STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G353	A. BUILDING -- B. WING	08/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	1012 PARKWAY DR ANDERSON, IN 46012

(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 State Department of Health in accordance with 42 CFR 483.475. Survey Date: 08/06/18 Facility Number: 000869 Provider Number: 15G353 AIM Number: 100244230 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 08/09/18 - DA The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0026 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants.	E 0026	**E0026 Roles Under a Waiver Declared by Secretary.** The facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care	09/05/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Findings include: Based on record review with the Program Supervisor on 08/06/18 between 12:00 p.m. and 11:30 p.m., no policies and procedures which include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was available for review. Based on interview at the time of record review, the Program Supervisor confirmed no such documentation was available for review.		and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475 (b) (8). **1.What corrective action will be accomplished?** ·IN Mentor will apply for the waiver in accordance with section 1135 of the Act in accordance with 42 CFR 483.475 (b) (8). ·Once received a copy of the waiver will be available at the site for review. **1.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. ·IN Mentor will apply for the waiver in accordance with section 1135 of the Act in accordance with 42 CFR 483.475 (b) (8). ·Once received a copy of the waiver will be available at the site for review. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·IN Mentor will apply for the waiver in accordance with section	

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			1135 of the Act in accordance with 42 CFR 483.475 (b) (8). ·Once received a copy of the waiver will be available at the site for review. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·The waiver will be applied for and renewed as indicated. ·The Program Supervisor will ensure that the waiver is available in the safety book for review. **1.What is the date by which the systemic changes will be completed?** September 5th, 2018	
E 0030 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c) (1). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Supervisor on 08/06/18 between 12:00 p.m. and 11:30 p.m., no policies and procedures which include the names and contact information for	E 0030	**E0030 Names and Contact Information** The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: Names and contact information for the following: (i.) Staff (ii.) Entities providing services under arrangement (iii.) Patients' physicians (iv.) other facilities (v.) Volunteers.	09/05/2018

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	staff were available for review. Based on interview at the time of record review, the Program Supervisor confirmed no such documentation was available for review.		**1.What corrective action will be accomplished?** ·Information for the property manager will be included. ·Information regarding community volunteers will be included. ·Client physician information will be updated on their face sheets and attached to the Emergency Preparedness Plan. ·A meeting will be requested with the local emergency management officials to discuss their participation in the Emergency Preparedness Plan. **1.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. ·Information for the property manager will be included. ·Information regarding community volunteers will be included. ·Client physician information will be updated on their face sheets and attached to the Emergency Preparedness Plan. ·A meeting will be requested with the local emergency management officials to discuss their participation in the Emergency Preparedness Plan.	

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			1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: ·Information for the property manager will be included. ·Information regarding community volunteers will be included. ·Client physician information will be updated on their face sheets and attached to the Emergency Preparedness Plan. ·A meeting will be requested with the local emergency management officials to discuss their participation in the Emergency Preparedness Plan. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·The Emergency Preparedness Plan will be updated to include additional contact numbers by the Area Director. ·The Emergency Preparedness Plan will be updated to include the determined involvement by the local emergency management officials. · The Program Supervisor and Program Director will update the client face sheets to include contact information for physicians. ·The Program Supervisor will	

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			ensure that the Emergency Preparedness plan and the client face sheets are available in the safety book for review. **1.What is the date by which the systemic changes will be completed?** September 5th, 2018	
E 0035 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Supervisor on 08/06/18 between 12:00 p.m. and 11:30 p.m., the facility was unable to provide documentation for a communication plan which includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives. Based on interview at the time of record review, the Program Supervisor confirmed no documentation was available for review.	E 0035	**E0035 LTC and ICF/IID Sharing Plan with Patients CFR (s)** The facility must ensure a communication plan includes the following: a method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents and their families or representatives. **1.What corrective action will be accomplished?** ·A consumer meeting will be conducted to review the emergency plan with the individuals living in the home. ·The Emergency Preparedness Plan will be shared with the client identified guardians or representatives. ·A meeting will be requested with the local emergency management officials to discuss their participation in the Emergency Preparedness Plan.	09/05/2018

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			1.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. ·A client meeting will be conducted to review the emergency plan with the individuals living in the home. ·The Emergency Preparedness Plan will be shared with the client identified guardians or representatives. ·A meeting will be requested with the local emergency management officials to discuss their participation in the Emergency Preparedness Plan. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·A client meeting will be conducted to review the emergency plan with the individuals living in the home. ·The Emergency Preparedness Plan will be shared with the client identified guardians or representatives. ·A meeting will be requested with the local emergency management officials to discuss their participation in the	

