	<p>To Correct tag K100 Residential Manager will be in-serviced on the importance of completing monthly Emergency Lighting test to include but not limited to a 90-minute annual test. Documentation of the start and end time of the 90min test must be place indicated on the Emergency Lighting Test form.</p> <p>Area Supervisor will monitor through weekly visits to ensure monthly Emergency Lighting test has been completed and that time has been documented for the 90 mins test.</p> <p>Program Manager will monitor through monthly visits to ensure monthly Emergency Lighting test has been completed and that time has been documented for the 90 mins test.</p> <p>Persons Responsible: Residential Manager, Area Supervisor and Program Manager</p>	08/13/2021	

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K S253 Bldg. 02	<p>seconds monthly during August, September, October, November, and December of 2020. Based on interview at the time of record review and observations, the Program Manager said there was no further documentation to show a 30 second monthly test during the months of August through December of 2020.</p> <p>This finding was reviewed with the Program Manager during the exit conference.</p> <p>NFPA 101 Number of Exits - Patient Sleeping and Non-SI Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Prompt) Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, each sleeping room shall have a second means of escape that consists of one of the following:</p> <ol style="list-style-type: none"> 1. It shall be a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape. 2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape. 3. It shall be an outside window or door operable from the inside without the use of 			

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	<p>tools, keys, or special effort that provides a clear opening of not less than 5.7 square feet. The width shall be not less than 20 inches. The height shall be not less than 24 inches. The bottom of the opening shall be not more than 44 inches above the floor. Such means of escape shall be acceptable where one of the following criteria are met:</p> <ol style="list-style-type: none"> a. The window shall be within 20 feet of finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an exterior balcony. <p>4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria:</p> <ol style="list-style-type: none"> a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following: <ol style="list-style-type: none"> 1. The ladder or steps do not extend more than 6 inches into the well. 2. The ladder or steps are not obstructed by the window. 5. If the sleeping room has a door leading directly to the outside of the building with access to finished ground level or to a stairway that meets the requirements of exterior stairs in 33.2.2.2.2, that means of escape shall be considered as meeting all the escape requirements for the sleeping room. 			

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	<p>a. A second means of escape from each sleeping room shall not be required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.</p> <p>b. Existing approved means of escape shall be permitted to continue to be used. 33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through 33.2.2.3.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 clients sleeping rooms were provided with a secondary means of escape in accordance with 33.2.2.3. LSC 33.2.2.3 requires a secondary egress from each sleeping room with multiple provisions. This deficient practice could affect 2 clients.</p> <p>Findings include:</p> <p>Based on observation on 07/14/21 at 11:30 a.m. during a tour of the facility with the Program Manager, bedroom #2 (second room on south side of house), there was no crank handle provided to open the window. Based on interview at the time of observation, this was acknowledged be the Program Manager.</p> <p>This finding was reviewed with the Program Manager during the exit conference.</p>	K S253	<p>Staff will be in-serviced on Fire and Safety Guidelines regarding an non-sprinkler home and the importance of making sure that all windows can be opened from the inside and to report all maintenance issues regarding windows and crank handle on windows to Area Supervisor immediately as a safety issue.</p> <p>Residential Manager will be in-serviced on Fire and Safety Guidelines regarding an non-sprinkler home and the importance of making sure that all windows can be opened from the inside and to report all maintenance issues regarding windows and crank handle on windows to Area Supervisor immediately as a safety issue.</p> <p>Area Supervisor will be in-serviced on Fire and Safety Guidelines regarding an non-sprinkler home and the importance of making sure that all windows can be opened from the inside and to report</p>	08/13/2021
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			<p>all maintenance issues regarding windows and crank handle on windows to ARAMARK immediately as a priority (P1) repair. Window crank handle was reported as urgent repair and has already been repaired WO#222021</p> <p>Area Supervisor will be in-serviced on Fire and Safety work orders sent to ARAMARK. Completion of priority Fire and Safety work orders are to be completed immediate (with-in 24hrs). If repairs are not completed Area Supervisor will contact the Program Manager to facilitate the repair. Residential Manager will ensure through daily observations in the home that all Fire and Safety policies are in place and that all repairs have been promptly completed. QIDP will ensure through weekly observations in the home that all Fire and Safety policies are in place and that all repairs have been promptly completed. Area Supervisor will ensure through weekly observations in the home that all Fire and Safety policies are in place and that all repairs have been promptly completed. Program Manager will ensure through monthly observations</p>	

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K S712 Bldg. 02	<p>NFPA 101 Fire Drills Fire Drills</p> <p>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:</p> <ul style="list-style-type: none"> 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. <p>2. The facility must:</p> <ul style="list-style-type: none"> 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. <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. 42 CFR 483.470(i)</p>		<p>in the home that all Fire and Safety policies are in place and that all repairs have been promptly completed.</p> <p>Person(s) Responsible: Staff, Residential Manager, QIDP, Area Supervisor and Program Manager.</p>		

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	<p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 1 of 3 shifts during 1 of 4 quarters during the past 12 months. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drill reports on 07/14/21 between 10:15 a.m. and 11:45 a.m. with the Program Manager present, there was no fire drill report available for the third shift (night) of the fourth quarter (October, November, and December) of 2020. Based on interview at the time of record review, the Program Manager confirmed the lack of a fire drill during the third shift of the fourth quarter of 2020.</p> <p>This finding was reviewed with the Program Manager during the exit conference.</p>	K S712	<p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions at least quarterly on each shift to familiarize staff and clients on establishing a routine. ResCare has a Fire Drill Policy and schedule in place that meets these requirements. All clients must actually evacuate the premises during at least 1 drill per shift(1st shift, 2nd shift& 3rd shift) per quarter to establish a familiar routine for clients to exit the premises in case of a real emergency.</p> <p>To correct K0712 Staff will be retrained on the importance of following the fire drill schedule and the importance of the proper evacuation and documentation each drill. Completed drills are to be faxed to the Area Supervisor and then placed in the fire drill book. A Minimum of 12 months of completed drills will always need to remain in the fire drill book. Residential Manager will be retrained on the importance of following the fire drill schedule and the importance of the proper evacuation and documentation each drill. Completed drills are to be</p>	08/13/2021

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			<p>faxed to the Area Supervisor and then placed in the fire drill book. A Minimum of 12 months of completed drills will always need to remain in the fire drill book.</p> <p>Residential Manager will ensure through daily visits that the fire drill schedule is being followed, that fire drills are completed and properly documented, faxed to the Area Supervisor and then placed in the fire drill book.</p> <p>QIDP will ensure through weekly visits that the fire drill schedule is being followed, that fire drills are completed and properly documented and then placed in the fire drill book.</p> <p>Area Supervisor will ensure through weekly visits that the fire drill schedule is being followed, that fire drills are completed and properly documented and then placed in the fire drill book.</p> <p>Program Manager will ensure through monthly visits that the fire drill schedule is being followed, that fire drills are completed and properly documented and then placed in the fire drill book.</p> <p>Persons Responsible: Residential Manager, QIDP, Area Supervisor and Program Manager.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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