

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G631	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
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NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1738 FIFTH ST LA PORTE, IN 46350
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K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 03/17/14</p> <p>Facility Number: 001204 Provider Number: 15G631 AIM Number: 100245720</p> <p>Surveyor: W. Chris Greeney, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Parents and Friends, Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors, in the living areas and in the client sleeping rooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p>	K010000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010130	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.52.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/18/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>	K010130	1) On 3/25/14 Approved Protection Systems conducted a thorough fire system inspection in all four group homes. During this inspection all emergency lighting was tested and passed. . To ensure future systemic compliance of this	04/16/2014			
	1. Based on observation, record review and interview, the facility failed to have evidence 5 of 12 monthly tests were conducted for interior emergency lights. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be						

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	<p>maintained or removed. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires a functional test be conducted at 30 day intervals for not less than 30 seconds and an annual test be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>During review of facility records on 3/17/14 at 11:00 A.M. at the group home office with the maintenance director, there was no documentation the emergency lighting installed in the home had monthly 30 second tests during the months of October 2013 through February 2014. Interview with the maintenance director on 03/17/14 at 11:00 A.M. indicated he noted the monthly inspections on a group home monthly checklists from 3/2013 through 9/2013 with the notation "checked emergency lights" handwritten on the</p>		<p>citation the Residential Director will create a new form that will include all mandatory checks/inspections to be completed by the maintenance department. The list will include reminders to place date and initials directly on the device tag. The completed form will be submitted to the Residential Director each month and she will maintain her own file. In the event she does not receive a report for one month, she will provide a reminder to the Maintenance Director and/or notify the Executive Director and the Corporate Compliance Officer.</p> <p>2) On 3/25/14 Approved Protection Systems conducted a thorough fire system inspection in all four group homes. During this inspection all automatic door closures were tested and passed. We are unsure why the northeast bedroom door failed to release during the Life Safety Code inspection and therefore we will replace the magnetic head on that door. To ensure systemic compliance of this citation all other homes were tested, as stated above, on 3/25/14. Staff will continue to conduct monthly fire drills and will monitor that all doors close automatically. In the event a door does not close, the staff will make a notation on the fire drill form. The Residential Program Manager maintains the file for disaster drills and she will communicate</p>				

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	<p>checklist. The checklists for October 2013 through December 2013 did not indicate a monthly check of the lights. Interview with the maintenance director indicated records for January and February 2014 were not at the office or the group home, and were not available for review during the onsite visit. During observation at the home from 11:15 A.M. to 12:00 noon on 03/17/14, an adhesive label on the emergency lights had the dates "3/14/13, 5/31/13 and 11/1/13 in three of the 12 spaces provided on the label. Maintenance staff present during the observation could not confirm if those were dates the lights were tested and if the blank areas indicated months the emergency lights were not tested.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 self closing bedroom doors released and closed upon activation of the fire alarm. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice would affect all the clients.</p> <p>Findings include:</p> <p>During observation at the home on 03/17/14 from 11:15 A.M. to 12:00</p>		anyproblems to the Residential Director and the Maintenance Director.				

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	<p>noon with maintenance staff, the home was observed to be fully sprinklered. The bedroom doors were observed to be self closing and held open by a magnet designed to release when the fire alarm was activated. At 11:38 A.M. on 03/17/14 during the observation the alarm was tested, at which time the northeast bedroom door failed to disengage from the magnet. After making the maintenance staff present during the observation aware, he tested the fire alarm again at 11:42 A.M. The door, which self closed when manually pulled away from the magnet, again failed to disengage from the magnet during the second alarm test. Interview with the maintenance staff indicated he was not aware there had been a problem with the door.</p>			