

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/27/2014
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NAME OF PROVIDER OR SUPPLIER  IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
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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: 05/27/14</p> <p>Facility Number: 001018 Provider Number: 15G504 AIM Number: 100239810</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, In-Pact, 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 with a basement was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in client sleeping rooms and in common living areas. The facility has a capacity of 5 and had a census of 5 at the time of this survey.</p>	K010000		

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 Prompt with an E-Score of 0.92.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/03/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>	K010130	<p>Functional tests of the emergency lighting will conducted on a monthly and on an annual basis. Responsible person: Ingrid Bullard, Group Home Manager. Written documentation of these visual inspections will be done and kept in the drill book for review. Responsible person: Ingrid Bullard, Group Home Manager. To ensure future compliance, monthly these documents will be reviewed to ensure that the tests were completed and documented. Responsible person: Sheila O'Dell, Group Home Director &amp; Traci Hardesty, QDDP</p>	06/26/2014

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K01S017	<p>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>Based on observation on 05/27/14 between 4:00 p.m. and 4:45 p.m. during a tour of facility with the Residential Instructor, there were two battery powered emergency light units in the home which functioned when tested. Based on interview at the time of observation, the Residential Instructor was unaware of any testing documentation of a 30 second monthly test or a 90 minute annual test for the battery operated emergency light units.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those</p>			

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	<p>of 1¾ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2.</p> <p>Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms are separated from escape routes by walls and doors that are smoke resistant.</p> <p>No louvers or operable transoms or other air</p>			

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K01S017	<p>passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 sleeping room doors was capable of resisting smoke. This deficient practice could affect 1 of 5 clients in the facility.</p> <p>Findings include:</p> <p>Based on observation during a tour of the home on 05/27/14 from 4:00 p.m. to 4:45 p.m. with the Residential Instructor, the main floor south bedroom door was not smoke resistant due to two holes through the top of the door near the door closer. Based on interview at the time of observation, the two holes were acknowledged by the Residential Instructor.</p>	K01S017	<p>Maintenance request will be filled out to fix &amp;/or replace main floor south bedroom door due to two holes through the top.</p> <p>Responsible person: Sheila O'Dell, Group Home Director. The main floor south bedroom door will be repaired &amp;/or replaced. Responsible person: Maintenance staff. To ensure future compliance, monthly all doors will be checked to be smoke resistant.</p> <p>Responsible person: Sheila O'Dell, Group Home Director &amp; Traci Hardesty, QDDP.</p>	06/26/2014
K01S018	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not</p>			

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K01S053	<p>required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation and interview, the facility failed to ensure 2 of 5 bedroom doors closed and latched into the door frame. This deficiency could affect the clients who resided in those rooms.</p> <p>Findings include:</p> <p>Based on observation during a tour of the home on 05/27/14 from 4:00 p.m. to 4:45 p.m. with the Residential Instructor, the west basement bedroom door and the south main floor bedroom door failed to securely latch into the door frame when the door was closed. Interview with the Residential Instructor during the observations confirmed the doors did not latch securely into the frame.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms are powered from the building electrical system and when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and</p>	K01S018	<p>Maintenance request will be completed to fix the west basement bedroom door and the south main floor bedroom door so that it securely latches into the door frame when closed. Responsible person: Sheila O'Dell, Group Home Director The west basement bedroom door and the south main floor bedroom door will be fixed, so that it securely latches into the door frame when closed. Responsible person: Maintenance staff. Management/staff will be retrained to ensure that they routinely notice, notify and fill out maintenance request if bedroom doors do not latch securely into the door frame Responsible person: Traci Hardesty, QDDP To ensure future compliance, monthly all doors will be checked to ensure that they latch securely into the door frame Responsible person: Sheila O'Dell, Group Home Director &amp; Traci Hardesty, QDDP</p>	06/26/2014

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	<p>unfinished attics. Additional smoke alarms are installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3.</p> <p>Exception No 1: Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system.</p> <p>Exception No. 2: Where buildings are protected throughout by an approved automatic sprinkler system, in accordance with 32.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms.</p> <p>Based on observation, record review and interview; the facility failed to ensure 100 % of the smoke detectors had been sensitivity tested. LSC 9.6.2.10.1 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 7-3.2 requires testing be accordance with Table 7-3.2 Testing Frequencies. Table 7-3.2 at 7-3.2.15(i) Smoke Detectors - Sensitivity (The requirements of 7-3.2.1 shall apply). NFPA 72 at 7-3.2.1 states Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required</p>	K01S053	Alert alarm is out every year for function and every two years for sensitivity. They will be called to find out why they did not test #7. If there is a problem with access/location, then they will need to relocate that particular smoke detector. Responsible person: Sheila O'Dell, Group Home Director. #7 detector will be tested or relocated to be more accessible during their routine testing. Responsible person: Sheila O'Dell, Group Home Director & Alert alarm tech. To ensure future compliance, monthly the smoke detector test	06/26/2014

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	<p>calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method,</li> <li>(2) Manufacturer's calibrated sensitivity test instruments,</li> <li>(3) Listed control equipment arranged for the purpose,</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside the listed sensitivity range,</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction.</li> </ol> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or be replaced.</p> <p>NOTE: The detector sensitivity shall not</p>		<p>report will be reviewed to ensure all detectors are tested and in the report. Responsible person: Sheila O'Dell, Group Home Director &amp; Traci Hardesty, QDDP.</p>	

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K01S152	<p>be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on interview during record review with the Residential Instructor on 05/27/14 from 4:00 p.m. to 4:45 p.m., the smoke detector test report dated 02/18/13 indicated the smoke detector identified as "EM/EXT #7" was not tested with a comment of "No Access." Based on interview of the Residential Instructor at the time of record review, EM/EXT #7 was the location of the smoke detector for the basement emergency exit stairwell from the basement. Based on observation, the smoke detector for this location would require a ten to fifteen foot ladder to access it for testing.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and</p>						

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	<p>procedures.</p> <p>(2) The facility must -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities:</p> <p>(iii) File a report and evaluation on each drill:</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the fire drill documentation at 4:15 p.m. on 05/27/14 with the Residential Instructor, there was no record of a fire drill for the third shift of the fourth quarter of 2013. This was acknowledged by the Residential Instructor at the time of record review.</p>	K01S152	<p>Management will be retrained to complete and review for completion of all required fire drills, including 1st, 2nd &amp; 3rd shift drill during each quarter within 90 days. Responsible person: Sheila O'Dell, Group Home Director. An extra third shift drill will be completed. Responsible person: Ingrid Bullard, Group Home Manager. A summary sheet will be completed to show which drill have been completed, when and by who. Responsible person: Ingrid Bullard, Group Home Manager. To ensure future compliance, monthly the drills will be reviewed to ensure completion of all required drills for each shift, each quarter. Responsible person: Sheila O'Dell, Group</p>	06/26/2014	

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

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			Home Director & Traci Hardesty, QDDP.		