

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

PRINTED: 08/15/2022

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2022
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP COD 112 E WESTMORELAND KOKOMO, IN 46901
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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: 07/28/22</p> <p>Facility Number: 012527 Provider Number: 15G802 AIM Number: 201024860</p> <p>At this Emergency Preparedness survey, Bona Vista Programs Inc was found 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 the survey, the census was 8.</p> <p>Quality Review completed on 08/01/22</p>	E 0000		
K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 07/28/22</p> <p>Facility Number: 012527 Provider Number: 15G802 AIM Number: 201024860</p> <p>At this Life Safety Code survey, Bona Vista Programs Inc. was found not in compliance with Requirements for Participation in Medicaid, 42</p>	K 0000		

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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K S222 Bldg. 01	<p>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 fully sprinklered with a basement. The facility has a fire alarm system with smoke detection on all levels in the corridors, common living areas and hard wired smoke detectors in the client sleeping rooms. The attic was not used for living purposes, storage or fuel-fired equipment and was provided with a heat detection system to activate 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 .5</p> <p>Quality Review completed on 08/01/22</p> <p>NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with</p>			

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	<p>7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5.</p> <p>Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited.</p> <p>Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 exterior exit doors and 1 of 1 Staff office doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on a facility tour and interview with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present on 07/28/22 between 1:50 p.m. and 2:45 p.m., the (1) front door required a number code to disengage a</p>	K S222	<p>Corrective action (K-S222) Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Bona Vista Director of Program Compliance communicated deficiencies to the Director of facilities. The office door will be completed on 8/12/22. The other two doors in question have human rights committee (HRC) approval to have the additional locks which have been in place since 2017 as a result of client behaviors and elopement risks. All staff working in the home have the combinations and are able to open them quickly in an emergent situation. Information on HRC is included with this plan of corrections.</p> <p>Describe how the facility reviewed</p>	08/31/2022

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K S345 Bldg. 01	<p>slide bolt to open the door. (2) the gate exiting the rear of the home into the driveway required a number code to disengage a slide bolt to open the door. Additionally, (3) The Staff office door had a deadbolt and a knob lock. All 3 doors/gate required more than one releasing operation to open the doors. The Director of Program Compliance stated she believed the facility had some sort of waiver due to behavioral issues for the door arrangements. The Director of Program Compliance did produce documentation on her phone but this surveyor was unfamiliar with the documentation and it's application to life safety.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present.</p> <p>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.</p>		<p>all clients in the facility that could be affected by the same deficiency and state what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>The facility will replace the locking mechanism on the office door to create a single releasing mechanism.</p> <p>Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include:</p> <p>The Quality Assurance Coordinator will check for HRC approval letter for the front door and the gate and will ensure all other doors have a single latching mechanism during her quarterly PSR's.</p>	

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	<p>Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present on 07/28/22 between 12:30 p.m. and 1:50 p.m., no documentation was available for review to show if the smoke detector sensitivity had been tested within the last two years. Additionally, no documentation was available for review to indicate if the sensitivity testing had occurred prior to January 2020 and the beginning of the COVID -19 Pandemic.</p> <p>This finding was acknowledged at the time of Discovery and again at the exit conference with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and</p>	K S345	<p>Corrective Action (K-S345) Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Director of program compliance communicated with Director of Maintenance to follow up with Brenneco to obtain the missing documentation.</p> <p>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made.</p> <p>Maintenance will continue to schedule inspections with Brenneco and will schedule repairs for any failed devices.</p> <p>Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include: The Quality Assurance Coordinator will monitor the Brenneco folder to ensure all documents are present and that there are no failed devices during her quarterly PSR's.</p>	08/31/2022

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	<p>Corporate Maintenance Coordinator present.</p> <p>2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:</p> <ul style="list-style-type: none"> a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices <p>This deficient practice could affect all building occupants.</p> <p>Findings include:</p> <p>Based on record review and interview with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present on 07/28/22 between 12:30 p.m. and 1:50 p.m., no documentation was provided regarding a visual inspection of the fire alarm system six months before or following the annual fire alarm inspection conducted on 01/25/22. Additionally, no documentation was available for review to indicate if the semi-annual visual fire alarm inspections had been occurring prior to January 2020 and the beginning of the COVID -19 Pandemic.</p> <p>This finding was acknowledged at the time of</p>		="" span="">	

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K S346 Bldg. 01	<p>Discovery and again at the exit conference with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present.</p> <p>NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four 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. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present on 07/28/22 between 12:30 p.m. and 1:50 p.m., the fire watch plan provided for review failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the</p>	K S346	<p>Corrective action (K-S346) Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Bona Vista Regional Vice President of Programs and Services communicated with Safety Director to update the EPP fire watch policy to include who would be responsible for contacting the gateway. Bona Vista Director of Program Compliance will update the EPP to reflect the added policy.</p> <p>Describe how the facility reviewed all clients in the facility that could be affected by the same deficiency and state what actions the facility took to correct the</p>	08/31/2022	

