

SAFETY AND PHYSICAL PLANT PROTOCOL

GENERAL GUIDELINES

This protocol section serves as the tool for review of an agency or facility's adherence to Regulatory Requirements applicable to certified programs. Also included, are OPWDD requirements as issued through Administrative Memorandum, Safety Alerts, or Guidance Memos. Attached to the end of this protocol are commonly needed or referenced ADMs, guidance documents and materials. Also included are regulatory requirements that are typically referenced in a pre-opening visit, but on occasion are needed during other visits. They will not be part of the routine review, but are included to provide guidance if needed.

Review for requirements will occur during site visits through physical plant walk-through, interview and review of documentation related to fire safety planning, training and equipment.

Be alert to the applicability of the requirement to the program type you are visiting and to the type of visit you are conducting.

Please Note:

- The guidelines in this document cannot be inclusive of every scenario a surveyor may encounter and are not meant to substitute for the judgment and knowledge base of experienced DQI staff. If items not specifically identified in the protocol are found to be inadequate for the welfare and safety of the individuals receiving services at the site, the surveyor is responsible to take appropriate action to identify, notify and ensure corrective action.
- Procedures identified in this document do not restrict OPWDD's ability to assess any environmental or safety item determined to influence the safety, well-being and comfort of people receiving services.
- While DQI intends to collect and aggregate data on all questions in the protocol, it is not our intent to issue routine statements of deficiencies for all items that are not met. If a deficiency results in a threat to an individual's safety and/or welfare, a deficiency statement will be issued. Other items that are not met will be communicated to the agency/program via exit conference form and correction will be verified at subsequent visits.
- For any deficiency that presents an immediate threat of significant harm to an individual, immediate danger procedures will be followed.

SAFETY - PHYSICAL PLANT REVIEW

PART 1

Completed by OFPC or BPC only if OFPC not visiting site

TAG	Reference	REQUIREMENT/ STANDARD	Not Met	GUIDELINES
SFGSR01	686.16(b)(1) <i>Additional:</i> 635-7.5(e) 633.10(b)(2) <i>Waiver App G Safeguards (a)(i)</i>	1. The certified site has an acceptable evacuation plan.		<p>An evacuation plan specifies emergency procedures that staff are to implement in the event of an emergency, e.g. fire. A floor plan should be included in the evacuation plan. In the case of IRAs, the site-specific protective oversight plan should include evacuation procedures or reference the evacuation plan, which is usually a separate document.</p> <p>The plan should follow generally accepted safety principles.</p> <p>The site's evacuation plan should describe actions to be taken upon discovery of an emergency. Review the site's evacuation plan. It should:</p> <ul style="list-style-type: none"> • Be clearly written and understandable • Be site-specific • Describe actions to be taken upon: <ul style="list-style-type: none"> ○ actual discovery of the fire ○ smelling smoke ○ hearing the alarm • Describe how to notify site occupants of the need to evacuate e.g. pull alarm. • Identify evacuation routes and exit doors • Describe how to safely check and enter rooms during the evacuation process • Describe any priorities with regard to the evacuation of specific individuals • Describe any priorities with regard to the use of exits • Clearly assign and describe individual staff responsibilities for protection, rescue, and evacuation, designated by staff role on the shift, not by name or title of staff • Instruct staff to call 911/Fire Department • Identify by name, the meeting place for head count • Be updated and revised and reviewed by all staff when new individuals are admitted to the site • Be updated & revised when individuals' abilities & needs for support change • The plan should take into account the individuals' significant fire safety needs as discussed in interview and indicated in assessments such as the ISP and individual protective oversight plans. This should include the level and type of supervision and assistance needed. • Note that defend-in-place strategies may be applicable, depending on the type of building. The plan should identify defend-in-place use and areas of refuge. For structures where the strategy used, the plan should include what should be done in the event that conditions become untenable in the building.

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				<ul style="list-style-type: none"> If defend-in-place strategies are used, the physical plant safety enhancements which allow for its use must be identified by the facility and their functionality verified by a <i>LSC surveyor</i>. <p>For Apartments: Additional Considerations for inclusion in evacuation plans for sites in apartment buildings. It is critical to make a distinction between apartment building fires that originate in the certified apartment unit and those that originate elsewhere in the building.</p> <ul style="list-style-type: none"> <u>When the fire is in the apartment unit</u>, the appropriate response is to get everyone in the apartment unit out of the building. <u>If fire is not in your apartment</u>, the following actions are appropriate practice in all apartments regardless of location: <ul style="list-style-type: none"> If you live in a non-fireproof building and there is a fire it is usually safer to leave the building immediately. If you live in a fireproof building and there is a fire (other than in your dwelling unit) it is usually safer to stay inside rather than entering smoke filled hallways, especially if the fire is above your apartment. Additional information on evacuation planning and preparedness in apartment settings is available on the New York City Fire Dept Website at www.nyc.gov/fdny <p>For Day Habs 635-7.5(e): The Day Habilitation Program must have an evacuation plan that is specific to the premises and designed with consideration of:</p> <ul style="list-style-type: none"> capabilities of the persons receiving services staffing of the premises physical plant configuration <p>Refer to the OPWDD document: <u>Essential Elements of a Fire Evacuation Plan</u> for additional information.</p> <p>For certified sites that provide waiver services, <u>this is a Waiver Application Federal requirement.</u></p>
SFGSR02	686.16(b)(1) 686.16(b)(2) 635-7.5(e) ADM 2012-02	2. All fire and evacuation drills or events MUST be documented on the standardized a drill report form developed by OPWDD.		<p>OPWDD has developed standardized evacuation drill report forms which are to be used in all certified programs. The facility should document evacuation drills on the standardized form appropriate to the program type. Use of the standardized fire drill forms is required effective 7/01/2012.</p> <p>NOTE: Drill reports used for drills occurring prior to the implementation of OPWDD standardized report forms should document relevant information regarding the evacuation/fire drill. Information provided should be sufficient to evaluate that the evacuation plan is implemented as written and effective.</p>
	ADM # 2012-02	3. The Evacuation Plan is practiced through drills with the frequency specified by OPWDD.		<p>OPWDD has standardized the <u>minimum</u> frequency of evacuation - fire drills in both residential and day program settings per ADM #2012-02.</p> <p>Through review of drill documentation, assess that evacuation/fire drills are minimally implemented as follows:</p>

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SFGSR03				<p>24 Hour Staffed Residential Settings:</p> <ul style="list-style-type: none"> • <u>Non-LSC</u>: One (1) full evacuation drill per shift per quarter • <u>LSC Board & Care Prompt or Slow</u>: One (1) full evacuation drill per shift per quarter • <u>LSC Board & Care Impractical</u>: One (1) full evacuation drill per shift per quarter • <u>LSC Board & Care Impractical, with individuals unable to participate</u>: One (1) drill per shift per quarter with One (1) drill per shift per year being full evacuation drills <i>if the site is designed to defend in place</i> • <u>LSC Health Care Occupancy</u>: One (1) drill per shift per quarter with One (1) drill per shift per year being full evacuation drills <p>Non-24 Hour Staffed Residential Settings (supportive IRAs and supportive CRs) :</p> <ul style="list-style-type: none"> • Four (4) full evacuation drills per year • For fire resistive apartment buildings with at least one hour enclosed interior stairs, two (2) of the four (4) evacuation drills could be limited to the stair well landing. • In situations where there is only one exit and the alternate means is a window or a porch not leading directly to grade level, four full evacuations and an additional two drills which practice use of the alternate means <p>Day Programs and Article 16 Clinics: One (1) full evacuation drill per quarter.</p> <ul style="list-style-type: none"> • Day programs which are designed to defend in place: four drills per year/two of which include two full evacuations per year.
SFGSR04	<p>686.16(b)(1) All IRAs</p> <p><i>Additional:</i> 633.4(a)(4)(i)</p>	<p>4. Evacuation drills are conducted in a manner to effectively train and assess participants, per OPWDD requirements.</p>		<p>Review drill documentation. Drills should be conducted as follows:</p> <ul style="list-style-type: none"> • Drills should normally mirror the elements of a real fire emergency. Drills should be held at unexpected times and under varying times and conditions. • Drills should be held with normal staffing levels; not with extra staff working. • Individuals and staff practice what they are actually going to be expected to do in the event of a fire emergency, as designated in their evacuation plan. • In LSC homes, the night shift drill should occur after the 1st hour of sleep and before the 3rd hour of sleep. • Evacuation drills should be occurring as quickly and safely as possible. Evacuation times for the facility should be appropriate to the site and time frames established for it, if applicable. <ul style="list-style-type: none"> ○ For Small IRAs (unless meeting LSC), the time frame should be three minutes or less ○ For Apartment Buildings, evacuation needs to occur to the exterior at ground level within the three minutes to meet the three minute all out requirement, unless the apartment building is a fire resistive building with an enclosed interior stairwell. In the case of an enclosed interior stairwell, the three minute maximum would apply to the time it took to get to that stairwell. ○ For LSC Board and Care IRAs evacuation should occur swiftly, but not to exceed the following maximums for the LSC designation for their site: Prompt – 3 minutes, Fast/Slow-8 minutes, Slow/Slow-13 minutes. ○ For all sites, drill times should be reviewed and any problems or concerns identified. See #6. <p>See also Essential Elements of Fire Drill Reporting.</p>

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SFGSR05	<p>ADM # 2012-02</p> <p><i>Additional: Waiver App G Safeguards (a)(i) FRFS10</i></p>	<p>5. The agency monitors the effectiveness of the fire evacuation plan, per OPWDD requirements.</p>		<p>Assess how management staff supervise that drills are conducted properly. There should be evidence of on-going review of the fire evacuation plan for effectiveness and for need for revisions.</p> <p>Talk to staff, supervisors and administrators. Ask how they monitor that the evacuation plan is appropriate and how often they do so. Review for the following monitoring actions:</p> <ul style="list-style-type: none"> • Verify that for supervised residences, that the facility/agency has conducted unannounced, management observed drills (i.e. by an administrative staff member above the level of a house manager). <ul style="list-style-type: none"> ○ These unannounced observations must be done minimally: <ul style="list-style-type: none"> ▪ Once per year on the overnight shift, and ▪ Once per year on a shift chosen by the agency ○ Verify that the observation results and any corrective actions are documented. • Reports of fire drills conducted by staff outside normal business hours (i.e. night shift) should be reviewed and verified by agency administrative staff (above the level of a house manager) within 24 hours (or next business day) to ensure that the report filed by staff is an accurate reflection of what actually occurred. <p>NOTE: Unannounced observed drills are required as administrative oversight of fire drills in supervised settings. In supportive settings it is the responsibility of the agency to periodically assess individuals' continued independence in evacuation, particularly in situations in which that independence is in doubt. The agency may apply whatever oversight methods are needed to provided reasonable assurances of this in the non-24 hour supervised setting.</p> <p>For certified sites that provide waiver services, <u>this is a Waiver Application Federal requirement.</u></p>
	<p>ADM # 2012-02</p>	<p>6. Drills are appropriately evaluated and corrective action taken as needed.</p>		<p>Through documentation review and interview, verify that the facility management effectively monitors evacuation drills, staff actions, and the effectiveness of the evacuation plan.</p> <ul style="list-style-type: none"> • UNSUCCESSFUL DRILLS: Verify that the facility/agency identifies and takes action for unsuccessful drills; i.e. those in which all program participants were not evacuated in the expected time frame and/or unsuccessful implementation of the fire plan. <ul style="list-style-type: none"> ○ Agency administrative staff are contacted immediately, regardless of shift, if a drill was unsuccessful. ○ The contacted administrative staff has decided if the situation requires immediate remediation response to preserve individuals' health and safety. ○ This decision is documented on the fire drill reporting form. ○ If an immediate response is not required, then action to correct occurs within 24 hours of the unsuccessful drill. ○ There is evidence that identified problems have been addressed

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SFGSR06				<ul style="list-style-type: none"> ○ If a pattern of unsuccessful drills is present, the agency takes timely and systemic action to ensure safety of the individuals served. ○ If such a pattern emerges, the agency must report it to the local DDSO and DQI-BPC for monitoring. <ul style="list-style-type: none"> ● The evacuation procedures are effectively reviewed for timeliness per requirements. ● The evacuation procedures are effectively reviewed for safety, and provision of appropriate assistance and supervision to individuals requiring it. ● Staff actions and the need for staff training are effectively reviewed and provided as needed. Each staff member participates in at least one drill per year. ● Staffing levels are effectively reviewed to ensure there is sufficient, capable staff on all shifts to ensure individuals with physical limitations, behavior issues, or other concerns can be evacuated safely. ● Administrative review includes review of implementation of protect-in-place strategies for appropriateness given the drill scenario ● Plans are modified based on drill performance concerns and staff recommendations.
SFGSR07	686.16(a)(2) LIRA (LSC) 686.16(a)(3) SIRA (LSC) <i>(Old Tags A602/603)</i>	7. If the facility is required to comply with NFPA Life Safety Code, it meets the code.		<p>The following programs must meet the 2000 version of the Life Safety Code:</p> <ul style="list-style-type: none"> ● All large IRAs ● All small IRAs with evacuation times in excess of three minutes ● State Operated ICFs converted to IRAs ● Supervised CRs established after September 01,1985 ● Any small IRA choosing to be certified under Life Safety Code <p><i>A LSC review must be conducted by appropriately trained survey staff to verify.</i></p> <p>For certified sites that provide waiver services, <u>this</u> is a Waiver Application Federal requirement.</p>
SFGSR08	686.16(b)(2) <i>Additional: Waiver App G Safeguards (a)(i) FRFS07</i>	8. Individuals' fire safety needs and abilities have been accurately assessed and documented, based on actual performance and this information is available to staff.		<p>This Requirement addresses assessment of individuals' fire safety needs based on actual performance, to include evacuation drills.</p> <p>There should be an assessment of the individual's ability to evacuate the facility in the event of a fire or other emergency. The assessment should be specific and take into account the person's cognitive ability, any physical limitations, impact of medication, physical plant of the facility, etc. The assessment must be based on actual performance of the person evacuating the facility and not just on the opinion of staff.</p> <p>This information may be found in the Individualized Service Plan (ISP) or a separate document maintained by the facility. For an IRA, the assessment information may be found in Individual Protective Oversight Plan (IPOP), which should be attached to the ISP.</p> <p>For certified sites that provide waiver services, <u>this</u> is a Waiver Application Federal requirement</p>

