

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

PRINTED: 05/21/2020

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G184		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 02/10/2020	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 1818 H ST BEDFORD, IN 47421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 02/10/20</p> <p>Facility Number: 000717 Provider Number: 15G184 AIM Number: 100234700</p> <p>At this Emergency Preparedness survey, Res Care Community Alt Se was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475.</p> <p>The facility has 8 certified beds. At the time of the survey, the census was 8.</p> <p>Quality Review completed on 02/17/20</p>			E 0000			
E 0039  Bldg. --	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements</p> <p>*[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p>						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 disclosable 30 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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

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

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

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

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

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	<p>exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is</p>			E 0039	<p>Residential Manager will conduct a full scale exercise, and conduct second tabletop exercise to be in compliance. Residential Manager and Area Supervisor will be trained on conducting the emergency exercises twice per year.</p> <p>Program manager will review schedule and after first exercise has been conducted ensure schedule date for second exercise to ensure compliance</p> <p>Persons Responsible: Residential Manager, Area Supervisor, Program Manager</p>		03/23/2020



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K 0000  Bldg. 01	<p>community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants</p> <p>Findings include:</p> <p>Based on record review and interview on 02/11/20 at 12:42 p.m., the Residential Manager stated the facility participated in and provided documentation for a tabletop exercise on 01/16/20. The Residential Manager stated the facility did not participate in any other exercise within the most recent twelve month period.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 02/10/20</p> <p>Facility Number: 000717 Provider Number: 15G184 AIM Number: 100234700</p> <p>At this Life Safety Code survey, Res Care</p>			K 0000			

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K S331  Bldg. 01	<p>Community Alternatives SE IN was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This two story facility with a basement was not sprinkled. This facility has a fire alarm system with smoke detection on all levels including the corridors, common living areas, basement and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.4.</p> <p>Quality Review completed on 02/17/20</p> <p>NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING (Prompt) Interior wall and ceiling finish in accordance with section 10.2. In Prompt Evacuation Capability facilities, Class A, Class B, or Class C is permitted. There are no requirements for interior floor finish. 33.2.3.3, 33.2.3.3.3 Based on observation and interview, the facility failed to ensure the interior finish in the entryway of the stairwell was rated Class A, Class B or Class C for a Prompt rated facility. This deficient practice could affect all occupants.</p> <p>Findings include:</p>			K S331	Maintenance provide will be contacted to complete any finish repairs needed to ensure paneling in entryway has appropriate rating. Residential Manager will keep documentation of materials used to cover paneling to provide		03/16/2020

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K S345  Bldg. 01	<p>Based on observation with the Residential Manager on 2/10/2020 at 12:28 p.m., the stairwell in the entryway was covered with wood paneling. Based on an interview at the time of observation, the Residential Manager stated she thought they treated the wood paneling but was unable to locate documentation to confirm the wood paneled stairwell was treated to provide a flame spread rating of a Class A, Class B or Class C interior finish.</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. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure the smoke detectors in 1 of 1 fire alarm systems 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</p>			K S345	<p>on site when needed. Area Supervisor and Residential Manager will be trained in keeping documentation of when such instances occur and to retain that information in the Emergency Plan book for future review. Program Manager will review Emergency Plan book to ensure information is available one time per quarter</p> <p>Persons Responsible: Residential Manager, Area Supervisor, Program Manager</p>		03/16/2020

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	<p>1 year of installation, and 14.4.5.3.2 states 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:</p> <p>(1) Calibrated test method.</p> <p>(2) Manufacturer's calibrated sensitivity test instrument.</p> <p>(3) Listed control equipment arranged for the purpose.</p> <p>(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.</p> <p>(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.</p> <p>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.</p> <p>Findings include:</p> <p>Based on record review with the Residential Manager on 02/10/20 at 11:31 a.m., documentation of a smoke detector sensitivity testing within the</p>				<p>contracted provider quarterly to ensure documentation of services are provided in Emergency Plan book</p> <p>Persons Responsible:Residential Manager, Area Supervisor, Program Manager</p>		

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OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G184		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 02/10/2020	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1818 H ST BEDFORD, IN 47421			
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K S346  Bldg. 01	<p>most recent two year period was not available for review. Based on an interview at the time of record review, the Residential Manager stated a recent sensitivity testing had not be completed on the smoke detectors in the home.</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 written fire watch policy for when the fire alarm system is out of service for more than 4 hours in a 24-hour period. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview on 02/10/20 at 12:01 p.m., the Residential Manager agreed the facility's fire watch policy documentation failed to state the person conducting the fire watch shall be properly trained in the duties and responsibilities of a fire watch.</p>			K S346	<p>Fire watch policy will state person conducting fire watch with be properly trained in the fire watch procedure. Residential Manager, Area Supervisor and Residential staff will be trained in conducting a fire watch based on this updated information. Program Manager will review Emergency Plan book quarterly to ensure needed documentation is available for review Persons Responsible: Residential Manager, Area Supervisor, Program Manager</p>		03/16/2020
K S363  Bldg. 01	<p>NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements:</p>						

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K S712  Bldg. 01	<p>1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed.</p> <p>2. No doors shall be arranged to prevent the occupant from closing the door.</p> <p>3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 first floor client sleeping room doors would close completely and latch automatically into the door frame. This deficient practice could affect at least 1 client.</p> <p>Findings include:</p> <p>Based on observation and interview on 02/10/20 at 12:46 p.m., the Residential Manager acknowledged the door to sleeping room near the kitchen did self close but failed to latch in the door frame when tested several times.</p> <p>NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and</p>			K S363	<p>Maintenance company will be contacted to adjust door to ensure it completely latches when closure is activated, Residential Manager and staff will be trained to check door closures monthly after practice fire drills to ensure latches are working as they should and contacting maintenance provider if not working. Documentation of this check will be kept in Emergency Plan book for future reference. Program Manager will review plan book quarterly to ensure documentation is available</p> <p>Persons Responsible: Residential Manager, Area Supervisor, Program Manager</p>		03/16/2020

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	<p>under varied conditions to:</p> <ul style="list-style-type: none"> <li>a. Ensure that all personnel on all shifts are trained to perform assigned tasks;</li> <li>b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</li> </ul> <p>2. The facility must:</p> <ul style="list-style-type: none"> <li>a. Actually evacuate clients during at least one drill each year on each shift;</li> <li>b. Make special provisions for the evacuation of clients with physical disabilities;</li> <li>c. File a report and evaluation on each drill;</li> <li>d. Investigate all problems with evacuation drills, including accidents and take corrective action; and</li> <li>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.</li> </ul> <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> <p>42 CFR 483.470(i)</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted at varying times for 4 of 4 quarters. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of "Emergency Evacuation Drills" documentation with the Residential Manager on 02/10/20 at 11:19 a.m., all first shift fire drills were conducted between 7:00 a.m. and 7:57 a.m. and all third shift fire drill were conducted between 3:00 a.m. and 3:00 a.m. for four of the last four calendar quarters. Based on interview at the time of record review, the</p>			K S712	<p>Residential staff will be trained on conducting fire drills based on appropriate times provided on fire drill schedule to meet standard, Area Supervisor will review drills and times to ensure completion</p> <p>Persons Responsible: Residential Manager, Area Supervisor, Program Manager</p>		03/16/2020

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	Residential Manager stated she followed the schedule provided to her by the main office.						