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			Emergency Preparedness Plan. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·The Emergency Preparedness Plan will be shared with families. ·The Program Supervisor will review the Emergency Preparedness Plan with the individuals in their monthly consumer meetings. ·The Emergency Preparedness Plan will be updated to include the determined involvement by the local emergency management officials. ·A copy of the Emergency Preparedness Plan will be shared with the local emergency management officials. **1.What is the date by which the systemic changes will be completed?** ·September 5th, 2018	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills 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	E 0039	**E0039 EP Testing Requirements** The facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. **1.What corrective action will be accomplished?**	09/05/2018

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	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 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 record review with the Program Supervisor on 08/06/18 between 12:00 p.m. and 11:30 p.m., no documentation was available for any community based exercises. Based on interview at the time of record review, the Program Supervisor confirmed that no community based exercises documentation was available for review.		·A meeting will be requested with the local emergency management officials to discuss their participation in the Emergency Preparedness Plan and the possibility of conducting a community based emergency drill. ·A facility based drill will be conducted at our day service building in Anderson. **1.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. ·A meeting will be requested with the local emergency management officials to discuss their participation in the Emergency Preparedness Plan and the possibility of conducting a community based emergency drill. ·A facility based drill will be conducted at our day service building in Anderson. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·A meeting will be requested with the local emergency management officials to discuss their participation in the	

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			Emergency Preparedness Plan and the possibility of conducting a community based emergency drill. ·A facility based drill will be conducted at our day service building in Anderson. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·The Program Supervisor and Program Director will ensure a facility based drill is conducted. ·The Program Supervisor will ensure that conducted drills are located in the safety book. **1.What is the date by which the systemic changes will be completed?** September 5th, 2018	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/06/18 Facility Number: 000869 Provider Number: 15G353 AIM Number: 100244230 At this Life Safety Code survey, Rem-Occazio Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR subpart 483.470(j), Life Safety from Fire, and the 2012	K 0000		

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	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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and none in resident sleeping rooms. 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 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.32. Quality review completed on 08/09/18 - DA			
K S222 Bldg. 01	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 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. Door-latching devices shall comply with			

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	7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. 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) Based on observation and interview, the facility failed to ensure 1 of 3 exterior exit 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. This deficient practice could affect all occupants in the facility. Findings include: Based on observation on 08/06/18 from 1:20 p.m. to 1:30 p.m. during a tour of the facility with the Program Supervisor the rear entrance/exit door near the dining room was equipped with two latching devices, a regular door handle and a separate deadbolt lock. Based on interview at the same time as observation the Program Supervisor agreed there is a deadbolt lock on the door.	K S222	**K0222 Egress Doors** The facility failed to ensure 1 of 3 exterior exit doors were provided with only one latching mechanism to release the door and open. **1.What corrective action will be accomplished?** ·The locking mechanism on the back door will be replaced to a single latching mechanism. **1.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. ·The locking mechanism on the back door will be replaced to a single latching mechanism. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·The locking mechanism on the	09/05/2018

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			back door will be replaced to a single latching mechanism. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·The Program Supervisor will monitor for environmental and maintenance needs. ·The Program Supervisor will arrange for identified environmental and maintenance needs to be addressed. **1.What is the date by which the systemic changes will be completed?** ·September 5th, 2018	
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 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			

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	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 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,			

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	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			
	1. Based on record review, observation and interview, the facility failed to document monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states an inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. This deficient practice could affect all clients in the facility. Findings include: Based on record review with the Program Supervisor on 08/06/18 from 12:30 p.m. to 1:20 p.m.	K S353	**K0353** The facility failed to document monthly sprinkler system inspection in accordance with NFPA 25. **1.What corrective action will be accomplished?** ·Training with staff will be completed regarding documentation of the monthly sprinkler system including the pressure gauge readings. ·Staff will document the pressure gauge readings on the fire suppression equipment checklist. ·A quarterly sprinkler inspection will be scheduled with Koorsens. ·Koorsens will be requested to complete quarterly sprinkler inspections moving forward. ·Training will be completed with the Program Coordinator and Program Director to review the expectations regarding signing off	09/05/2018

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	15G353	A. BUILDING 01 B. WING	08/06/2018

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	there was no documentation to be reviewed for the monthly gauge and control valve inspections. Based on interview at the same time as record review the Program Supervisor agreed there was no documentation available of the inspections. 2. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records on 08/06/18 from 12:30 p.m. to		on the sprinkler riser gauges monthly. . **1.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. ·Training with staff will be completed regarding documentation of the monthly sprinkler system including the pressure gauge readings. ·Staff will document the pressure gauge readings on the fire suppression equipment checklist. ·A quarterly sprinkler inspection will be scheduled with Koorsens. ·Koorsens will be requested to complete quarterly sprinkler inspections moving forward. ·Training will be completed with the Program Coordinator and Program Director to review the expectations regarding signing off on the sprinkler riser gauges monthly. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