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SFGSR09	635-7.2 (c)(2-4)	9. The facility maintains a current E-score if an E-score is required.		<ul style="list-style-type: none"> Where there is the need for the site to maintain an E-Score, there is a system for updating it based on accurate F-1 table values as changes in Individuals' performance and in the Individuals living at the site occur. The rating of Individuals' risk factors (commonly known as F-tables) should be based on their actual performance in evacuation drills; behavioral patterns; medications and medical issues; and mobility abilities and needs. <p>Review of E-Scores and Ratings of Individual Risk factors much be completed by a person appropriately trained in Life Safety Code.</p>
SFGSR10	<p>635-7.4 (b)(3)(xiii)</p> <p>635-7.3(h)(2)</p> <p>Waiver App G Safeguards (a)(i) FRFS02</p>	10. The <u>certified site</u> provides safe exiting to a public way.		<p>Safe exiting includes the exterior of the building (to the street and/or – in New York City – a courtyard, which shall be a minimum of 30 feet unless there is an unlocked gate with access to adjacent yard or open public space).</p> <p>Through observation and physical plant walk through, verify the following:</p> <ul style="list-style-type: none"> Doors (except in Supportive CRs, Self-Preserving CRs and small IRAs) should be provided with single-function locks. Occupants must be able to use a dual-function locking arrangement if one exists at small IRAs or Supportive and Self-Preserving CRs. If any individual is unable to use a dual function lock in these settings, a single function locking mechanism must be used. Aisles/corridors are unobstructed. There is adequate lighting of exit ways <ul style="list-style-type: none"> EXTERIOR: This is applicable to facilities that serve individuals during hours of darkness/nighttime. During Physical Plant "walk through" assess whether exterior lights work. Evaluate their locations to see if they are sufficient to guide individuals from the facility to the meeting place. If possible (early mornings and evenings, winter late afternoons) note during times of darkness whether illumination is sufficient to allow safe travel to meeting areas. Also when possible, test that lights that are activated by darkness or motion do so. There is a clear path to a public way in good condition. It is not required that these surfaces are paved. The facility has a reliable system for the removal of snow and ice from exterior exit ways including exterior stairs and walkways in a timely manner. Gates along the exit way and the street, can be opened easily Apartment windows provided with gates, are of the Fire Dept. approved variety only and can be opened from the inside without a key. <p>For Apartment Buildings</p> <ul style="list-style-type: none"> The exit routes from the apartment unit to the public way must be properly lit and unobstructed. In cases where the apartment building has enclosed interior stairs, surveyors should check the common corridor at the certified apartment unit level and at the level of exit discharge as well as the integrity of stair doors at all intervening levels. In open stairwell construction, surveyors would need to assess all levels. In particular, check the following: <ul style="list-style-type: none"> The door to the certified site apartment unit should self-close and latch. Stairwell doors (if provided) should self-close and latch.

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				<ul style="list-style-type: none"> ○ Trash compactor chutes or doors to trash compactor rooms should self-close and latch. ○ Emergency lighting units should be operational. ○ If egress routes pass boiler, laundry, storage, trash compactor or other utility rooms, the hardware provided on those rooms (self-closers and latches) must be operational. ○ Doors noted above should not be propped open. <ul style="list-style-type: none"> ● Note that while the agency may have no jurisdiction over the building, it is the agency's responsibility to ensure safe and unobstructed exit routes for the home. This would involve identifying problems, bringing them to building management, and monitoring for resolution. <p>For certified sites that provide waiver services, this is a Waiver Application Federal requirement</p>
SFGSR11	<p>635-7.3(h)(4) All but SI Ext.</p> <p>635-7.4(b)(3)(vi) SIRA Exting.</p> <p>635-7.3(e)(1) CR LIRA Det & Alarm</p> <p>635-7.4(b)(3)(v) SIRA Det & Alarm</p> <p>635-7.5(f)</p> <p>ADM # 97-01</p> <p>635-7.3(e)(1) (i) - (vii)</p> <p>635-7.4(b)(3)(v)(a)</p> <p>635-7.4(b)(3)(v)(b)</p> <p>635 7.4(b)(3)(v)(c)</p>	<p>11. There is fire protection and detection equipment in the facility as required by regulation.</p>		<p><i>Refer to the grid entitled:</i> REQUIRED FIRE PROTECTION EQUIPMENT BY FACILITY TYPE</p> <p>Verify during the physical plant walkthrough that fire safety equipment, including smoke detectors, heat detectors, is provided in accordance with regulatory requirements.</p> <p>NOTE: For situations that present an immediate risk to the safety of an individual, contact your regional director & require immediate correction.</p> <p><u>SMOKE & HEAT DETECTION & ALARM:</u></p> <ul style="list-style-type: none"> ● Surveyors should familiarize themselves with the different types of smoke and heat detectors (or combo smoke/heat detectors). ● During a physical plant walk-through, surveyors should ensure that the facility is meeting the requirements for smoke and heat detection identified. ● Some detectors can be physically tested for interconnectivity. ● Ensure that smoke detectors are installed greater than three (3) feet or less of operable ceiling fans. Smoke detectors in a room with a ceiling fan must be photoelectric vs. ionization type unless specifically listed for conditions of rapid air movement. <i>See attached ADM # 99-01.</i> <p><u>RESIDENTIAL SITES:</u> General Smoke detection Requirements: Systems are required to be:</p> <ul style="list-style-type: none"> ● hard wired ● powered by house electrical service ● must sound an alarm that is audible in all parts of the facility ● The battery operated smoke detector exception should be applied in VERY RARE instances. Battery-operated smoke detectors are allowed <u>by exception only</u>, and if used must be a combination photoelectric/ionization type. For guidelines for exceptions to battery-operated smoke detectors ban, see referenced memorandum. (ADM #97-01) <p><i>Applies to Supervised CRs, IRAs (9+) and ICFs.</i></p> <p>(i) All required heat and smoke-detecting services are interconnected to ensure that activation of any</p>

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	ADM #2012-02 Waiver App G Safeguards (a)(i) FRFS11			<p>one device will sound an alarm that is audible throughout the facility.</p> <p>Heat-detecting devices are either the rate-of-rise or fixed self-restorative type. Older fixed temperature heat detectors need to be replaced according to manufacturers' instruction (usually every 10 years). Replacements should be rate-of-rise or fixed self-restorative.</p> <p>(ii) Smoke detectors are installed:</p> <ol style="list-style-type: none"> a. in each bedroom b. in each corridor adjacent to sleeping rooms c. in corridors or adjacent open areas such as living rooms, dining rooms or recreation rooms d. at a maximum of 30 feet on center and no more than 15 feet from a wall e. at the head of each open stairway located within the facility or a smoke detector is installed within six feet of the bottom opening of a stairway that is enclosed at the top. <p>(iii) At least one smoke detector is installed in a basement and at least one heat detector installed in accessible and usable attics at a ratio of one detector for each 1,000 sq. ft. of floor space. Additional detectors may be required for those basements and attics subdivided by partitions.</p> <p>(iv) A heat detector is installed:</p> <ol style="list-style-type: none"> a. in each kitchen. b. in each storage room c. near a furnace, boiler or any heat producing equipment located within the facility. <p>Applies to Small IRA's (8 beds or less):</p> <ul style="list-style-type: none"> • A smoke detector is installed in each corridor adjacent to sleeping rooms. • Smoke detectors are installed in corridors or adjacent open areas such as living rooms, dining rooms or recreation rooms at a maximum of 30 feet on center and no more than 15 feet from a wall. • A smoke detector is installed at the head of each open stairway located within the home or IRA or a smoke detector is installed within six feet of the bottom opening of a stairway that is enclosed at the top. • At least one smoke detector is installed in basements (see section 635-99.1). If a basement alarm is placed six feet from the bottom of the staircase, it counts as coverage for the basement (a detector at the top of the staircase does not). • Additional detectors may be required for those basements and attics subdivided by partitions <p>DAY HABILITATION SITES ONLY:</p> <ul style="list-style-type: none"> • Unless the building is fully sprinklered, each certified site shall be equipped with interconnected, hardwired smoke detection and alarm devices to assure early notification of the certified site. At a minimum, the devices shall be installed in required exit ways from the certified space. • Smoke detectors in hallways should be spaced every 30 feet. This is under normal conditions where the hallways are of average width, height and slope.
SFGSR12	Q.I. ADM 2012-02	12. Heat detectors are present in the residential facility as required by OPWDD.		See ADM 2012-02. In an effort to increase the level of detection, and therefore safety in residential sites, OPWDD is requiring that specified areas of the residences will be equipped with heat detectors as indicated below.

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				<p>The installation of heat detection per these requirements is effective 05/01/2012 in the following circumstances:</p> <ul style="list-style-type: none"> • All new residential development projects where construction begins after 5/01/2012 • All significant physical plant upgrades to meet "gap analysis" targets, or upgrades or replacement of existing fire alarm/smoke detection systems <p>The heat detection requirements are:</p> <p>All attics, crawl spaces and roofed porches within residential sites will be equipped with <u>rate-of-rise or fixed self-restorative heat detectors</u> that are <u>hard wired, powered by the building electrical service</u> and are <u>interconnected</u> to the building's fire alarm and smoke detection system. ADM #2012-02.</p> <ul style="list-style-type: none"> • <u>Attics:</u> <ul style="list-style-type: none"> ○ All attics need heat detectors and must be accessible for inspection. If inaccessible, attics must be made accessible and heat detectors installed. • <u>Crawl Spaces:</u> <ul style="list-style-type: none"> ○ Accessible crawl spaces need heat detectors ○ Previously inaccessible crawl spaces need not be made accessible. ○ Crawl spaces that are not accessible to routine staff, have only restricted access for inspection purposes, and with no equipment installed, do not require heat detectors. (Restricted access: e.g. locked gate or access panel for which access is limited to maintenance staff or a contractor.) ○ Heat detectors are required for overhangs that extend out from the building four (4) feet or more when the overhang is at least four (4) feet wide. ○ Heat detector coverage must not exceed 1000 sq. ft. of coverage per detector ○ Heat detectors must provide lateral coverage of thirty (30) feet on center. ○ In specific locations exposed to weather, heat detectors rated for outdoor use should be used. <p>Surveyors will routinely visually review for the presence of heat detectors per these requirements during re-survey site visits. Lack of the heat detectors in attics, crawl spaces, and roofed porches will be identified on the Exit Conference Form and in data entry for this protocol.</p> <p>For specific sites in which the lack of heat detectors in proposed locations appears to present a particular vulnerability, based on the population served or other factors, surveyors will strongly recommend that the provider agency promptly explore the feasibility of installing heat detectors at the site.</p>
SFGSR13	<p>633.4(a)(4)(i)</p> <p><i>Additional:</i></p> <p>635-7.3(h)(9)</p> <p>635-7.4 (b)(3)(xviii)</p> <p>686.16(b)(5)</p>	<p>13. Fire alarm and notification systems are operational and effective.</p>		<p>All fire alarm systems must be maintained in continuously operable condition at all times. Fire alarm and notification systems may include but are not limited to: Alarms, strobes, bed and pillow shakers, and any other mechanisms installed to support notification. No one may interfere with the operation of the equipment by practices such as silencing fire alarm systems.</p> <p>Review the documentation of the testing, inspection, and maintenance of the fire alarm/notification equipment. The documented reports should indicate that the equipment is operational and that any problems identified have been addressed/corrected. Testing documentation must adhere to NFPA 72 requirements. See ADM 2012-02 for guidance.</p> <p>During the walk-through, review the following:</p>

