STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING -- B. WING	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 04/18/23 Facility Number: 000840 Provider Number: 15G322 AIM Number: 100244010 At this Emergency Preparedness survey, REM Occazio LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 7. Quality Review completed on 04/18/23 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracy Price	Area Director	05/04/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct			

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	exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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	facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires			

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	activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual,			

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	facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.			

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	(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale 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 individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a	E 0039	**E039 EP Testing Requirements** The facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. **1. What corrective action will be accomplished?** · Table top exercise testing the EP plan will be conducted with direct support staff. · Community drill testing the EP plan will be conducted with direct support staff. **2. How will we identify other residents having the potential to be affected by the same**	05/18/2023

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	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; (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. Findings include: Based on review of "Emergency Preparedness - Response Plan" documentation dated May 2022 and "S.A.F.E. Program" documentation dated 08/05/22 with the Direct Services Provider (DSP) during record review from 11:00 a.m. to 12:30 p.m. on 04/18/23, documentation of a community based disaster drill within the most recent twelve month period was not available for review. Based on interview at the time of record review, the DSP agreed the facility is currently experiencing an actual natural emergency due to Covid-19 and Covid-19 policy and procedures currently in effect for the pandemic are stated in the emergency preparedness documentation but agreed the facility has not conducted a second community based disaster drill or conducted a tabletop exercise within the most recent twelve month period and agreed additional testing documentation was not available for review at the time of the survey. These findings were reviewed with the DSP during the exit conference.		**deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Supervisor provided with schedule of drills designed to test the EP plan. · Program Supervisor provided with drill form with guidance on conducting community drill. · Program Supervisor trained on conducting a community drill and a table top exercise with staff. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Director will review documentation of drills monthly to ensure schedule of drills has been followed. · Area Director will review documentation of drills monthly to ensure schedule of drills has been followed. **5. What is the date by which the systemic changes will be completed?** May 18. 2023	

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K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 04/18/23 Facility Number: 000840 Provider Number: 15G322 AIM Number: 100244010 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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a fire alarm system with manual fire alarm boxes, sprinkler system flow switches and alarms hard wired to the fire alarm system. The facility has interconnected smoke detectors powered from the building electrical system installed in corridors and in all common living areas. The facility has heat detection in the attic. The facility has a capacity of 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.2. Quality Review completed on 04/18/23	K 0000		

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K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, 14.2.1.2.1 states the requirements of Section 10.19 shall be applicable when a system is impaired. Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Alarm System Inspection" documentation dated 01/05/23 with the Direct Services Provider (DSP) during record review from 11:00 a.m. to 12:30 p.m. on 04/18/23, fire alarm system "Battery #2" was listed as "Fail" for the results of inspection and testing. Based on interview at the time of record review, the DSP stated to contact the Area Director for the facility for additional fire alarm system inspection documentation but agreed battery replacement documentation on or after 01/05/23 was not available for review at the time of the survey.	K S345	**KO345 Fire Alarm System – Testing and Maintenance** The facility failed to ensure 1 of 1 fire alarm systems was maintained. The facility failed to ensure all facility smoke detectors were within their listed and marked sensitivity. **1. What corrective action will be accomplished?** · Koorsen contacted to schedule deficiency listed on Annual fire alarm inspection. · Sensitivity test completed by Koorsen in January, 2022. Document placed in Safety book for review. **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	05/18/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 01 B. WING	04/18/2023

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	Based on observations with the Direct Services Provider (DSP) during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 04/18/23, two batteries were installed in the main fire alarm control panel located in the sprinkler riser room. 10/10/20 was written on one of the batteries and 11/08/20 was written on the second battery. This finding was reviewed with the DSP during the exit conference. 2. Based on record review and interview, the facility failed to ensure all facility smoke detectors were within their listed and marked sensitivity range. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the		same deficient practice. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Director will review inspection reports upon receipt to ensure all deficiencies listed on report is addressed. · Koorsen inspections will be forwarded to Program Supervisor upon receipt to be placed in safety book. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Area Director will review inspection reports and contact Koorsen to have deficiencies addressed. · Program Director will review safety book during documentation monthly reviews to ensure Koorsen inspections are available in the safety book. **5. What is the date by which the systemic changes will be completed?** May 18, 2023	

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	15G322	A. BUILDING 01 B. WING	04/18/2023

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	purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on record review with the Direct Services Provider (DSP) from 11:00 a.m. to 12:30 p.m. on 04/18/23, documentation of smoke detector sensitivity testing within the most recent two-year period was not available for review. Based on interview at the time of record review, the DSP stated to contact the Area Director for the facility for additional fire alarm system inspection documentation but agreed documentation of smoke detector sensitivity testing within the most recent two-year period was not available for review at the time of the survey. These findings were reviewed with the DSP during the exit conference.			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance			

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	15G322	A. BUILDING 01 B. WING	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

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	with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant			

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	15G322	A. BUILDING 01 B. WING	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, except as discussed in 14.2.1.1 and 14.2.1.4, an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch	K S353	**KO353 Sprinkler System – Maintenance and Testing** The facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping. **1. What corrective action will be accomplished?** · Koorsen contacted to schedule internal pipe inspections.	05/18/2023

