

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G800	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2014
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6803 LUTZ DR SOUTH BEND, IN 46614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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: 04/15/14</p> <p>Facility Number: 012598 Provider Number: 15G800 AIM Number: 201023280</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist; Tim Shebel, Licensed Social Worker</p> <p>At this Life Safety Code survey, ADEC, 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 32, New Residential Board and Care Occupancies.</p> <p>This one story facility with a finished basement was fully sprinklered. The facility has a monitored fire alarm system with smoke detection on both levels in the corridors, in client sleeping rooms and in common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 2.74.</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>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/21/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: 483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was tested and maintained. NFPA 101, Section 7.9.2.3 states emergency generators providing power to emergency lighting systems shall be installed tested, and maintained in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110 Section 6-4.1 requires Level 1 and Level 2 EPSS's, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Section 6-4.2 requires generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 110, Section 6-3.4 requires a written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written</p>	K010130	<p>Maintenance staff will be trained on completing the monthly load test. Maintenance staff will complete a form that includes documentation of the load test as well as all of the requirements of the test. It is unknown why the weekly test had been discontinued, but the new testing will take place on a monthly basis and documentation will be maintained at the facioity for further review. Failure to comply will result in disciplinary action. Person Responsible: Maintenance ADDENDUM: Maintenance staff will complete weekly generator load testing and will document that the test took place on teh form located in the basement of the facility. The maintenance supervisor will train the staff on conducting the test and documentation. This documentation will be reviewed by the maintenance supervisor and will include the following:1. The date of the maintenance report2. Identification of the servicing personnel3. Notation of any unsatisfactory condition and the corrective action taken,</p>	04/28/2014			

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K01S150	<p>record shall include the following:</p> <ul style="list-style-type: none"> a. The date of the maintenance report b. Identification of the servicing personnel c. Notation of any unsatisfactory condition and the corrective action taken, including parts replaced d. Testing of any repair for the appropriate time as recommended by the manufacturer. This deficient practice could affect any staff and clients. <p>Findings include:</p> <p>Based on observation at 3:30 p.m. on 04/15/14 with the Qualified Intellectual Disability Professional (QIDP), the facility had an emergency generator outside the house which automatically powered the home in the event of a power failure. Based on record review at the time of observation, the following was noted:</p> <ul style="list-style-type: none"> a. The monthly load testing did not include the nameplate rating; the operating temperature or the load percentage. b. There was documentation of a weekly generator test for 2013 but not for 2014. Based on interview at the time of record review, the QIDP acknowledged there was no other documentation pertaining to the generator available for review. <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with the provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p> <p>Based on interview and observation, the facility failed to ensure new curtains were flame resistant. LSC Section 10.3.1 requires</p>	K01S150	<p>including parts replaced. Testing of any repair for the appropriate time as recommended by the manufacturer. Person Responsible: Maintenance</p> <p>On 4/16/14 the curtains were removed from the home. The curtains will not be returned until treated with a flame resistant solution and documentation will</p>	04/16/2014

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K01S152	<p>draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect all clients in the facility.</p> <p>Findings include</p> <p>Based on observations made between 4:00 p.m. and 4:15 p.m. on 04/15/14 with the Qualified Intellectual Disability Professional (QIDP), window curtains were provided in the family room and kitchen which lacked documentation of flame resistance. Based on interview, it was acknowledged by the QIDP at the time of observation, documentation of flame resistance for the window curtains was not available.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>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</p>		<p>be maintained in the home. No future curtains will be purchased and hung without this treatment. Person Responsible: Director</p>				

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	<p>evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>Facilities meet the requirements of paragraphs (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>Based on record review and interview, the facility failed to conduct a fire drill on one shift during 2 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the fire drill reports on 04/15/14 at 1:45 p.m. with the Qualified Intellectual Disability Professional (QIDP), documentation of fire drills was lacking for the following:</p> <ul style="list-style-type: none"> a. The second and third shift of the second quarter of 2013. b. The second shift of the third quarter of 2013. <p>Based on interview a the time of record review, the QIDP acknowledged there were no other fire drills available for review.</p>	K01S152	<p>The facility QIDP and Res manager have completed a calendar to complete fire drills in accordance with the regulations. The QIDP and Res Manager will be trained on the importance of running these drills as scheduled. The DSP's will be trained on the importance of running the drills as scheduled. The residential training coordinator is maintaining the drills. If a drill is not done as scheduled, the director will be notified for follow-up. Failure to comply with this correction will result in disciplinary action. Person Responsible: QIDP, Res Manager, Director</p>	04/28/2014			