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	<i>Waiver App G Safeguards (a)(i) FRFS03</i>			<ul style="list-style-type: none"> In all sites except apartment buildings, request facility staff to activate the alarm system in the most naturally occurring way possible: e.g. test/activate smoke detection, activate the pull station, etc. If the facility is connected to the fire department or a central monitoring station, it may be helpful to remind staff to notify the parties that a test will be occurring. Verify the following: <ul style="list-style-type: none"> The alarms activate Alarms are clearly audible in sleeping areas with intervening doors closed, and typical ambient room noise such as air conditioners or televisions running. The sound should be likely to wake the occupants. Strobes flash Bed shakers activate, properly placed and are protected from tampering The alarm relays to the monitoring station or fire department, if applicable For sites that are divided into apartments, the alarm, when sounded in one apartment, must be audible in all apartments
SFGRS14	633.4(a)(4)(i) Other sites <i>Additional:</i> 635-7.3(h)(9) 635-7.4 (b)(3)(xviii) <i>Waiver App G Safeguards (a)(i)</i>	14. <u>Other</u> fire protection equipment is operational.		<p>All fire safety equipment must be maintained in continuously operable condition at all times. <u>Other</u> fire protection equipment may include: Self Closing and Auto-Closing doors, special locking devices; emergency lighting units; smoke dampers, and any other mechanisms installed to support fire and smoke protection and evacuation.</p> <p>Interview knowledgeable management staff, conduct a walk through and review maintenance documentation to determine whether the site has any additional fire safety equipment. Some of the items may not be specifically addressed in fire alarm system or sprinkler system testing and maintenance reports.</p> <p>Through review of maintenance reports and during the walk-through verify that the equipment works as intended. Some items are best verified at the time of alarm activation. Review may include but is not limited to the following:</p> <ul style="list-style-type: none"> Locked exit doors automatically disengage Auto-closing doors close and latch. There should be nothing that interferes with the action of doors that are required to be equipped with self-closing devices. These doors are so equipped to provide fire and smoke partitions; separation of potentially hazardous areas, separation of stories and separation of egress routes from common living areas. Using tie backs, door stops etc defeats the function of the self-closing device. Emergency lighting illuminates when tested
SFGRS15	635-7.3(h)(5) <i>Additional:</i> 635-7.4(b) (3)(xviii) <i>(Old Tags V2155 All but SI V2218 SI)</i>	15. Automatic sprinkler systems must have a water supply that is sufficient to operate the required number of sprinkler heads for the period of time that is specific to the system type that is in place.		<p>Review the facility documentation of the sprinkler system and testing to determine the water supply. The facility /agency should have documentation noting the sprinkler system type and that evidences the water supply is sufficient. Verify through observation during the walk through. Testing documentation must adhere to NFPA 25 requirements. See ADM 2012-02 for guidance.</p> <p>LSC Residences: Residential programs certified utilizing the Life safety Code (LSC) that are equipped with automatic sprinkler systems, including NFPA 13D systems, are required to have a water supply that is sufficient to operate the sprinkler system for specific periods of time.</p> <p>The 2000 Board and Care Life Safety Code requires that sprinkler systems have a water supply that is</p>

TAG	Reference	REQUIREMENT/ STANDARD	Not Met	GUIDELINES
				<p>sufficient to operate up to two (2) sprinkler heads at the appropriate rate of flow (26 Gallons per minute) for a minimum of ten (10) Minutes for Prompt evacuation capability homes and a minimum of thirty (30) Minutes for Slow and Impractical evacuation capability homes.</p> <p><i>A LSC review must be conducted by appropriately trained survey staff to verify.</i></p>
SFGRSR16	635-7.3(i)(1) Additional: 635-7.4(b) (3)(xviii) (Old Tags V2165 All but SI V2219 SI)	16. Fire alarm, smoke detection and sprinkler systems must be inspected and maintained at the frequency required for each specific system.		<p>Through documentation review and interview, verify that this equipment was tested, inspected and maintained in accordance with the manufacturer's recommendations.</p> <p>Refer to attached MAINTENANCE INSPECTION SCHEDULE for specific requirements for maintenance frequency per equipment/system type.</p> <p>In the absence of contrary instruction on the Inspection Schedule or by manufacturer, quarterly inspection is required.</p>
SFGRSR17	ADM # 2012-02	17. Maintenance and inspection of Fire Alarm and Detection Systems is performed by competent parties and according to OPWDD standards.		<p>While completing the site reviews, verify that there are testing and maintenance reports for Alarm and Detection Systems that provide a full record of all testing (including results) and maintenance actions in regards to the system taken by the responsible person.</p> <p>With ADM 2012-02, OPWDD provided templates for service contracts for the testing of Fire Alarm systems. Per the ADM, agencies negotiating or renewing contracts for the service must utilize these templates to ensure that contracts are sufficiently clear and comprehensive with regard to the responsibilities of the vendor for testing and maintenance of the system per NFPA 72. Agency use of the contract templates will be verified during the Central Review. Alarm System contracts due for renewal are to use the standardized format by 11/01/2012.</p> <p>In some situations, an agency's own appropriately trained staff may be completing the testing and maintenance. Qualifications will be reviewed during the Central Review.</p>
SFGRSR18	ADM # 2012-02	18. Maintenance and inspection of Sprinkler Systems is performed by competent parties and according to OPWDD standards.		<p>While completing the site reviews, verify that there are testing and maintenance reports for Sprinkler Systems that provide a full record of all testing (including results) and maintenance actions in regards to the system taken by the responsible person.</p> <p>With ADM 2012-02, OPWDD provided templates for service contracts for the testing of Sprinkler systems. Per the ADM, agencies negotiating or renewing contracts for the service must utilize these templates to ensure that contracts are sufficiently clear and comprehensive with regard to the responsibilities of the vendor for testing and maintenance of the system per NFPA 25. Agency use of the contract templates will be verified during the Central Review. Sprinkler Maintenance contracts due for renewal are to use the standardized format by 11/01/2012.</p> <p>In some situations, an agency's own appropriately trained staff may be completing the testing and maintenance. Qualifications will be reviewed during the Central Review.</p>

TAG	Reference	REQUIREMENT/ STANDARD	Not Met	GUIDELINES
SFGSR19	635-7.3(h)(8) <i>Additional:</i> 633.4(a)(4)(i)	19. When required by other State agencies, the facility shall keep records that document compliance with the sanitation, health and environmental safety codes of NYS or the City of NY.		The facility may not meet this requirement if there is any evidence that the facility is not in compliance with entities such as the local building inspector (i.e. significant construction without a building permit), the local health Dept (i.e. Septic system dysfunction) etc.
SFGSR20	633.4(a)(4)(i) <i>Additional:</i> 635-7.3(h)(8)	20. There is a carbon monoxide alarm in all new and existing residences containing one or more carbon monoxide sources on sleeping levels.		Carbon monoxide detectors are required in the following locations: <u>Buildings constructed before January 1, 2008:</u> A carbon monoxide alarm shall be installed on the lowest story having a sleeping area. <u>Buildings constructed on or after January 1, 2008:</u> A carbon monoxide alarm shall be installed in each of the following locations: 1. On each story having a sleeping area. 2. On each story where a carbon monoxide source is located. See Amanda's Law Requirements Memorandum attached to this protocol.
SFGSR21	635-7.4 (b)(3)(vi) <i>Additional:</i> 635-7.4 (b)(3)(xvii) 635-7.3(h)(4)	21. At least one fire extinguisher equal to Class-1-A-5BC, 2.5 pound unit, approved and labeled by the Underwriters Laboratories, is located in an accessible place on each floor, and tested and recharged in accordance with the recommendation of the manufacturer and the NFPA.		<ul style="list-style-type: none"> ● Fire extinguishers should be located on each floor of the facility ● Extinguishers should be mounted so that their location is fixed so they can be accessed easily ● Testing and recharge should occur per manufacturer and NFPA recommendations. Minimally, extinguishers should be inspected monthly to ensure that: <ul style="list-style-type: none"> < There is no obstruction to access < The pressure gauge is in the operable range ● Inspections/testing should be documented to include date and inspector's initials <p>See Also: Fire Safety Maintenance/Inspection Schedule chart.</p>
SFGSR22	635-7.3(c)(2) <i>Additional:</i> 635-7.4 (b)(3)(ii)	22. The use of portable or temporary space heaters as the sole source of heat is prohibited, without appropriate exceptions.		Space heaters should not be routinely in use since they are indicative of inadequacy in the facility heating equipment. Exceptions for cause for temporary supplemental use may be granted where the Commissioner has determined that the safety and welfare of the persons receiving services in the facility have not been compromised. The use of electric space heaters with visible radiant elements is prohibited. Heating units must be designed to turn off if tipped over. If multiple units are in use, it is recommended that an electrician verify the adequacy of the facility wiring for the extra load.

TAG	Reference	REQUIREMENT/ STANDARD	Not Met	GUIDELINES
SFGSR23	<p>635-7.4 (b)(3)(xv)</p> <p><i>Additional:</i></p> <p>635-7.3(h)(7)</p> <p><i>Waiver App G Safeguards (a)(i) FRFS06</i></p>	<p>23. The facility, at the time of the inspection, was free from observed fire safety hazards.</p>		<p>During the survey and during the physical plant walk through, surveyors must be vigilant in the assessment of facilities for potential fire hazards. Possible examples of fire hazards are; but not limited to; as follows:</p> <p>GENERALFIRE SAFETY ISSUES may include:</p> <ul style="list-style-type: none"> • Overloaded electrical outlets including "piggy-backed" power strips. • Fixtures or appliances with damaged electrical wiring • Wiring that is placed so that it is routinely run over such as by bed wheels and may become damaged • Use of narrow gauge extension cords • Extension cords draped over doors or under carpets • Staff complaints of tripping circuit breakers when certain appliances are turned on • Smells of gas or the smell of the products of combustion • Noisy or dust clogged exhaust fans in bathrooms, kitchens etc. • Improperly stored combustibles in the home i.e. propane tanks, gasoline for mowers etc., oil based paints, charcoal lighter fluid etc. Typically flammable materials are not permitted indoors. If they are kept on premises quantities must be strictly limited and kept either in an exterior shed or a vented metal cabinet within a properly enclosed hazardous area. • Items such as outdoor grills, backup generators etc. too close to exterior siding such as vinyl or wood. Less than 3 feet clearance around grills. Grills placed under a roof. • Combustibles such as paper towel or dish towels hung close to or over the stove. • Significant grease accumulations on stove tops or in ovens • Halogen lights should be avoided in lamps that can tip over such as torch lamps • Use of toaster ovens on flammable surfaces such as wooden cutting boards or their observed unattended. • Unattended lit candles <p>CLOTHES DRYERS:</p> <ul style="list-style-type: none"> • The use of a plastic or flexible foil vent duct to vent clothes dryers IS NOT PERMITTED. Clothes dryer vent conduit must be constructed of rigid or flexible solid metal. • Torn Lint Filter (This leads to extensive lint build up in dryer vent conduits.) • Extensive kinking in dryer vent conduit • Extensive lint accumulation on the lint filter in the dryer and/or at the terminus of the dryer vent arrangement (indicative of infrequent cleaning) • An accumulation of clothes or debris behind the dryer <p>For further information refer to the January 2012 OPWDD Health and Safety Alert: <i>Preventing Dryer Fires.</i></p> <p>For situations that present an immediate risk to the safety of an individual, contact your Area Director & require immediate correction.</p>

PART 1 STOPS HERE

SAFETY - PHYSICAL PLANT REVIEW

PART 2

Completed by BPC Always

PART 2 – SAFETY- PHYSICAL PLANT

TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
SPGSR01	633.4(a)(4)(i) <i>Additional:</i> 635-7.3(h)(9) 635-7.4 (b)(3)(xviii) 686.16(b)(5)	24. The fire alarm system is operational upon activation.			Through observation, interview and documentation review, assess the following: <ul style="list-style-type: none"> • Facility staff report no known problems with the fire alarm system. • Testing/maintenance of the fire alarm system has been completed in the past three months and any problems noted with the testing have been satisfactorily addressed • Ask facility staff to activate the alarm in the most natural way possible and assess if it causes the intended effects (see Standard # 13, above.)
SPGSR02	635-7.3(h)(5) <i>Additional:</i> 635-7.4(b) (3)(xviii)	25. The sprinkler system is operational.			Through observation, interview and documentation review, assess the following: <ul style="list-style-type: none"> • Facility staff report no known problems with the sprinkler system • Testing/maintenance of the sprinkler system has been completed in the past three months, and any problems noted during the testing have been satisfactorily addressed
SPGSR03	635-7.4 (b)(3)(xiii) <i>Additional:</i> 635-7.3(h)(2)	26. Exits are clear of obstructions.			Reviewing for exits clear of obstructions should include the interior and exterior of the building to include the following: <ul style="list-style-type: none"> • Aisles/corridors/exit doors are unobstructed by furniture, equipment, supplies, etc. • Delayed locking mechanisms disengage upon alarm activation and touch • There is a hard surface, clear path to a public way. • The facility has a reliable system for the removal of snow and ice from exterior exit ways including exterior stairs and walkways in a timely manner. • Gates along the exit way and the street, can be opened easily
SPGSR04	686.16(b)(1) All IRAs <i>Additional:</i> 633.4(a)(4)(i)	27. In LSC Facilities , a review of the fire drill records conducted in the last 60 days indicates that all individuals are able to be evacuated from the facility in accordance with the safety level of the building.			Evacuation times for the facility should be appropriate to the site and time frames established for it, if applicable. <ul style="list-style-type: none"> ○ For residences meeting LSC evacuation should occur swiftly, but not to exceed the following maximums for the LSC designation for their site: Prompt – 3 minutes, Fast/Slow-8 minutes, and Slow/Slow-13 minutes. ○ Interview staff to determine if any individuals have experienced any deterioration in health, mobility or behavioral status. If any such changes have occurred, ask if the change has affected any individual's ability to evacuate. If so, verify that the program has taken adequate steps to address the change in evacuation ability. <p>NOTE: If drill times exceed the maximums, evaluate what the agency is doing to address and contact the Area Director.</p>