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	line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler System Inspection" documentation dated 01/05/23 with the Direct Services Provider (DSP) during record review from 11:00 a.m. to 12:30 p.m. on 04/18/23, the facility's wet sprinkler system "needs a 5 year pipe internal" inspection. Based on interview at the time of record review, the DSP stated to contact the Area Director for the facility for additional sprinkler system inspection documentation but agreed documentation of an internal pipe inspection conducted within the most recent five year period was not available for review at the time of the survey. This finding was reviewed with the DSP during the exit conference.		**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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Supervisor will review inspections to ensure Koorsen is contacted regarding deficiencies listed on annual/quarterly reports. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Area Director will review Koorsen reports and coordinate scheduling to ensure deficiencies listed on reports are addressed. **5. What is the date by which the systemic changes will be completed?** May 18, 2023	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 01 B. WING	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

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	complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure electrical receptacles in 1 of 1 kitchens were properly wired and grounded in accordance with NFPA 70. LSC 33.2.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector.	K S511	**KO511 Utilities – Gas and Electric** The facility failed to ensure electrical receptacles in 1 of 1 kitchens were properly wired and grounded. The facility failed to ensure 1 of 1 extension cords including power strips were not uses as a substitute for fixed wiring. **1. What corrective action will be accomplished?** · Maintenance company contacted to have wiring issue addressed. · Power strips removed from home. **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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Supervisor will	05/18/2023

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	15G322	A. BUILDING 01 B. WING	04/18/2023

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	The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect all clients and staff. Findings include: Based on observations with the Direct Services Provider (DSP) during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 04/18/23, the two-wall mounted electrical receptacles in the outlet box nearest the stove in the kitchen were found to have been wired with as "hot neutral" when tested with an Ideal Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the DSP agreed the testing device showed the aforementioned electrical receptacles needed repair. This finding was reviewed with the DSP during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring according to 33.2.5.1. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect two clients and staff in the southwest bedroom. Findings include:		check for environmental hazards during weekly observations. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Area Director will check for environmental hazards during monthly observations. **5. What is the date by which the systemic changes will be completed?** May 18, 2023	

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	15G322	A. BUILDING 01 B. WING	04/18/2023

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	Based on observations with the Direct Services Provider (DSP) during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 04/18/23, a refrigerator and an operating portable space heater with a temperature gauge reaching 120 degrees Fahrenheit was plugged into a power strip on the floor near the bed nearest the corridor door in the southwest bedroom. Based on interview at the time of the observations, the DSP agreed a power strip was being used as a substitute for fixed wiring in the southwest bedroom. This finding was reviewed with the DSP during the exit conference.			
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified			

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	15G322	A. BUILDING 01 B. WING	04/18/2023

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	under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct fire drills under varied conditions on the third shift for 3 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Direct Services Provider (DSP) during record review from 11:00 a.m. to 12:30 p.m. on 04/18/23, three of four third shift fire drills conducted within the most recent twelve month period on 06/11/22, 09/16/22 and 12/07/22 were conducted at, respectively, 2:30 a.m., 3:05 a.m. and 2:30 a.m. Based on interview at the time of record review, the DSP stated the facility operates three shifts per day and agreed the aforementioned third shift fire drills were not conducted under varied conditions.	K S712	**KO712 Fire Drills** The facility failed to conduct fire drills under varied conditions on the third shift for 3 of 4 quarters. **1. What corrective action will be accomplished?** · Retraining with Program Supervisor on regulations for conducting fire drills. **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. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Program Supervisor provided with drill schedule for year. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Program Director will review	05/18/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 01 B. WING	04/18/2023

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REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

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			drills monthly to ensure that are in compliance with regulations. **5. What is the date by which the systemic changes will be completed?** · May 18, 2023	
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on record review, observation and interview; the facility failed to provide a smoking policy for a facility allowing client smoking. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Direct Services Provider (DSP) from 11:00 a.m. to 12:30 p.m. on 04/18/23, documentation of a facility smoking policy for client smoking was not available for review. Based on interview at the time of record review, the DSP stated one client, EM, smokes occasionally, the facility has a smoking policy but agreed the smoking policy was not available for review at the time of the survey. Based on observations with the DSP during a tour of the facility from 12:30 p.m. to 12:50 p.m. on 04/18/23, smoking is permitted outside the facility near the front door with noncombustible safety type ashtrays or receptacles provided at this location	K S741	**KO741 Smoking Regulations** The facility to provide a smoking policy for a facility allowing client smoking. **1. What corrective action will be accomplished?** · Smoking Policy will be placed in safety book for review. **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. **3. What measures will be put into place or what systemic**	05/18/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING 01 B. WING	04/18/2023

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REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

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	where client smoking is allowed. This finding was reviewed with the DSP during the exit conference.		**changes will be made to ensure that the deficient practice does not recur:** · Program Director will review documents in Safety Book during monthly documentation review to ensure all documents are available. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Area Director will review documents in Safety Book during quarterly documentation review to ensure all documents are available. **5. What is the date by which the systemic changes will be completed?** May 18, 2023	