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	1:20 p.m. with the Program Supervisor, there was no quarterly sprinkler system inspection report available for the second quarter (April-June) of 2018 or the third quarter (July-September) or fourth quarter (October-December) of 2017. During an interview at the time of record review, the Program Supervisor agreed there was no written documentation available to show the sprinkler system had been inspected during the second quarter of 2018 or the third and fourth quarter of 2017.		·Training with staff will be completed regarding documentation of the monthly sprinkler system including the pressure gauge readings. ·Staff will document the pressure gauge readings on the fire suppression equipment checklist. ·A quarterly sprinkler inspection will be scheduled with Koorsens. ·Koorsens will be requested to complete quarterly sprinkler inspections moving forward. ·Training will be completed with the Program Coordinator and Program Director to review the expectations regarding signing off on the sprinkler riser gauges monthly. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·The Program Supervisor and Program Director will review the monthly fire drills and fire suppression equipment checklist to ensure staff documentation. ·The Program Coordinator will ensure that the inspections are completed. ·Koorsen's Fire and Security will monitor. ·The Program Coordinator and/or Program Director will complete quarterly health and safety forms that monitor the safety needs of	

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			the home. **1.What is the date by which the systemic changes will be completed?** ·September 5th, 2018	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping 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 Based on observation and interview, the facility failed to ensure 3 of 3 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. Findings include: Based on observation with the Program Supervisor during a tour of the facility on 08/06/18 from 1:20 p.m. to 1:30 p.m. an extension cord was found plugged into the outlet powering a fan in bedroom #1. Based on interview at the same time as observation the Program Supervisor agreed the fan was plugged into an extension cord.	K S511	**K0511 Utilities- Gas and Electric** The facility failed to ensure 3 of 3 flexible cords was not used as a substitute for fixed wiring according to 33.2.5.1. **1.What corrective action will be accomplished?** ·The extension cords have been removed from use. ·Training with staff regarding the use of extension cords will be reviewed at the next team meeting. ·The removal from use of extension cords will be reviewed with the clients in the home at their next consumer meeting. **1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	09/05/2018

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			·All residents have the potential to be affected by the same deficient practice. ·The extension cords have been removed from use. ·Training with staff regarding the use of extension cords will be reviewed at the next team meeting. ·The removal from use of extension cords will be reviewed with the clients in the home at their next consumer meeting. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·The extension cords have been removed from use. ·Training with staff regarding the use of extension cords will be reviewed at the next team meeting. ·The removal from use of extension cords will be reviewed with the clients in the home at their next consumer meeting. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·The Program Supervisor will monitor to ensure the removal of extension cords.	

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			·The Program Coordinator and/or Program Director will complete quarterly health and safety forms that monitor the safety needs of the home. **1.What is the date by which the systemic changes will be completed?** ·September 5th, 2018	
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 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.			

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	42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 3 of the last 4 calendar quarters. This deficient practice could affect all clients. Findings include: Based on record review of the "Fire Drill Report" with the Program Supervisor on 08/06/18 from12:30 p.m. to 1:20 p.m., documentation of a first shift fire drill for the second quarter of 2018 (April-June) a first and second shift fire drill for the third quarter of 2017 (July-September) and a third shift fire drill for the fourth quarter (October-December) of 2017 was not available for review. Based on an interview at the same time of record review, the Program Supervisor agreed there was no documentation available to review for the above missing fire drills.	K S712	**K 0712 NFPA 101 Fire Drills** The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions. **1.What corrective action will be accomplished?** ·Additional drills for each shift of personnel will be completed (1st, 2nd and 3rd shift drills). ·A schedule identifying when each emergency drill should be ran has been implemented. ·The Program Coordinator will receive training on the emergency drill tracking. ·The importance of ensuring emergency drills are ran each month for the appropriate time period will be reviewed with staff. **1.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. ·A schedule identifying when each emergency drill should be ran has been implemented. ·The Program Coordinator will receive training on the emergency drill tracking. ·The importance of ensuring emergency drills are ran each month for the appropriate time	09/05/2018

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			period will be reviewed with staff. ·The Program Director will monitor the emergency drills monthly. ·Quarterly Health and Safety assessments will be completed. The assessment includes ensuring evacuation drills are completed as scheduled. **1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** ·A schedule identifying when each emergency drill should be ran has been implemented. ·The Program Coordinator will receive training on the emergency drill tracking. ·The importance of ensuring emergency drills are ran each month for the appropriate time period will be reviewed with staff. ·The Program Director will monitor the emergency drills monthly. ·Quarterly Health and Safety assessments will be completed. The assessment includes ensuring evacuation drills are completed as scheduled. **1.How will the corrective action be monitored to ensure the deficient practice will not recur?** ·The Program Coordinator will	

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			monitor monthly and after each drill is to be ran to ensure completion. ·The Program Director will monitor on a monthly basis and during monthly supervisory visits. ·The Quality Assurance Specialist will monitor as the quarterly health and safety assessments are completed. **1.What is the date by which the systemic changes will be completed?** September 5th, 2018	