PART 2 – SAFETY- PHYSICAL PLANT

TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
SPGSR05	<p>635-7.2 (a)(1)(iii) Small IRAs</p> <p><i>Additional:</i> 635-7.2(c)(1) CRs</p>	<p>28. For facilities that do not meet LSC, a review of fire drill records conducted in the past year or since last review, indicates all individuals can <u>be evacuated in 3 minutes or less</u> in an IRA, or evacuate in 2.5 minutes in a CR.</p>			<p>For small IRAs (eight beds and less), apartments and supervised CR's, individuals fire safety needs must be met. Talk to individuals and staff and review fire drill records for the past year or since the last review:</p> <ul style="list-style-type: none"> • Evaluate if individuals are able to safely evacuate the residence or apartment to ground level (or to evacuate to the enclosed interior stairwell of a fire resistive apartment building) in 3 minutes or less. • Evaluate if evacuation times for the facility are realistic based on individual characteristics and staffing level • If evacuation time maximums are not consistently met, evaluate what the agency doing to address the problem <p>PLEASE NOTE:</p> <ul style="list-style-type: none"> • In the case of small IRAs of eight beds or fewer, where drills show that at least one individual cannot be consistently evacuated within three (3) minutes a Statement of Deficiencies (SOD) will be issued. While conversion to LSC is an option, the facility must adhere to the three minute time frame by reorganization of evacuation procedures (e.g. use wheelchair for someone who walks slowly, revise staffing patterns, etc.), until conversion is completed. • In supportive settings individuals are expected to be independent. The agency must periodically reassess their status, a process that would include fire drills and interview of residents. If individuals in supportive settings lose their independence in evacuation they will require supervision when at home. • If a Supervised CR was established prior to the requirement that such facilities meet the requirements of NFPA Chapter 33, assess that all residents evacuate the premises in 2.5 minutes or less. Review fire drill records to determine this. For consumers who have not evacuated properly, ensure that intensive training been provided to bring the person's performance up to standard and/or has the facility now met the requirements of Chapter 33. During the retraining, determine the actions the facility has taken to ensure the safety of the individuals who reside there.
SPGSR06	<p>633.4(a)(4)(i)</p> <p><i>Additional:</i> 686.16(b)(1) 686.16(b)(2) (IRAs & Apts)</p> <p>635-7.5(e) (Day Habs)</p>	<p>29. Facility staff can describe fire safety and emergency evacuation procedures.</p>			<p>Through interview with staff, assess that:</p> <ul style="list-style-type: none"> • All Staff (supervisory and direct care) have been trained on and know about individuals' fire safety needs, including level of physical assistance needed • Staff have received training on the implementation of the evacuation plan • Staff can describe the procedure in full, including use of: all fire protection equipment to include use of alarm activation devices and central station, notification of staff and occupants, and 911. • Staff can describe use of primary and alternate exits. <p>See also Essential Elements* of Fire Safety Training for information on required curriculum of staff fire safety training.</p>

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TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
SPGSR07	ADM # 2012-02	30. The local fire authority with jurisdiction is kept informed regarding the special needs <u>of the individuals and the facility</u>			<p>Through interview and record review, verify that the program has contacted the responsible local fire authority regarding:</p> <ul style="list-style-type: none"> • The type of individuals served • Any special needs of the individuals which would impact evacuation • Fire safety features of the program site (including central notification ability) • Staffing patterns of the program • Any changes in program physical plant or profile of individuals served that would significantly impact evacuation • In the course of notifying the fire dept, the facility should inform the dept. of the agency's non-24 hour staff staffed sites. While it is not expected that the Fires Dept. would do pre-planning activities in these buildings, there may be occasions when the FD's participation is warranted. <p>The facility should maintain current documentation of contacts with the local fire authority.</p>
SPGSR08	635-7.4 (b)(3)(xvi) <i>Additional:</i> 635-7.3(h)(5) 635-7.3 (h)(10) <i>if HVAC not working</i>	31. The maintenance and/or cleaning of any heating, air conditioning and/or air filtration equipment shall be performed on a regular basis and in accordance with the recommendations of the manufacturer.			<p>Review maintenance records and interview staff:</p> <ul style="list-style-type: none"> • Through discussion with the person responsible for oversight, verify that the facility has a system is for monitoring that the HVAC system is fully operational, periodically inspected, serviced and tested as needed. • Interview staff and individuals regarding the effectiveness of HVAC at the site. While level of comfort is individualized, assess the general appropriateness of the comfort of the site regarding temperature. • If the HVAC system is designed to shut down upon operation of the fire alarm/smoke detection system, there should be periodic testing that the mechanism is operational
SPGSR09	633.4(a)(4)(i) <i>Additional:</i> 686.16(b)(4)	32. In situations where individuals live in individual apartments but the group of apartments is considered a supervised site, there are mechanisms in place to ensure that staff can be summoned to individual apartments in an emergency.			<p>In such supervised apartment living situations, the following must be assured:</p> <ul style="list-style-type: none"> • Staff on duty will be <i>automatically</i> notified of a fire alarm activation in the service recipient's home and • Staff must be able to get to the individual within 1 minute of notification of fire or other emergency and • The service recipient must have a way to notify the staff of his/her need for assistance when the staff is not in the individual's home, and • All direct support staff must have a key or other means of immediate access to the consumer's home.

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TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
SPGSR10	635-7.4 (b)(3)(xv) <i>Additional:</i> 635-7.3(h)(7)	33. The environment free from other hazards/hazardous conditions?			Some examples of physical plant hazardous conditions not related to fire safety include, but are not limited to: <ul style="list-style-type: none"> • Faulty bedrail system issues (Refer to Bed safety Checklist) • Non-Ambulatory people in house without acceptable means of egress. • Environmental factors causing a pattern of falls resulting in injury with no action from facility • Failure to keep the environment appropriately free of PICA hazards if applicable to participants at the site
SPGSR11	635-7.4 (b)(3)(xv) <i>Additional:</i> 635-7.3(i)(2) 635-7.3(h)(7)	34. The temperature of the hot water is no greater than 110° F where people have not been or are not being trained to use and control water. The temperature of hot water is less than 140° F where people have been trained to control water.			<p>No individual in any setting including supportive living environments may be exposed to hot water temperature of 140° Fahrenheit or greater.</p> <p>The temperature of the hot water at all faucets accessible to persons residing in an ICF or Large IRA may not exceed 110 degrees Fahrenheit except in areas utilized to train individuals in the use and control of hot water.</p> <p>The surveyor should measure the temperature of hot water in a bath or shower at every site visit.</p> <p>Temperatures in excess of 140° F or more are considered to be imminent danger whether or not persons served have been or are being trained and regardless of program type.</p> <p>Also verify:</p> <ul style="list-style-type: none"> • The facility has a thermometer to check water temperature • There is facility procedure for regular testing of hot water temperature • Access to hot water heating equipment is controlled to prevent tampering <p>Note: Some Day Program facilities may have bathing facilities as well.</p>
	633.4(a)(4)(i)) <i>Additional:</i> 635-7.3(h)(7) 635-7.4 (b)(3)(xv) ADM # 2012-02	35. For All Facilities Smoking is performed in a safe manner.			<p>Smoking, if it occurs, must be conducted in the safest manner possible as follows. See ADM #2012-02: Through observation and interview, evaluate the following:</p> <ul style="list-style-type: none"> • Smoking is prohibited inside OPWDD operated and certified site buildings, with the following exception: <ul style="list-style-type: none"> • In supportive IRAs and CRs smoking <u>may</u> be allowed. The agency must have a smoking policy for each certified home. It may be site specific. The policy should take into account whether local laws, building policies or management policies allow smoking in the building. It must also address agency restrictions or parameters related to smoking (e.g. use of specific receptacles); the preferences of all individuals living in the home regarding smoking inside the home; and the individual safety concerns related to smoking. • In all other settings smoking is only allowed outdoors, but only in the designated smoking area. • In apartment of commercial buildings with other tenants smoking activities abide by local laws and/or building policy regarding smoking outside. An area is designated 30 feet from building or as far as possible without infringing on neighbors or putting people in unsafe locations.

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TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
SPGSR12					<ul style="list-style-type: none"> • Smoking remnant receptacles, specifically designed for that purpose, are located outside the facility, at least 30 feet from any buildings; a 'best practice' would be 50 feet away. • If there is no available spot that can be designated which is 30 ft. away from the building, then the designated area should be as far from the building as is practical while still remaining on the property. Placement may also be per recommendation of the local fire authority provided it is located away from the structure and attachments (e.g. decks, ramps) • There must be a regular schedule to ensure these receptacles are emptied and it is implemented • Staff are aware to not put items such as coffee cups, empty cigarette packs or other trash in the receptacle that is intended solely for cigarette butts. • Designated smoking areas are free of combustible materials • Note whether there is evidence that smoking is being performed in non-designated areas or receptacles not being utilized, i.e. cigarettes on the ground around the exterior of the facility or close to the building • For individuals who smoke, their ability to routinely practice smoking safely should be assessed and documented in their written plan (e.g. IPOP). Plans should also specify supports needed to smoke safely. Agencies are responsible for monitoring cigarette use by individuals including counseling individuals when they are discovered to be exhibiting problematic behaviors related to smoking. If problems are identified, the issue should be addressed in protective oversight plans. <p>NOTE: If evidence of smoking in violation of OPWDD's smoking directive per ADM #2012-02 is found, surveyors will identify deficiencies accordingly. For situations that present an immediate risk to the safety of any individual, contact your regional director & require immediate correction.</p>
SPGSR13	635-7.3(c)(4) <i>Additional: 635-7.4 (b)(3)(xx)</i>	36. Facilities with a private water source for drinking and cooking test their water annually for conformance with established bacteriologic and chemical standards.			Obtain and review a copy of the facility's well water test reports. Include these documents in the survey file. Refer to ADM 96-02 "Revised Testing Standards for Private Wells" dated April 8, 1996. The memo is applicable to <u>all</u> OPWDD-certified facilities that have wells as their source of potable water. Annual testing is required for the following four (4) parameters: coliform, standard plate count; chlorides; and, nitrates. Testing parameters exceeding the maximum contaminant level for that substance in drinking water will require corrective action. This typically is noted on the test report. Additional testing may be required if the well is located near potential sources of contamination, such as lead, unspecified organic contaminants, heavy metals, or sodium. ADM 96-02 provides guidance for determining if these tests are necessary.
	686.3(a)(1) <i>Additional: 633.4(a)(4)(i)</i>	37. The physical plant is appropriate to the needs of the individuals who receive services there.			During the survey at the site and related observations, verify the following: <ul style="list-style-type: none"> • The physical plant is easily navigated by individuals with and without adaptive equipment • For capable individuals, appliances are easily accessible • The environment allows people to be as independent as possible. For example: the floors are kept impediment free for individuals who clinically are appropriate to scoot, crawl on the floor for

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TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
SPGSR14					mobility. <ul style="list-style-type: none"> • Supplies such as toilet paper, soap and towels for drying are available in bathrooms • Adaptive equipment is available and correctly installed as needed (grab bars, railings, ramps, etc.) • Furniture accommodates the needs of individuals, e.g. tables with appropriate height for wheelchairs are available if individuals must remain in their chairs for clinical reasons • There is adequate space so that individuals can have privacy during phone calls and with visitors • Lighting is adequate based on individuals' needs and appropriate to their activities • If you have concerns about size of rooms ore use of space , see #s 5-9 under reference requirements at the back of this document for more guidance.
SPGSR15	635-7.4 (b)(3)(xii) <i>Additional:</i> 635-7.3(h)(1)	38. Toilet rooms and Bathrooms Provide Personal Privacy			Through observation, verify that bathrooms are equipped with doors that close fully and window coverings that ensure privacy.
SPGSR16	633.4(a)(4)(i) <i>Additional:</i> 635-7.3(j)(2)	39. There are insect screens on all windows used for ventilation.			Review that screens are available for use if applicable. If survey staff observe open windows without screens, especially in the warmer months, this creates an avenue for the entrance of flies and other insects into the facility. This also applies to doors that are left open for significant amounts of time without a screen door being utilized. If a number of flies are observed in the facility, do a more thorough check of window screens. If a facility is equipped with central AC this is usually not an issue.
SPGSR17	635-7.3(h)(6) <i>Additional:</i> 635-7.4 (b)(3)(xix)	40. The facility is clean.			NOTE: Surveyors are to use their best judgment when assessing for compliance with this requirement. Take into account the environment as a whole and the number and degree of cleaning issues noted. a) During routine observations at the facility and during the formal physical plant "walk through" make note of the condition and cleanliness of the environment. A clean environment should include but is not limited to the following: <ul style="list-style-type: none"> • Walls, doors, door knobs are not stained and are free of food or other residues • Floors surfaces and rugs are clean and free of large or excessive stains. • Furniture is clean, unstained and free of residue • Bedrooms, allowing for some personal variances are relatively clean, organized, and free of clutter which can impede safe exiting. • Bathrooms and bathroom fixtures are clean and sanitary, including adaptive equipment needed for hygiene activities. <ul style="list-style-type: none"> ○ Bathrooms are clean and free of visible mold and mildew on walls, ceiling, showers and tubs, shower curtains, toilets, adaptive equipment and non-slip bath mats.

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TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
					<ul style="list-style-type: none"> ● Kitchens <ul style="list-style-type: none"> ○ Kitchen surfaces are clean ○ Appliances are clean and free of food spillage. Range burners and reflector pans are clean. ○ The oven interiors are clean and free from spill-over and burnt on food ○ Exhaust Fans and/or filters above the stove are clean. ● Facility grounds are free of litter. Trash is disposed of properly and not littered on the grounds posing a PICA risk. <p>b) All areas of the facility are free of unpleasant odors. During visit to the facility take note of whether any of the following are present:</p> <ul style="list-style-type: none"> ● Urine odors in bathrooms ● Urine odors in bedrooms (May be a result of incontinence and/or inappropriate urination. Take follow-up action to determine whether the issue has been identified and whether it is being addressed from a service planning and provision perspective.) ● Odors emanating from furniture or mattresses ● Odors from uncovered garbage receptacles ● Musty smells associated with mold and mildew; this may be indicative of water leaks or seepage
SPGSR18	<p>635-7.3(h)(6)</p> <p><i>Additional: 635-7.4 (b)(3)(xix) 633.4(a)(4)(i)</i></p>	<p>41. The facility is well maintained for the safety and comfort for the individuals receiving services.</p>			<p>NOTE: Surveyors are to use their best judgment when assessing for compliance with this requirement. Take into account the environment as a whole and the number and degree of and maintenance issues noted.</p> <p>During routine observations at the facility and during the formal physical plant "walk through" make note of the condition of the environment. Ask service recipients and staff about the condition of the site, whether everything (e.g. appliances, plumbing, lighting) is working properly and whether anything is broken. An adequately maintained environment should include but is not limited to the following:</p> <p>All facilities:</p> <ul style="list-style-type: none"> ● Walls and doors are free from damage and holes. ● Doors fit properly in casing and close and open freely. Door knobs are firmly installed and work easily. ● Floors surfaces are in good repair without uneven surfaces, chips, loose tiles, bare spots, loose tiles, curled seaming etc. ● Carpets and area rugs are without bare spots, and are laying flat without lumps, bumps, fraying or poor seaming that create trip hazards. ● If throw rugs are used, they should lay on the floor smoothly, without curling or bunching. They should be arranged so that they stay in place.

