

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

PRINTED: 09/18/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155732	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2023
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NAME OF PROVIDER OR SUPPLIER RIVEROAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 1244 VAIL ST PRINCETON, IN 47670
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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
E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 08/22/23</p> <p>Facility Number: 004130 Provider Number: 155732 AIM Number: 200491050</p> <p>At this Emergency Preparedness survey, Riveroaks Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 68 certified beds, with a current census of 63.</p> <p>Quality Review completed on 08/25/23</p>	E 0000		
K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 08/22/23</p> <p>Facility Number: 004130 Provider Number: 155732 AIM Number: 200491050</p> <p>At this Life Safety Code survey, Riveroaks Health</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Lucas	Executive Director	09/08/2023

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 0345 SS=F Bldg. 01	<p>Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 68 and had a census of 63 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a small plastic shed used for facility storage.</p> <p>Quality Review completed on 08/25/23</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section</p>	K 0345	<p>1. Corrective Action for the resident(s) affected by the alleged deficient practice: This alleged deficient practice had</p>	09/21/2023

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	<p>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 occupants in the facility.</p> <p>Findings include:</p> <p>Based on record review on 08/22/23 between 9:00 a.m. and 1:00 p.m. with the Director of Plant Operations and Regional Facility Support person present, there was documentation provided regarding an annual fire alarm system inspection dated 04/26/23 by the facility's fire alarm inspection vendor, furthermore, there was a semi-annual visual inspection document provided, however, this document was not provided with a date the visual inspection was performed. Based on interview at the time of record review, the Regional Facility Support person agreed the semi annual visual inspection document was not provided with a date the visual inspection was performed.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Regional Facility Support person during the exit conference.</p> <p>3.1-19(b)</p>		<p>the potential to affect 63 residents, staff, and visitors at the time of the survey.</p> <p>2. Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:</p> <p>No residents, staff or visitors were identified or reported any findings suggestive of having been affected by the alleged deficient practice.</p> <p>3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:</p> <p>The Executive Director and/or designee provided re-education to the Director of Plant Operations on Fire Alarm System - Testing and Maintenance 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.</p>	

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			<p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>The Director of Plant Operations immediately conducted a visual inspection with a date to ensure campus in compliance with state regulations.</p> <p>4. Corrective Actions that will be monitored to ensure the alleged</p> <p>will not re occur:</p> <p>The Director of Plant Operations and/or Designee has ensured the completion of the visual inspection. A task has been created in TELs with the due date of the visual inspection to be monitored for timeliness.</p> <p>Results of these audits will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>5. The time frame the campus is alleging compliance.</p>	

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K 0353 SS=F Bldg. 01	<p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire department connections were in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following:</p> <p>(1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition.</p>	K 0353	<p>Date: September 21st, 2023.</p> <p>1. Corrective Action for the resident(s) affected by the alleged deficient practice: This alleged deficient practice had the potential to affect 63 residents, staff, and visitors at the time of the survey.</p> <p>2. Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice: No residents, staff or visitors were</p>	09/21/2023
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	<p>(5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations on 08/22/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Regional Facility Support person, the facility's fire department connections (FDC) was located on the back side of the facility. There was no FDC signage provided around the fire department connection or at the front of the building for the responding fire department to lead them to the FDC for easy identification. Based on interview at the time of observation, this was acknowledged by the Director of Plant Operations who agreed there should be FDC signage at the FDC and the front of the facility.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Regional Facility Support person during the exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 6 smoke compartments covered with a foreign substance/loaded were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g.,</p>		<p>identified or reported any findings suggestive of having been affected by the alleged deficient practice.</p> <p>1. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:</p> <p>The Director of Plant Operations has contacted the contractor and scheduled the replacement of the sprinkler head in kitchen walk in cooler, and health center medical storage room.</p> <p>The Director of Plant Operations purchased and installed signage to easily identify the FDC.</p> <p>The Director of Plant Operations was educated by the Executive Director on Sprinkler System – Maintenance and testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with the NFPA 25.</p> <p>The Director of Plant Operations re-fire caulked the seven water lines which penetrated the ceiling in the water heater/boiler room that had been dislodged. DPO also re-fire caulked several other areas.</p> <p>4. Corrective Actions that will</p>	