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	<p>Incident Reporting form and e-mailing it to incidents@isdh.in.gov.</p> <p>Based on interview during the record review, the Director of Program Compliance acknowledged the fire watch documentation provided was incomplete.</p> <p>This finding was acknowledged at the time of Discovery and again at the exit conference with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present.</p>		<p>deficient practice for any client the facility identified as being affected.</p> <p>The facility reviewed all clients, not only in this home but others, to ensure that the emergency preparedness plan is updated to reflect the added policy in each location.</p> <p>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made.</p> <p>The EPP will be updated and all staff will be trained annually on the EPP during annual agency training.</p> <p>Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include:</p> <p>The Quality Assurance Coordinator will monitor the Life Safety Manual to ensure that the EPP is updated during her quarterly PSR's. The House Managers will ensure that staff are trained annually.</p>	

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K S354 Bldg. 01	<p>NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 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.</p> <p>33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p>	K S354	<p>Corrective action (K-S354) Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Bona Vista Director of Program Compliance updated the document to reflect the deficiency.</p> <p>====> ====> ====> ====> ====></p> <p>/p> Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>The facility reviewed all clients, not only in this home but others, to</p>	08/31/2022	

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K S511 Bldg. 01	<p>Based on record review and interview with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present on 07/28/22 between 12:30 p.m. and 1:50 p.m., the fire watch plan provided for review failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov.</p> <p>Based on interview during the record review, the Director of Program Compliance acknowledged the fire watch documentation provided was incomplete.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present.</p>		<p>ensure that this section will be updated in all individual house plans.</p> <p>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>/p> ="" span=""> /p> Updated document in the Life Safety Emergency Plan. Describe how the corrective action will be monitors to ensure the deficient practice will not recur, IE what quality assurance program will be put into place The Quality Assurance coordinator will monitor the life safety manual during her quarterly PSRs</p> <p>/p> ="" span=""> /p> ="" span=""> ="" span=""> /p> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""></p>	

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	<p>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code.</p> <p>32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring according to 33.2.5.1. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. 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 all occupants.</p> <p>Findings include:</p> <p>Based on a facility tour and interview with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present on 07/28/22 between 1:50 p.m. and 2:45 p.m., (1) in the consumer sleeping room to the right of the restroom an extension cord was in use powering electronic equipment and partially concealed in plastic snap together conduit. Based on interview at the time of observation, the Director of Program Compliance agreed the extension cord was in use. Additionally, (2) in the consumer sleeping room nearest the basement restroom, electrical equipment including a phone and a charging device was plugged into and powered by a multi-plug adaptor. Based on interview at the time of observation, the Director of Program Compliance agreed the multi-plug adaptor was in use.</p>	K S511	<p>Corrective Action (K-S511)</p> <p>Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Bona Vista Director of Program Compliance consulted with House Manager to discuss the extension cord concerns. Bona Vista Quality Assurance Coordinator contacted the Bona Vista Maintenance team to remove the extension cords.</p> <p>/p> ="" span=""> ="" span=""></p> <p>Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>Maintenance removed the extension cords.</p> <p>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made.</p> <p>Maintenance removed the extension cords.</p> <p>="" span=""></p>	08/31/2022

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(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
K S712 Bldg. 01	<p>This finding was acknowledged at the time of discovery and again at the exit conference with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present.</p> <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.</p>		Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include: The Quality Assurance Coordinator will monitor the use of extension cords during her quarterly PSRs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2022
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	<p>42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct 3 of 12 quarterly shift fire drills in accordance with 42 CFR 483.470(i), which states the following: (1) The facility must hold 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 fire protection features. Or, per 2019 Novel Coronavirus Disease (COVID-19) 1135 Waiver allowances, a documented orientation training program related to the current fire plan, which considers current facility conditions. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on record review and interview with the Director of Program Compliance, Quality Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present on 07/28/22 between 12:30 p.m. and 1:50 p.m., the facility could not provide fire drills or allowed training documentation for the 1st shift during the first and Third quarters of 2022 or 2021, or the 2nd shift during the second quarter of 2022. Based on interview at the time of record review, the Director of Program Compliance agreed the drills or training for the periods previously mentioned were not conducted and stated it appeared someone conducted the missing drills to early.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Director of Program Compliance, Quality</p>	K S712	<p>Corrective action (KS712) Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>Bona Vista reviewed the schedule for the Fire Drills to ensure that these are scheduled one per shift per quarter.</p> <p>Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>In-service training on how to conduct fire drills. In-service training on the importance of fire drills.</p> <p>Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>The House Manager will ensure that Fire Drills have been conducted each month on the appropriate shift, with the appropriate documentation,</p>	08/31/2022

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

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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/28/2022
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	Assurance Coordinator, Maintenance and Corporate Maintenance Coordinator present.		through quarterly audits in the home.		