PART 2 – SAFETY- PHYSICAL PLANT

TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
					<ul style="list-style-type: none"> ● Furniture is in good condition. Wooden furniture and chairs are not broken. Upholstery is not ripped. Seat cushions and mattresses are not sagging. ● The facility is free of rodent or insect infestation, and the facility has addressed potential entry access points for such vermin. ● Light fixtures and lamps are working and bulbs are not missing or burnt out ● Lighting is sufficient for the space and activities ● Bathroom fixtures work properly. Sinks, tubs and showers drain adequately. Toilets flush properly. There is no evidence of leaks. Verify that special adaptive tubs and their lifts operate properly, and grab bars and shower chairs are secure and safe. ● Ground Fault Interrupters in bathrooms, kitchens and laundry rooms are operable. GFIs should be installed within 6 feet of sinks, tubs etc. including laundry sinks. ● Appliances are in good working order and can be used by the facility <ul style="list-style-type: none"> ○ The Range/Oven is in working order ○ All range burners are working ○ The over door should close fully and seal. ○ Exhaust fan is working ○ If the facility stove(s) has an ANSUL or residential fire suppression system, there is evidence that it is inspected and serviced as needed. ○ Without evidence to the contrary, refrigerators and freezers are maintained to ensure that food is stored at appropriate temperatures for safe storage. During routine observation for adequate food supply, verify that the refrigerators appear to be in working appropriately. Evidence to the contrary may include a loose seal when opening, the interior feels warmer than normal, there is water pooling, there are unpleasant odors. Only if such examples or others indicate that there may be a problem, use a thermometer to verify that refrigerators are maintained between 32 – 40 degrees Fahrenheit, and freezers are maintained at 0 degree F or less. It is ideal that refrigerators and freezers should be equipped with thermometers. ● There is no evidence of roof leaks, broken windows ● Exterior of the facility appears in good repair. Exterior surfaces are appropriately maintained, painted and cleaned. Gutters are not sagging and are free from excessive debris. Walkways/driveways are free of large cracks and height changes that may pose trip hazards. Outdoor furniture - picnic tables are in good repair. ● House numbers are clearly visible from the street. This maintenance issue is important for timely 911 responses by emergency services such as ambulance or fire department. Upon arrival to the site, you should be able to identify the address of the site from the road while in your vehicle. Avoid use of numbers similarly colored to the background.

PART 2 – SAFETY- PHYSICAL PLANT

TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
					<p>Workshop (Day Training) Considerations:</p> <ul style="list-style-type: none"> • Machines such as packaging and sealing equipment are in good working order • There are staff on duty who have expertise in equipment maintenance • The facility adequately vented; there are no odors such as chemical smells • The lighting appears sufficient • The facility is maintaining minimum paths of travel on the work floor. Pallets do not obstruct paths of travel • There are no trip hazards due to wires or other obstructions • Means of egress are maintained at all times <p>NOTE: The facility is required to ensure that fire protection equipment is in good working order. However, problems with the equipment should be cited elsewhere in this document.</p> <p>NOTE: At times, poor maintenance may cause hazardous conditions. Such findings should be cited elsewhere in this document.</p>
SPGSR19	686.16(b)(4) <i>Additional: 633.4(a)(4) (ix)</i>	42. Facility staff can describe the safe operation of the special adaptive tubs (e.g. Century, Parker) and associated lifts.			<p>Through interview with the direct support professionals, verify that if they are assigned bathing activities using special tubs, they have been trained in how to use them and maintain the safety of individuals using them.</p> <p>It is not the intended that surveyor reviews staff training rosters.</p> <p>Note: It is a good facility practice to have written instructions on special tubs and lifts available for staff.</p>
SPGSR20	635-7.4 (b)(3)(xiv) <i>Additional: 635-7.3(h)(3)</i>	43. All ramps, doors, handrails, elevator controls, telephones and similar devices installed for use by individuals with physical disabilities, are in an operable/usable condition.			<p>Based on observation and interview, verify the condition of special devices and adaptive equipment in place. E.g.:</p> <ul style="list-style-type: none"> • Handrails are secured • Ramps are in good condition • Door opening devices are working • Elevators work • Phones and associated equipment for people with hearing impairments are operable
SPGSR21	633.4(a)(4)(i)	44. Based on observation and/or interview, the facility vehicle(s) are properly maintained, including specialized adaptive equipment.			<p>Note: The intent of this standard is to note problems that come to the surveyor's attention during routine survey activities.</p> <p>When possible, observe staff assisting individuals in or out of vehicles. Ask staff working and individuals whether the vehicles have been working okay. Review the facility communication log.</p> <p>The vehicle should be free of any obvious maintenance problems such as doors tied shut etc</p> <p>If present at the facility, check that there is a current inspection sticker.</p>

PART 2 – SAFETY- PHYSICAL PLANT

TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
					<p>If the vehicle has a lift or ramp for W/C access it is in good repair and operable.</p> <p>Staff and individuals report that vehicles are working and maintained.</p> <p>Best Practice - A seat belt cutter is in each facility vehicle used to transport individuals.</p>
SPGSR22	<p>686.16(b)(4)</p> <p><i>Additional: 633.4(a)(4) (ix)</i></p>	<p>45. Based on observation and/or interview, staff are competent to operate the van adaptive equipment safely including utilizing the mechanisms designed to secure wheelchairs for transport.</p>			<p>If possible, observe staff assisting individuals in or out of vehicles and interview staff. Staff should know how to safely operate the lifts, ramps and mechanisms designed to secure wheelchairs for transport.</p> <p>If observation is not possible, interview staff to verify that they have the knowledge to operate the adaptive equipment safely.</p>
SPGSR23	<p>635-7.3(h)(8)</p> <p><i>Additional: 633.4(a)(4)(i)</i></p>	<p>46. Swimming pools are appropriately secured and maintained.</p> <p><i>Applies to sites with pools only.</i></p>			<p>Security: The pool should be adequately protected.</p> <ul style="list-style-type: none"> • This can change depending on the type of pool (in-ground or aboveground) or local laws. Generally, in-ground pools require a four (4) foot high enclosure, with self-closing locked gate. For aboveground pools, the barrier can be around the pool or mounted on top of the pool structure. For both types of pools, the barriers must be sturdy. Removable ladders should not be draped across a barrier (which defeats the purpose of the barrier). • Pools constructed or substantially modified after 12/14/06 are equipped with an approved pool alarm • Safety devices must be working properly (pool alarms, door alarms, etc.) <p>Maintenance:</p> <ul style="list-style-type: none"> • The program/agency should have policies and procedures in place to ensure that the pool is properly maintained. • There should be evidence that the pool is being appropriately maintained. Consider the following: <ul style="list-style-type: none"> ○ The pool looks to be in adequate condition ○ Devices are working properly ○ The pool is relatively clear and clean with no excessive build-up of debris or algae ○ There are covers on suction valves
SPGSR24	<p>635-7.3(h)(8)</p> <p><i>Additional: 633.4(a)(4)(i)</i></p>	<p>47. Facilities with pools implement procedures to safeguard individuals and prevent drowning.</p>			<p>Please refer to the Safeguarding Alert from OPWDD 00-01-Drowning Alert for specific safety recommendations, and verify the following, through interview and observation:</p> <ul style="list-style-type: none"> • The program/agency have policies and procedures in place to ensure the safety of individuals using the pool (in accordance with the Alert) • Staff and program participants are trained in pool safety precautions developed by the agency • Individuals are assessed regarding their swimming capabilities/needs • Staff are aware of each individual’s needs regarding pool safety, such as limitations, need for supervision, adaptive devices, etc. • Program participants understand pool safety, to the best of their ability

PART 2 – SAFETY- PHYSICAL PLANT

TAG	Reference	REQUIREMENT/ STANDARD	Met	Not Met	GUIDELINES
SPGSR25	635-7.3(h)(11) <i>Additional:</i> 635-7.3 (h)(11)(i) 635-7.3 (h)(11)(ii) 635-7.4 (b)(3)(iii)	48. The facility has a communication system and staff are aware of policies for the following: (i) prompt contacting of on-duty personnel and (ii) prompt contacting of other responsible personnel in emergencies			Through interview and observation, verify the following: <ul style="list-style-type: none"> • Staff have access to a list of multiple administrative and nursing contact phone numbers • Staff know where to find the list • Staff report the system is meeting the needs of the program
SPGSR26	635-7.4 (b)(3)(iii) <i>Additional:</i> 635-7.3(c)(6)	49. The home shall have land line (see section 635-99.1) telephone service which is in working order and functions during power outages.			There must be at least one "land Line" phone on premises. <ul style="list-style-type: none"> • Cordless phones with a base unit that requires electricity are not acceptable as the only phone available. • Phone service through a Cable TV provider is not acceptable as the sole source of phone service. • If the facility uses digital phones as the main source of communication, there should be a fully charged cell phone accessible at the site as an emergency back-up.
SPGSR27	633.10(b)(2) All Facilities	50. There is a written plan for how the facility will deal with life-threatening emergencies.			This standard will be typically used by surveyors to assess for life threatening emergencies other than fire emergencies Such emergencies may include activation of CO detectors, weather emergencies (e.g. tornado warning); and medical emergencies. Review the facility's plan(s). Assess that it provides necessary information to include but not limited to: <ul style="list-style-type: none"> • A Communication System for the prompt contacting of emergency personnel in the event of the emergency • A plan to evacuate the site, to include relocation if needed • Plan to access emergency medical services • Plan to address/provide CPR/First Aid as needed • Prompt contacting of responsible agency personnel once the immediate needs of the individuals/site are addressed Assess whether the plan is likely to effectively handle the emergency. Ensure that there is a system to train staff on the emergency plan(s). Based on interview of direct staff, verify that they are aware of the contents of the emergency plans and their responsibility for implementing.

PART 2 STOPS HERE

REFERENCE REQUIREMENTS AND MATERIALS

The reference documents below are intended to provide information and clarification for commonly occurring issues that arise during site reviews. It includes the following:

- Regulatory references for issues that should typically be addressed during pre-opening visits but at times become issues during regulatory and annual reviews.
- Charts identifying fire protection equipment required and related testing and maintenance.
- Essential Elements documents issued by OPWDD which identify practices that are required for state operated facilities, and recommended for voluntary operated facilities.
- Memos issued by OPWDD describing requirements related to safety and physical plant expectations.

REQUIREMENT/ STANDARD	GUIDELINES
ADM 2012-02 requires an Architect's Letter containing all needed information, on which a certification decision will be based, must be available on or before the time of the pre-opening visit. See also, 635-7.1(e)(1-3)	Refer to guidance document, "Format and Content of Architectural Report" for what should be included in an Architect's Letter. See Addendum, below.
<p>Supervised Community Residences initially certified or granted certification of need and approval for construction subsequent to 9/1/85 and Supervised Individualized residential alternatives (IRAs) housing Nine or more persons, must meet the following LSC requirements:</p> <p>Chapter 32 (New) or 33 (Existing), Residential Board and Care Occupancies, of the NFPA 101 Code, 2000 Edition, or Chapters 18 (New) or 19 (Existing) Health Care Occupancies of the NFPA 101 Life Safety Code, 2000 Edition.</p>	<p>Life Safety Code Requirement: 635-7.2(a)(1)(ii)</p> <p>If unsure of which portion of the LSC or Part 635 to apply consult with your area director or obtain the assistance of a survey staff person who is trained in LSC survey procedures.</p>
<p>The following requirements apply to those Supervised Community Residences initially certified or granted certification of need of approval for construction prior to September 1, 1985:</p> <p>(1) All people in residence can evacuate the facility in 2.5 minutes or less, with or without verbal and/or physical prompts (see section 686.99 of this Title) for those facilities which do not meet the requirements of chapter 32 (new) or 33 (existing) of the Life Safety Code (paragraph [a][1] of this section).</p> <p>(2) For those facilities which cannot document total person evacuation from the sleeping areas in 2.5 minutes or less, the facility has an established and documented E-score for the facility.</p> <p>(3) If an E-score is maintained by the facility, the agency/facility shall comply within its policies and procedures for maintaining an acceptable E-score and a level of evacuation difficulty, as described in NFPA 101A, Guide on Alternative</p> <p>Approaches to Life Safety, 2001 edition that is based on the actual mix of people being served and the staffing pattern for such facility.</p> <p>(4) If an E-score is maintained by the facility, there are written policies and procedures evaluating an applicant's effect on the facility's E-score prior to admission.</p>	<p>Life Safety Code Requirements: 635-7.2(c)(1-4)</p> <p>If unsure of which portion of the LSC or Part 635 to apply consult with your area director or obtain the assistance of a survey staff person who is trained in LSC survey procedures.</p>