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	<p>up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect kitchen staff plus all resident while in the adjoining dining room.</p> <p>Findings include:</p> <p>Based on observations on 08/22/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Regional Facility Support person, the following was noted:</p> <p>a. There was one sprinkler head in the Med Room covered with a black dripping substance which appeared to be antifreeze.</p> <p>b. There was one sprinkler head in the kitchen walk-in refrigerator covered with a hard crusty substance which appeared to be dried antifreeze. Based on interview at the time of observations, the Director of Plant Operations agreed there was a foreign substance on both sprinkler heads.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Regional Facility Support person during the exit conference.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 6 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect mostly staff, and visitors.</p>		<p>be monitored to ensure the alleged will not re occur:</p> <p>The Director of Plant Operations will audit signage placement 1 x week for 1 month and 1 x a month for 3 months.</p> <p>The Director of Plant Operations will audit sprinkler heads for corrosion and dirt 1 x week for 1 month and 1 x a month for 3 months.</p> <p>The Director of Plant Operations will audit the ceiling in the water heater/boiler room for proper fire caulking 1 x week for 1 month and 1 x a month for 3 months.</p> <p>Results of these audits will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>5.The time frame the campus is alleging compliance.</p> <p>Date: September 21st, 2023.</p>	

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K 0712 SS=C Bldg. 01	<p>Findings include:</p> <p>Based on observations on 08/22/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Regional Facility Support person, there were seven water lines which penetrated the ceiling in the water heater/boiler room. There was at least a half inch gap around each of the water lines that penetrated the drywall ceiling. At least five of the water lines had been fire caulked, however, the caulk had dislodged from the ceiling location which created the half inch gaps. Based on interview at the time of observation, the Director of Plant Operations acknowledged the half inch gaps around the water lines that penetrated the ceiling and said he would fire stop them as soon as possible.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Regional Facility Support person during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Drills Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p>			

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	<p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drill reports on 08/22/23 between 9:00 a.m. and 1:00 p.m. with the Director of Plant Operations and Regional Facility Support person present, 3 of 4 second shift (evening) fire drills were performed between 6:30 p.m. and 6:50 p.m. Based on interview at the time of record review, the Director of Plant Operations acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Regional Facility Support person during the exit conference.</p> <p>3.1-19(b)</p>	K 0712	<p>1. Corrective Action for the resident(s) affected by the alleged deficient practice: This alleged deficient practice had the potential to affect 63 residents, staff, and visitors at the time of the survey.</p> <p>2. Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice: No residents, staff or visitors were identified or reported any findings suggestive of having been affected by the alleged deficient practice.</p> <p>3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: The Director of Plant Operations has scheduled a fire drill on second shift at 9pm on 9/19/23. The Director of Plant Operations was educated by the Executive Director on NFPA 101 Fire Drills. Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift.</p> <p>4. Corrective Actions that will be monitored to ensure the alleged will not re occur:</p>	09/21/2023	

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K 0000 Bldg. 02	<p>A Life Safety Code Certification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>The new addition to the 300 Hall includes resident rooms 313 through 323, with a total of 15 certified beds.</p> <p>Survey Date: 08/22/23</p> <p>Facility Number: 004130 Provider Number: 155732 AIM Number: 200491050</p> <p>At this Life Safety Code survey, Riveroaks Health Campus was found not in compliance with</p>	K 0000	<p>The Director of Plant Operations will inspect drills 1 x per month x 3 months for proper varying timing of fire drills.</p> <p>Results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>5.The time frame the campus is alleging compliance.</p> <p>Date: September 21st, 2023.</p>	