<p align="center">REQUIREMENT/ STANDARD</p>	<p align="center">GUIDELINES</p>
<p>The following Life Safety Code Requirements must be met by the herein specified facility class:</p> <p>Supervised Individualized residential alternatives (IRA) for eight or fewer people in which the occupants CANNOT be evacuated in three minutes or less must meet either Chapter 33 (Existing) Residential Board and Care Occupancies, of the NFPA 101 Life Safety Code, 2000 Edition, or</p> <p>Chapter 19 (Existing) Health Care</p> <p>Occupancies of the NFPA 101 Life Safety Code, 2000 Edition. NOTE: This requirement applies to both new AND existing IRAs.</p>	<p>Life Safety Code Requirement: 635-7.2(a)(1)(iii)</p> <p>If unsure of which portion of the LSC or Part 635 to apply consult with your area director or obtain the assistance of a survey staff person who is trained in LSC survey procedures.</p>
<p>The following Life Safety Code Requirements must be met by the herein specified facility class:</p> <p>Private Schools (Including an Integrated Residential Community):</p> <p>a.) A facility serving 15 or fewer persons with the ability to Evacuate said facility in less than 2.5 Minutes. Chapter 11, Residential Occupancies, of the NFPA 101 Life Safety Code, 1973 Edition</p> <p>b.) A facility servicing more than 15 persons or where one or more persons are unable to Evacuate said facility in less than 2.5 Minutes. Chapter 10, Institutional Occupancies, of the NFPA 101 Life Safety Code, 1973 Edition</p> <p>c.) Any Private School residential facility or residential building constructed after 4/1/08. Chapter 32 (New) Residential Board and Care Occupancies of the NFPA 101 Life Safety Code, 2000 Edition.</p>	<p>Life Safety Code Requirements: 635-7.2(a)(1)(iv)(a-c)</p> <p>If unsure of which portion of the LSC or Part 635 to apply consult with your area director or obtain the assistance of a survey staff person who is trained in LSC survey procedures.</p>
<p>The maximum number of beds in any bedroom of these residential facilities shall be two, except when exceptions are allowed.</p> <p>Large IRA, Supervised CR, Private School : 635-7.3(d)(1)</p> <p>Small IRA: 635-7.4(b)(3)(x)</p>	<p>Verify that no more than two individuals share/occupy a bedroom, unless the following exceptions apply. (Exceptions apply only to Large IRAs and Supervised CRs)</p> <p>If more than two individuals are found to occupy a bedroom, the site must be a Large IRA or Supervised CR, and one of the following must be in place:</p> <ul style="list-style-type: none"> ● There is documentation that permission for exception was granted by the Commissioner. OR ● The facility was certified prior to May 1, 1990 and is continuing their existing bedroom capacity configuration.

<p align="center">REQUIREMENT/ STANDARD</p>	<p align="center">GUIDELINES</p>
<p>Bedrooms are appropriately sized per regulation and norm.</p> <p>Large IRA, Supervised CR, Private School, ICF : 635-7.3(d)(2)</p> <p>Small IRA: Best Practice</p>	<p>Based on observation, use your best judgment to determine whether the bedroom size and arrangement appears to be sufficient for the number of individuals using the room. Situations which may require particular attention are bedrooms which have been converted from other uses (e.g. offices, storage). Assess that they provide appropriate bedroom space with natural lighting, adequate ventilation and egress without impediment.</p> <p>NOTE: There is not an expectation that reviewers routinely measure bedroom size during site visit. This should be an observational assessment. Measure only if room size appears significantly small, strangely configured, or non-homelike and has a negative impact on the individual(s). The exception would be pre-openings.</p> <p>Effective as of 8/1/07, regulation requires that bedrooms in Large IRAs and Supervised CRs provide, exclusive of closets, at least 70 sq. ft. per person in multiple sleeping rooms, and at least 80 sq. ft. in single bedrooms.</p> <p>This is a best practice for Small IRAs. See also V2208</p>
<p>An area is set aside and furnished specifically for dining, which is sufficient to accommodate members of the residence both ambulatory and non-ambulatory.</p> <p>Large IRA, Supervised CR, ICF: 635-7.3(e)(2)</p> <p>Small IRA: 686.3(a)(1)</p>	<p>Based upon observation assess whether the facility's dining area can comfortably accommodate residents and supporting staff during mealtime. People should be able to move about and in and out of the dining area without great disruption to others (e.g. Individuals using wheelchairs or walkers should be able to move from their place and leave the room without everyone else needing to move out of their way?</p> <p>The space may be used for other purposes/activities but these should not negatively impact on use for dining nor compromise its character as a dining area. (E.g. Large food storage freezer, office space- desks and/or file cabinets in dining room.)</p> <p>NOTE: There is not an expectation that reviewers routinely measure room size during site visit. This should be an observational assessment. Measure only if dining space appears significantly small and has a negative impact on the individual(s). The exception would be pre-openings.</p> <p>Per Regulation, applicable only to Large IRAs and Supervised CRs dining area space requirements are a minimum of 15 sq. ft. per ambulatory individual residing at the facility, and 27 sq. ft. per non-ambulatory individual. This is a best practice for Small IRAs. See also V2208.</p>
<p>Space for staff work areas shall be provided in the facility. The location and amount of space shall be determined by the types of services offered by the facility and the characteristics of the individuals who reside at the facility. Each facility that provides sleeping quarters for staff shall also have space for at least one staff work area.</p> <p>Large IRA, Supervised CR, ICF: 635-7.3(e)(3)</p> <p>Small IRA: Best Practice</p>	<p>Observe to determine whether the residence looks and "feels" like a home. There should be sufficient staff work areas/office space so that office equipment and activities do not appear to encroach on the home environment. Consumer space such as common living space should not be used for administrative purposes. This may be unavoidable in some existing facilities. Surveyor judgment as to the appropriateness must be executed. Recommendations should be included on the exit conference form if opportunities for improvement are noted.</p> <p>Clinical and administrative information about people should not be posted in common living</p>

<p align="center">REQUIREMENT/ STANDARD</p>	<p align="center">GUIDELINES</p>
	<p>areas of the home accessible to others such as guests. For example: Lists of food allergies, dietary restrictions, birthdays, behavioral strategies, feeding protocols, toileting schedules, chore lists, special staff assignments, individual sign language vocabularies, day program rosters, bus schedules, medical appointment calendars, family addresses and phone numbers, etc.</p> <p>Also consider the following:</p> <ul style="list-style-type: none"> ● Does the site feel like a home or business? ● Are there filing cabinets, a photo copy machine, a fax machine etc. in the living room? ● Is there a staff related bulletin board in the consumer’s area of the home? <p>This is a best practice for Small IRAs. See also V2208</p>
<p>The residence provides adequate common living space to meet the day-to-day needs of the individuals living there.</p> <p>Large IRA, Supervised CR, ICF: 635-7.3(e)(4)</p> <p>Small IRA: 686.3(a)(1)</p>	<p>Based on observation, determine whether the home provides sufficient common living area(s) and space to accommodate the daily activities and needs of the people who live there. Consider the following:</p> <ul style="list-style-type: none"> ● There should be sufficient space to allow all individuals to be at home and participating in leisure activities outside their bedroom. ● There should be sufficient space to accommodate adaptive equipment and the storage of it when not in use. <p>NOTE: There is not an expectation that reviewers routinely measure the facility during site visit. This should be an observational assessment. Measure only if space appears significantly small and has a negative impact on the individual(s).</p> <p>Per regulations applicable to Large IRAs and Supervised CRs, adequate habitable space for lounge, communal living or other non-program space shall be provided in the facility of at least 25 square feet per person.</p> <p>This is a best practice for Small IRAs. See also V2208.</p>

The following table provides an outline of the **basic** fire protection/detection equipment required of each facility listed below. Surveyors should note that a facility may upgrade the level of fire protection equipment, but may not downgrade if the type of programming at the site changes.

REQUIRED FIRE PROTECTION EQUIPMENT BY FACILITY TYPE

TYPE OF FACILITY	HARD-WIRED SMOKE DETECTORS	CARBON MONOXIDE DETECTORS	EMERGENCY LIGHTING	EXIT SIGNS	FIRE ALARM PULL BOX	HEAT DETECTORS	SPRINKLERS
Supportive CR	R	R	NR	NR	NR	R ¹	NR
Supervised CR	R	R	NR (except in LSC Chapter 19)	NR (except in LSC Chapter 19)	NR (except in LSC Chapter 19 & 33)	R ¹	NR (except in LSC Chapter 18 & 33 Impractical)
Small IRA	R	R	NR	NR	NR (except in LSC Chapter 18/19 & 32/33)	R ¹	NR (except in LSC Chapter 32)
Large IRA	R	R	NR (except in LSC Chapter 19)	NR (except in LSC Chapter 19)	NR (except in LSC Chapter 19 & 33)	R ¹	NR (except in LSC Chapter 32 & 33 Impractical)
Day Treatment	NR	NR	Emergency lighting required in buildings four stories or more	R	R	NR	NR
Clinics	NR	NR	Emergency lighting required in buildings four stories or more	NR (except in buildings over 2,500 sq. ft. on any story)	NR (except in buildings over two stories or more than 30' in height)	NR	NR
Day Training	NR	NR	Emergency lighting required in buildings four stories or more	NR (except in buildings over 2,500 sq. ft. on any story)	NR (except in buildings over two stories or more than 30' in height)	NR	NR
Day Hab	NR (except in exit ways)	NR	Emergency lighting required in buildings four stories or more	NR (except in buildings over 2,500 sq. ft.)	NR (except in buildings over two stories or more than 30' in height)	NR	NR

NR = Not Required

***Fire extinguishers** are required in all facility types.

***Battery Powered Smoke Detectors:** Battery-powered smoke detectors are not permitted at any site unless by exception. For exceptions to the battery-operated smoke detectors ban, see Administrative Memorandum No. 97-01 dated January 22, 1997 from Mr. Richard Johnson to Executive Directors of Voluntary Agencies and DDSO Directors.

¹**Heat Detectors:** As required by regulation and ADM# 2012-02

The table below provides a cleaning and maintenance schedule for fire protection equipment by program type:

MAINTENANCE/INSPECTION SCHEDULE

TYPE OF FACILITY	FIRE EXTINGUISHERS	HARD-WIRED SMOKE DETECTORS*	BATTERY-POWERED SMOKE DETECTORS*	EMERGENCY LIGHTING	EXIT SIGNS	FIRE ALARM PULL BOX	HEAT DETECTORS	SPRINKLERS
Supportive CR	Monthly Annually Every 6 years	Quarterly	Per manufacturers' instructions	Monthly	NR	Annually (if installed)	Annually (if installed)	Quarterly (if installed)
Supervised CR	As above	Quarterly	Per manufacturers' instructions	Monthly	NR	Quarterly	Quarterly	Quarterly
Small IRA	As above	Quarterly	Per manufacturers' instructions	Monthly	NR	Quarterly	Annually (if installed)	Quarterly (if installed)
Large IRA	As above	Quarterly	Per manufacturers' instructions	Monthly	NR	Quarterly	Quarterly	Quarterly
Day Treatment	As above	Quarterly (if installed)	Per manufacturers' instructions	Monthly	NR	Quarterly	Annually (if installed)	Quarterly (if installed)
Clinics	As above	Quarterly (if installed)	Per manufacturers' instructions	Monthly	NR	Quarterly	Annually (if installed)	Quarterly (if installed)
Day Training	As above	Quarterly (if installed)	Per manufacturers' instructions	Monthly	NR	Quarterly	Annually (if installed)	Quarterly (if installed)
Day Hab	As above	N/A if building is sprinklered Quarterly (if installed)	Per manufacturers' instructions	Monthly	NR	Quarterly	Annually (if installed)	Quarterly (if installed)

NOTE: When a facility does not require specific fire protection equipment, a maintenance/inspection schedule should be followed in facilities where fire equipment is installed.

*All smoke detectors should be reviewed for replacement every 10 years.

Essential Elements of a Fire Evacuation Plan

While planning for every situation that may occur in any type of an emergency is impossible, being as prepared as possible is important. All fire plan must be "site-specific". Evacuation routes and safe areas will be different for each agency facility and these must be detailed in the plan. However, the following minimum elements are essential to all facility fire plans:

COMPONENTS OF ACCEPTABLE FIRE PLANS

1. The plan must detail the specific actions to be taken upon:
 - a) Actual discovery of the fire;
 - b) Smelling smoke; and/or
 - c) Hearing the alarm
2. How to safely check and enter rooms during the evacuation process
3. How to evaluate evacuation priority
4. Individual staff responsibilities during the evacuation process
5. An identified safe area for head count
6. Notification of the fire department

The night shift is normally the least staffed shift and the one in which the residents are the most vulnerable should a real fire occur. The plan shall, therefore, address this worst-case scenario while including other duties to be assigned to any additional staff available on the day or evening shifts.

1a. Actions to be taken upon discovery of a fire

- This is the most important aspect of the fire plan. Staff must react decisively, promptly and in the correct sequence to assure maximum safety when they encounter a real fire situation.

The **RACE** acronym can be used to reinforce the extremely important sequence of rescuing, closing the door, pulling the alarm and then evacuating the building.

- R** – Rescue and Close the Door to the room of the fire origin.
- A** – Alarm – pull the nearest alarm box (or if there is none, alert everyone by shouting fire or other predetermined signal).
- C** – Confine the fire by closing all doors while exiting.
- E** – Evacuate the building by the closest exit and go to the designated meeting area.

1b. Actions to be taken upon smelling smoke

- If an individual smells smoke, he/she shall immediately pull the nearest alarm box and begin evacuating the floor he/she is on while carefully checking doors to see if they are hot. Revert to **RACE** when the fire is actually found. The staff must then go to their assigned meeting area(s).

1c. Actions to be taken when alarm sounds

- Each staff person shall have an assigned area to look after in the event an alarm rings. Night shift staff shall be assigned responsibility for sleeping areas and/or particular floors.
- Staff may have several duties in addition to evacuating an area (e.g. staying at the designated safe area to ensure individuals do not wander back into the house and/or away from the residence, check the panel box to determine the location of the fire and direct critical assets to that location, contact the fire department from the building next door or the municipal pull box.) These duties shall be specifically explained and assigned to staff when they report for duty.

2. How to safely enter rooms during the evacuation process

- All plans shall have instruction on how to safely enter rooms during a fire emergency. It is important that staff is aware of the dangers of flash-over and how entering a room too quickly could be disastrous. The staff member shall touch the door to determine if it is hot. If it is, staff shall proceed to the adjacent room.

3. How to evaluate evacuation priority

- Plans shall reflect consideration given to the specific needs of the individuals (e.g. cognition, motor skills, ability to follow directions,) as well as their location within the house, proximity to exits, etc.

4. Individual staff responsibilities during an evacuation

- All plans must list the specific responsibilities of staff during the evacuation process. Staff shall be given assignments by floor/area, rather than being assigned to specific residents, excepts when an individual requires two staff to evacuate or has been designated to have 1:1 staffing. All staff must know exactly what their job is when the alarm sounds and must be trained to react properly and quickly.

5. Identified site for the safe area

- All plans shall identify a specific location to gather after evacuating to determine if everyone evacuated safely. The "safe area" shall be at a safe distance from the building, avoiding roads, fire hydrants and areas to which rescue equipment/personnel may need access.

6. Notifying the fire department

- Some facilities have a direct line to the local fire department or a central monitoring station, most have only a local alarm and, therefore, at some point the fire department must be notified. In most cases, notifications of fire department occur after all individuals have evacuated.

ESSENTIAL ELEMENTS OF FIRE DRILL REPORTING

Fire drills and evacuation drills are required by OPWDD in certified settings for a variety of reasons. First and foremost, the safety of individuals that we serve is always the highest priority and fire safety is an essential safeguard. There are a number of specific regulatory requirements that relate to fire safety and the need for fire and evacuation drills at supervised settings such as Intermediate Care Facilities, Supervised CR's and IRA's, Private Schools, Day Treatment Programs, Day Habilitation Programs and Day Training Programs.

Fire and evacuation drills are specifically required in all setting that are certified using the Life Safety Code. The Life Safety Code, published by the National Fire Protection Association, provides a reasonable level of life safety, but it is only one component. Staff Action and proper planning for emergencies is crucial. In IRA's fire safety and fire drills are an integral part of the concept of Protective Oversight. For individuals enrolled in Medicaid Service Coordination the agency must maintain an accurate assessment regarding his or her capacity to evacuate, and the assessment must be performance based.

Fire drills and evacuation drills are also essential to ensure that all staff on all shifts are trained to perform their assigned tasks outlined in the facility's evacuation plan and to ensure that all staff on all shifts are familiar with the use of the facility's fire protection equipment. In addition, individuals who are capable should be trained to participate and respond to fires or other emergency conditions.

Drills also serve to provide agencies with a mechanism for evaluating the effectiveness of evacuation and disaster plans on an on-going basis and to capture information on changes in consumer status. Changes such as those resulting from advancing age, medical changes or new admissions may result in the need to modify the physical environment of the facility, revise the evacuation plan or provide additional staff resources to the facility to meet consumer needs.

Many individuals live in supportive settings such as 'supportive' CR's and IRA's not staffed 24 hours a day. In these types of settings there is an underlying presumption and requirement that individuals be independently evacuating, which means that they are able to initiate and complete an evacuation of their home or other environments in which they spend time, in three minutes or less without any prompts or assistance.

Just as in the supervised settings described above, individuals who live in supportive settings must be assessed on an on-going basis to ensure that they maintain their independent evacuation capabilities. Changes in consumer status resulting from advancing age or medical changes may result in the need to modify the physical environment of the facility or may result in the need to reassess the viability of the consumer continuing to be able to live in the supportive setting.

In all settings, individuals should be aware of the facility's policies and procedures regarding the need to conduct fire and evacuation drills to the extent possible, so drills should not come as a surprise. Individuals should understand that their ability to demonstrate independent evacuation skills on an on-going basis is a requirement for participation in the supportive housing program as well as being in their own best interest even though it may result in occasional personal inconvenience.

FIRE DRILL REQUIREMENTS

The following outlines the most salient features of what is expected in a reasonably complete fire drill report. Remember that drills are only one component required for fire safety and must be coordinated closely with the actual fire evacuation plans which is discussed in detail in another section.

- Program participants and staff must be aware of the facility's policies and procedures regarding the need to conduct fire and evacuation drills.
- All facilities must have a written evacuation plan (discussed in greater detail in another section) and staff must be regularly trained in the implementation of the plan. In some Life Safety Code certified settings, it is required that staff reviews the evacuation plan every two months. Facilities should extend this proactive measure to other settings.
- Drills shall be conducted at varied times of the day and night and under circumstances which include; shift, time of day, day of the week, weather conditions, etc. The overnight shift drills at Life Safety Code homes shall be conducted after the first half hour of sleep and during the first three hours of sleep. This is the period of time referenced in NFPA 101A, related to a consumer's ability to respond to an alarm during a period of sleep when he or she is most likely in the soundest sleep. Conducting drills during this period of sleep at other certified residential program types is strongly recommended, as it is the best way to gauge the consumer's ability to be awakened by an alarm.
- Fire drill scenarios shall be based on a fire potentially starting in a variety of locations within the building, such as laundries, kitchens, mechanical rooms, garages, common living areas or an individual's bedroom. Staff and individuals shall have an opportunity to participate and practice in a variety of scenarios since the location of a fire will influence which exit is used or the order in which various steps within the evacuation plan are implemented.
- The requirement for the frequency of fire drills varies depending on the type of facility in question and the specific regulatory requirements for that facility as well as the agency's policies and procedures. As a general guideline however, in supervised residential facilities a minimum frequency of one drill per shift per quarter is recommended. In day program a minimum frequency of one drill per quarter is recommended.
- Each staff member must participate in at least one full evacuation drill per year. This is a minimum requirement.
- All fire and evacuation drills or events MUST be documented on the standardized form (See Attachment).
- Any Significantly problematic drills such as a circumstance where a consumer could not be evacuated due to refusal etc. should be addressed by the agency administrative staff within 24 hours. Actions taken may involve a repeat drill, consumer counseling etc.
- The length of time a drill takes and whether or not that time is acceptable is dependent on the type of facility in question and whether or not the facility is certified using the Life Safety Code. The general rule for the public at large and for individuals in non-Life Safety Code certified setting is that evacuation will take three minutes or less.
- If staff are going to observe a fire drill but are not going to participate, they should ensure that they do not inadvertently influence individuals by not evacuating with the group. Staff who are observing should try to position themselves so that they are not readily visible. Individuals should not be exposed to mixed messages during an evacuation drill.
- Fire drills and evacuation drills should always be initiated using the facility's fire alarm system so that individuals and staff are fully familiar with the sound of the system and will immediately realize the significance of the situation and take appropriate action.
- Once the fire alarm sounds staff should immediately react based on the training they have received

regarding implementation of the evacuation plan as well as the principles inherent in the R.A.C.E system. Staff should not be trying to guess if this is a drill or a false alarm. If staff does not take the alarm seriously, individuals will not take it seriously. Staff's only responsibility is to get everyone out (or, in certain limited circumstances, move people to a point of safety). Answering the phone, finding possessions or deciding whether or not to try using a fire extinguisher are all peripheral concerns.

- Staff and individuals should remain outside the building in an evacuation drill until the all clear is given.

Once outside, staff's main responsibility is to ensure that all individuals and other building occupants are accounted for and that they remain accounted for until the all clear signal is given. Individuals must be supervised to ensure that no one tries to reenter the home.

FIRE AND EVACUATION DRILLS IN SUPPORTIVE SETTINGS:

Many individuals live in supportive settings such as supportive CR's and non-24 hour staffed IRAs. In these types of settings there is an underlying presumption and requirement that individuals independently evacuate, which means that individuals are able to initiate and complete an evacuation of their home or other environments in which they spend time, in three minutes or less without any prompts or assistance.

- Individuals who live in supportive settings must be assessed on an on-going basis to ensure that they maintain their independent evacuation capabilities.
- Changes in consumer status resulting from advancing age or medical changes may result in the need to modify the physical environment of the facility or may result in the need to assess the viability of the consumer continuing to be able to live in the supportive setting.
- Conducting an unannounced evacuation drill in a supportive setting can be challenging due to the issues of access to the home's fire safety equipment and expectations of personal privacy. One method some agencies have developed involves the use of a cell phone. It is usually not practical to enter a consumer's home, especially during hours of sleep, in order to set off a smoke detector. Instead, staff stations themselves in a location such as an apartment building's common corridor and then call the consumer on the phone. When the consumer answers the phone, staff announces that this is a fire drill and then observes the consumer's response.
- As in all other settings, the program participants should be aware of the facility's policies and procedures regarding the need to conduct fire and evacuations drills, so drills should not come as a surprise. Individuals should understand that their ability to demonstrate independent evacuation skills on an on-going basis is a requirement for participation in the supportive housing program as well as being in their own best interest even though it may result in occasional personal inconvenience.
- There is no specific frequency requirement for fire drills in supportive settings in applicable regulation but as in other settings, the assessment of individuals regarding their self-evacuation capabilities should be performance based. Supportive settings require four drills per year; recommended best practice is two drills conducted when the consumer is asleep.

Essential Elements of Fire Safety Training

Buildings may be constructed to the highest building code and life safety standards but in reality, they are only as safe as the behaviors of their occupants. Staff at all OPWDD residential and day facilities must know and practice fire prevention and fire safety. Shall a fire still occur, occupants must have practiced and be thoroughly familiar with evacuation procedures to maximize the benefits of the building's fire safety features. Fire Safety Training is the single most important element to ensure everyone is safeguarded in case of a fire emergency.

The following guidelines, practices and recommendations have been taken from the current fire safety training practices of various DDSOs and COMPASS agencies, the NFPA 101 (Life Safety Code) and NFPA 1 (Uniform Fire Code) as well as the New York State Uniform Fire Prevention and Building Codes.

Those who train others in fire safety must be totally committed to the importance of fire safe behavior, have the necessary knowledge to communicate accurate fire safety information and model fire safe behavior.

Staff training curricula for fire safety shall reflect the following content and characteristics:

CONTENT

1. The **properties of fire** (what is the fire 'triangle', (Oxygen, heat, fuel), causes and effects of fire and smoke, what is flashover and its dangers, fire spread, etc.)
2. **Understanding human behavior** during fire emergencies; overcoming common misconceptions
3. **Fire safety systems** and their proper uses
 - Fire alarms/pull stations
 - Fire extinguishers, sprinkler systems, smoke detector, carbon monoxide detectors, etc., fire doors
4. Fire **Safe Practices** (i.e. How to prevent fires from happening in the conduct of staff assigned duties).
5. Site specific evacuation plans and **RACE** (Rescue, Alarm, Confine, Evacuate)
 - Fire drill training shall reflect the philosophy that drills are not only for staff but for residents as well.
 - Evacuation plans have components for, and are understandable to individuals as appropriate (e.g. large pictures or other audio/visual devices for fire and/or smoke for training in alternate exiting locations, symbols, etc.)
6. Knowledge and identification of potential hazards
 - Electrical hazards
 - Fuel loading

- Candles and open flame devices
- Cooking
- Halogen lighting
- Live Christmas trees and vegetation
- Impact of individual behaviors on the safety of others
- Smoking inside and outside the building

CHARACTERISTICS

1. Staff conducting fire safety training shall consider the need to include outside experts such as fire department personnel, local code enforcement officials, and fire alarm and sprinkler consultants.
2. **Multi model instruction techniques** (in person training, videos on fire safety from NFPA and other sources, hands on equipment use and demonstration), use of real life examples.
3. **Hands on** training with fire safety equipment as appropriate.
4. **Evaluation of training:** the agency shall ensure that all staff have received training and understand the concepts of Fire and Fire Safety.
5. **Refresher training** occurs on an ongoing basis with attendance records maintained.

George E. Pataki
Governor



Thomas A. Maul
Commissioner

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
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**DIVISION OF QUALITY ASSURANCE
ADMINISTRATIVE MEMORANDUM NO. 99-01**

**TO: Executive Directors, Voluntary Agencies
DDSO Directors**

**FROM: Jan Abelseth, 
Deputy Commissioner
Division of Quality Assurance**

SUBJECT: Smoke Detectors Near Ceiling Fans

DATE: July 14, 1999

The purpose of this memo is to provide guidance to agencies regarding a potential problem with ceiling fans located in rooms with smoke detectors. OMRDD has consulted with both HCFA and the New York Department of State. The following revised procedures should be implemented immediately:

If there is no ceiling fan in the room and the agency wishes to install one:

- The detector must be located a minimum of three (3) feet from the edge of the ceiling fan blade, measured horizontally.
- In accordance with the National Fire Code (NFPA 72), any smoke detector in a room with a ceiling fan should be a **photoelectric** type and not an ionization type (unless the detector type has been specifically listed for conditions of rapid air movement; i.e. greater than 300 feet per minute).

If there currently is a ceiling fan in the room, and it is less than three feet from the smoke detector:

- Option A- move either the fan or the detector to a distance greater than three feet and ensure the detector is of the photoelectric type (or appropriately listed).



Providing supports and services for people with developmental disabilities and their families.