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K 0293 SS=E Bldg. 02	<p>Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies.</p> <p>The new 300 Hall addition is a one story facility and was determined to be of Type V (111) construction and was fully sprinklered. This portion of the facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 68 certified beds and had a census of 63 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a small plastic shed used for facility storage.</p> <p>Quality Review completed on 08/25/23</p> <p>NFPA 101 Exit Signage Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 door to the outside courtyard in the 300 Hall could not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO</p>	K 0293	<p>1. Corrective Action for the resident(s) affected by the alleged deficient practice: This alleged deficient practice had the potential to affect 63 residents, staff, and visitors at the time of the survey. 2. Corrective Actions taken for those resident(s)</p>	09/21/2023

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	<p>EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8 inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect up to 10 residents, as well as staff and visitors in the new portion of the 300 Hall.</p> <p>Findings include:</p> <p>Based on observations on 08/22/23 between 1:00 p.m. and 3:00 p.m. during a tour of the facility with the Director of Plant Operations and Regional Facility Support person, the 300 Hall lounge door to the courtyard was not posted with a NO EXIT sign. Based on interview at the time of the observation, the Director of Plant Operations said the 300 Hall lounge door to the courtyard is not considered an exit to the public way and acknowledged it did not have a NO EXIT sign posted.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Regional Facility Support person during the exit conference.</p> <p>3.1-19(b)</p>		<p>having the potential to be affected by the alleged deficient practice:No residents, staff or visitors were identified or reported any findings suggestive of having been affected by the alleged deficient practice. 3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:</p> <p>The Director of Plant Operations placed NO EXIT signage to the door on the 300-hall lounge leading to the courtyard. The Director of Plant Operations was educated by the Executive Director on NFPA 101, Exit Signage, 2012 Edition, LSC 7.10.8.3.1</p> <p>4. Corrective Actions that will be monitored to ensure the alleged will not re occur:The Director of Plant Operations will audit the door located on the 300-hall lounge leading to the courtyard for proper NO EXIT signage 1 X per week X 8 weeks.Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. 5.The time frame the campus is alleging compliance.Date: September 21st, 2023.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2023
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NAME OF PROVIDER OR SUPPLIER RIVEROAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
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K 0712 SS=C Bldg. 02	<p>NFPA 101 Fire Drills Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>18.7.1.4 through 18.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drill reports on 08/22/23 between 9:00 a.m. and 1:00 p.m. with the Director of Plant Operations and Regional Facility Support person present, 3 of 4 second shift (evening) fire drills were performed between 6:30 p.m. and 6:50 p.m. Based on interview at the time of record review, the Director of Plant Operations acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough.</p> <p>This finding was reviewed with the Executive Director, Director of Plant Operations, and Regional Facility Support person during the exit conference.</p>	K 0712	<p>1. Corrective Action for the resident(s) affected by the alleged deficient practice: This alleged deficient practice had the potential to affect 63 residents, staff, and visitors at the time of the survey.</p> <p>2. Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice: No residents, staff or visitors were identified or reported any findings suggestive of having been affected by the alleged deficient practice.</p> <p>3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:</p>	09/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2023
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NAME OF PROVIDER OR SUPPLIER RIVEROAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 1244 VAIL ST PRINCETON, IN 47670
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	3.1-19(b)		<p>The Director of Plant Operations has scheduled a fire drill on second shift at 9pm on 9/19/23.</p> <p>The Director of Plant Operations was educated by the Executive Director on NFPA 101 Fire Drills. Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift.</p> <p>4. Corrective Actions that will be monitored to ensure the alleged will not re occur:</p> <p>The Director of Plant Operations will inspect drills 1 x per month x 3 months for proper varying timing of fire drills.</p> <p>Results of these inspections will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.</p> <p>5. The time frame the campus is alleging compliance.</p> <p>Date: September 21st, 2023.</p>	