- Option B- In general, smoke detection systems are engineered systems and must be designed for the needs and specific environmental conditions of each house. Therefore, the agency must perform smoke tests as determined by a licensed professional engineer to determine that the operation of the ceiling fan (in both directions and at different speeds) will not create more than a 20 second delay in the activation of the detector (beyond the detector response time absent the fan).
- If the tests indicate a detector response time delay greater than 20 seconds, a second smoke detector must be installed in the room at a distance greater than three feet from the fan blade. Such detector must be a photoelectric type.

If there is currently a ceiling fan more than three feet from a smoke detector:

- Verify that the detector is a photoelectric type (or as appropriately listed). If not, it should be replaced.

If there are any questions, please contact Joel Altschul at (518) 473-7032.

George E. Pataki
Governor



Thomas A. Maul
Commissioner

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**Division of Quality Assurance
Administrative Memo No. 97-01**

MEMORANDUM

TO: Executive Directors of Voluntary Agencies
DDSO Directors

FROM: Mr. Richard P. Johnson *R.P.J.*
Division of Quality Assurance

SUBJECT: Smoke Detectors in Residences

DATE: January 22, 1997

There has been some confusion arising from ADM 96-03, regarding a change in the New York State Uniform Fire Prevention and Building Code (NYSUFP&BC), referencing the requirement for additional smoke detectors in one/two family dwellings and apartments. The following points should clarify the policy of OMRDD regarding smoke detectors:

1. **New residences** (those constructed after 7/95) are **required to comply** with the **current** NYSUFP&BC. That means they must have detectors outside each bedroom area, in each sleeping room, and on every floor level.
2. **Residences** with a valid **Certificate of Occupancy** (C of O) in an existing building, **do not** need to add the additional smoke detectors required by the new code.
3. **Residences which do not have a current C of O** (e.g. 100 year old brownstone, etc.) **must meet the new code requirement** since there is no evidence that they meet **any** code.

The above is operative for all residences seeking initial certification. Residences certified prior to 7/95 are assumed by virtue of that certification, to have met the NYSUFP&BC requirements in effect at that time.



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Another related issue requires clarification. This has to do with the requirement for hard wired smoke detectors. At the September training for DDSO staff, it was noted that the Division of Quality Assurance policy was that all required smoke detectors were to be hard wired. **This continues to be the case.** However, the Division recognizes that there may be instances where it may be a hardship for an agency to install hard wired detectors in a residence. The requirements, if an agency were to request exception to the hard-wired requirement, and use battery operated detectors instead, are as follows:

1. Detailed justification for a hardship exception for a particular site must be submitted to the Division of Quality Assurance Regional Director.
2. The battery operated smoke detector must:
 - a) be a **combination** photo-electric/ionization type. (A potential source for information regarding this type of smoke detector may be the local fire department.)
 - b) be equipped with a distinctive audible trouble signal which is given before the battery is incapable of operating the detector unit for alarm purposes.
 - c) be capable of producing an alarm signal for at least four minutes at the battery voltage at which a trouble signal is normally obtained, followed by seven days of trouble signal operation; the audible trouble signal is produced at least once every minute for seven consecutive days.
3. A readily noticeable visual indicator is displayed when a primary battery is removed from the unit. (This may or may not be part of the unit.)
4. Staff must develop a system to conduct a manual battery check of the detector once each week, and results must be documented.

If you have any questions regarding the above, please contact Joel Altschul at (518) 474-8007.



NYS Office of Mental Retardation and Developmental Disabilities

Thomas J. Cuite, Deputy Commissioner
Division of Quality Assurance
44 Holland Avenue, Albany, NY 12229
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Thomas A. Maul
Commissioner

Harold F. Hopkins
Executive Deputy Commissioner

**Division of Quality Assurance
Administrative Memo No. 96-02**

TO: Executive Directors
Voluntary Agencies
DDSO Directors

FROM: Thomas J. Cuite *Cuite*
Deputy Commissioner
Division of Quality Assurance

DATE: April 8, 1996

SUBJECT: **REVISED TESTING STANDARDS FOR PRIVATE WELLS**

OMRDD, in conjunction with the New York State Department of Health, has established new testing parameters for ALL OMRDD certified facilities which have wells as their source of potable water. This change reflects a more focused approach to testing and ensures a safe supply of water while substantially reducing the number of tests and the expense for these tests. In the past, 16 parameters were required to be tested on an annual basis. The revised testing requirements for all certified programs with wells are now in effect.

All facilities (residential and non-residential) with wells will be required to have just the following four tests on an annual basis.

1. Coliform
2. Standard Plate Count
3. Chlorides
4. Nitrates

Any parameter which exceeds the maximum contaminant level for that substance in drinking water will require corrective action.

The following additional testing requirements may be necessary based upon the location of the well relative to potential sources of contamination:

1. **Lead:** All facilities built prior to 1980 will have a lead test done to determine if there is any lead migrating from lead piping or lead solder into the water supply. If there is a positive test, a retest should be done six months after



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corrective action has been taken and annually thereafter. If the lead source is removed and the facility has a subsequent negative test, or if there is no lead noted on the initial test, no further testing would be required.

2. **Unspecified Organic:** This test must be done for wells which are located near farms, old underground gasoline tanks, and landfills where there would be a high probability of contamination from pesticide spraying or infiltration of the well from contaminants in a landfill. If there is a positive test, corrective measures will be taken until a negative result is obtained. Thereafter, the facility must test for this parameter on an annual basis.
3. **Heavy Metals:** These metals will be tested when the facility is located near a landfill. Minimal testing should include mercury, lead, arsenic and others as recommended by the local county health department. Once corrective measures are taken, the facility must retest on a biannual basis.
4. **Sodium:** This parameter will be tested if the facility has any individuals who are on sodium free or sodium restricted diets. If the test is positive, corrective measures should be taken to ensure that the sodium level falls within the acceptable limits for the restriction. Retests must be done on a biannual basis thereafter.

If there are any questions relative to this change, please call Michael Schongar, Principal Sanitarian, at (518) 473-7032.



David A. Paterson, Governor
Diana Jones Ritter, Commissioner

MEMORANDUM

Quality Management

Sheila McBain, Ph.D., Deputy Commissioner

TO: Executive Directors of Voluntary Providers

FROM: Sheila McBain, Ph.D. *Sheila M. McBain*
Deputy Commissioner
Division of Quality Management

DATE: February 19, 2010

SUBJECT: Amanda's Law Requirement for Carbon Monoxide Alarm Installations

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This is to inform OMRDD providers of their responsibilities resulting from the adaption of Amanda's Law. Any questions you have regarding the requirements of this law may be sent to Quality.Management@omr.state.ny.us

Definition:

Carbon Monoxide Source: A carbon monoxide source includes any solid, liquid or gaseous fuel-fired appliance, equipment, device, system, fireplace, garage, motor vehicle, or motor vehicle related occupancy that may emit carbon monoxide.

Where Required:

Carbon Monoxide alarms are required in all new and all existing buildings containing one or more carbon monoxide sources without regard to the date of construction of the building.

Buildings constructed before January 1, 2008:

A carbon monoxide alarm shall be installed on the lowest story having a sleeping area.

Buildings constructed on or after January 1, 2008:

A carbon monoxide alarm shall be installed in each of the following locations:

1. On each story having a sleeping area
2. On each story where a carbon monoxide source is located

Exception: One carbon monoxide alarm installed on a story of a building having both a sleeping area and a carbon monoxide source shall suffice for that story within that building.

Where Not Required:

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Carbon monoxide detectors are not required where no carbon monoxide source is located within or attached to the building. They must, however, be installed at such later date as any carbon monoxide source is subsequently located within or attached to the building.

Where Prohibited/Not Allowed:

Carbon monoxide alarms shall not be located within or near the openings to garages, bathrooms or furnace rooms. Carbon monoxide alarms shall also not be located in or near locations specified as 'prohibited,' 'not recommended' or the like in the manufacturer's installation instructions.

Power Source:

Carbon monoxide alarms shall receive their primary power from the building wiring when such wiring is served from a commercial source or an on-site electrical power system, and when primary power is interrupted, shall receive power from a battery. Wiring shall be permanent and without a disconnecting switch other than those required for overcurrent protection.

Exceptions:

1. Carbon monoxide alarms installed in buildings without a commercial or on-site power source shall be permitted to be battery operated.
2. In buildings and structures constructed before January 1, 2008, cord-type, direct plug, or battery-operated carbon monoxide alarms shall be permitted.

Interconnection Requirements:

When more than one carbon monoxide alarm is required to be installed within a building, the alarms shall be interconnected in such a manner that the actuation of one alarm will activate all of the alarms in the individual unit. The alarm shall be clearly audible in all sleeping areas over background noise levels with all intervening doors close.

Exception: Interconnection is not required where cord-type, direct plug, or battery-operated carbon monoxide alarms are permitted.

Combination smoke and carbon monoxide alarms:

Combination smoke and carbon monoxide alarms are permitted, provided they are listed for such use. Combination smoke and carbon monoxide alarms shall have distinctly different alarm signals for smoke or carbon monoxide alarm activation.

Bed Safety Checklist (Updated 10/2002)

Individual: _____

Address: _____

For both standard twin and hospital beds:

1. Yes ___ No ___ A risk assessment has been completed for the person, and a determination made that bed rails are required for safety.
2. Yes ___ No ___ With the mattress pushed against one side rail, the space between the mattress and the other side rail is minimal, if any. ["Minimal space" is when you feel resistance on both sides of your OPEN hand when you place it between the mattress and the side rail.]
3. Yes ___ No ___ The mattress is in good, firm condition, and can support a person's weight without excessive compression on the sides. [This should be determined with individual or person of equivalent size in the bed.]
4. Yes ___ No ___ Bed sheets are a proper fit. ["Proper fit" means that the mattress is not compressed when the sheets are used on the mattress.]
5. Yes ___ No ___ NA ___ If needed, cross bars and side rails are appropriate for use with the person's bed. ["Appropriate for use" means the cross bars and side rails are compatible with the bed as defined by manufacturer's instructions.]
6. Yes ___ No ___ The bed rails, including cross bars, locking mechanism and side rails, are not damaged or broken.
7. Yes ___ No ___ NA ___ All four pull pins or other securing mechanism actually lock and hold the side rails in the up position.
8. Yes ___ No ___ NA ___ The side rails are located appropriately to prevent entrapment points at the headboard/footboard ends of the bed. ["Appropriately" means that with the bed flat, the side rails should be less than or equal to 2 1/3 inches, or greater than or equal to 10 inches from the headboard/footboard.
9. Yes ___ No ___ NA ___ Both cross bars are adjusted for a tight fit and all push buttons are locked into the adjustment holes.
10. Yes ___ No ___ NA ___ The bottom bar of the side rail overlaps the side of the mattress.
11. Yes ___ No ___ There are no gaps covered or filled by any devices, such as pads, pillows or bolsters.
12. Yes ___ No ___ NA ___ If bed-rail covers/side-rail pads are used to protect a person from impact injuries, there are NO tears, rips, loose straps, etc. They are also securely attached to the side rail.
13. Yes ___ No ___ Spacing between the bars (inter-bar) is appropriate to the size of the person to prevent injury or entrapment. ["Appropriate spacing" for a child or small adult will be less than for an adult of "normal size." If a person is 35 inches or less in height, the space between the side rails must be 2 1/3 inches or less.]
14. Yes ___ No ___ The side rails are high enough to prevent the person from rolling out of bed, particularly when the specialty mattress and/or alternate positioning wedges are used.

For standard twin beds:

- 15. Yes No The bed frame, mattress and box spring ar
- 16. Yes No NA When a headboard is used, it overlaps the
- 17. Yes No NA When a footboard is used, the space b
minimal. ["Minimal space" is when you
open hand when you place it between
mattress pushed against the headboard.]

For hospital beds:

- 18. Yes No The mattress is at least the same length and
- 19. Yes No With the bed flat and the mattress push
maximum of a 3" gap between the mattress
allow for adjustment of mattress position.]
- 20. Yes No With the head of the bed raised, the triang
and the mattress is not large enough to ent
- 21. Yes No NA If split side rails are used, with the bed f
inches apart or more than 10 inches apart.

(Note: There is a wide variation in the operation of hospital beds.] appropriate for the specific type of hospital bed being reviewed. In instructions.)

- 22. Yes No NA Each cross bar is attached to either both si
bed deck.
- 23. Yes No NA Both side rails telescope smoothly when th
lowered.

24. Provide detailed comments for any NO response above:

Bed Safety Checklist and User's Guide (Updated 10/2002)**For both standard twin and hospital beds:**

1. Yes ___ No ___ A risk assessment has been completed for the person, and determination made that bed rails are required for safety.

Once in place, an annual review is recommended to verify this check point.

The risk assessment is to be included in the person's record. Remember to consider the least restrictive bed set up for the person and eliminate side rails whenever possible. Many other alternatives to side rails are available, which have proven to be effective and safe. These options include but are not limited to low beds and special perimeter defined mattresses, and should be seen as viable options within the assessment process.

Remember: The safest bed rail is no bed rail when possible.

The risk assessment should be completed or reviewed by a health care professional in the following circumstances:

- **If bed rails are considered for the person;**
- **When there is a change in the person's bed or bed rail set up; or**
- **When the person's medical, physical or behavioral needs change.**

A risk assessment should focus on the person's current unique needs. As part of the assessment process, the following factors should be considered, to establish whether the person is actually at risk of injury while in bed:

- **Physical mobility and/or transfer skills;**
- **Cognitive functioning and communication abilities;**
- **In bed behavior; and**
- **Medical conditions such as seizures, contractures, osteoporosis, physical anomalies, and/or medication.**

The following is a risk assessment format that can be used or adapted to assess the factors noted above.