STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IN-PACT INC	723 N 200 E VALPARAISO, IN 46383

(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
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in Accordance with 42 CFR 483.470(j). Survey Date: 04/15/16 Facility Number: 000792 Provider Number: 15G272 AIM Number: 100249020 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. This two story facility with a basement was not sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in the living areas, and hard wired smoke detectors in the resident sleeping rooms. The facility has a capacity of 6 and had a census of 6 at the time of this survey. Calculation of the Evaluation Difficulty	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.7. Quality Review completed on 04/19/16 - DA			
K S046 Bldg. 01	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 6 residents. Findings include: Based on observation with the Quality Intellectual Disability Professional on 04/15/16 at 1:06 p.m., a surge protector cord was powering a refrigerator in the basement living room. Based on interview at the time of observation, the Quality Intellectual Disability Professional acknowledged the	K S046	All extension cords have been removed and/or replaced with surge protectors that are directly plugged into the outlet. Responsible person: Traci McKinney, GH Manager. All management staff will be retrained that extension cord will not be used as a substitute for fixed wiring. Responsible person: Sheila O'Dell, GH Director. All staff will be retrained that extension cord will not be used as a substitute for fixed wiring. Responsible person: Traci McKinney, GH Manager. To ensure future compliance, the home will be inspected that no extension cords are being used monthly. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP.	04/15/2016

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	aforementioned condition.			
K S120 Bldg. 01	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In addition to the primary route, each sleeping room in facilities that use Exception No. 1 to 32.2.3.5.1 has a second means of escape that consists of one of the following: (a) It is a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape. (b) It is a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to an approved means of escape. (c) It is an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 sq. ft. The width is not less than 24 inches. The bottom of the opening is not more than 44 inches above the floor. Such means of escape is acceptable where one of the following criteria are met: (1) The window is within 20 ft of grade. (2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. (3) The window or door opens onto an exterior balcony. 33.2.2.3 Exception No. 1: If the sleeping room has a door leading directly to the outside of the building with access to grade or to a			

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	stairway that meets the requirements of exterior stairs in 33.2.3.1.2, that means of escape is considered as meeting all the escape requirements for the sleeping room. Exception No. 2: A second means of escape from each sleeping room is not required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5. Exception No. 3: Existing approved means of escape is permitted to continue to be used. Based on observation and interview, the facility failed to ensure 3 of 6 client sleeping rooms was provided with a secondary means of escape. This deficient practice could affect 3 of 6 clients. Findings include: Based on observation with the Quality Intellectual Disability Professional on 04/15/16 between 12:50 p.m. and 12:55 p.m., three bedrooms on the third level, which was greater than 20 ft from grade, had windows as a secondary egress. Two of the three windows required that a client exited onto the roof. From the roof a resident would have to walk down the roof to a second floor stairway. Based on interview at the time of each observation, the Quality Intellectual Disability	K S120	The three upstairs bedroom on the second floor have two means of egress; going down the stairs to the main floor exit door, which is located at the bottom of the stairs (primary means) and going out the window in the upstairs hallway to the fire escape on the outside of the building (secondary means). We can add a third egress by having window ladders in each of the bedrooms. Responsible person: Sheila O'Dell, GH Director.	04/15/2016

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	Professional acknowledged each aforementioned condition.			
K S123 Bldg. 01	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Every bathroom door is designed to allow opening from the outside during an emergency when locked. 32.2.2.5.4, 33.2.2.5.4 Based on observation and interview, the facility failed to ensure 1 of 1 3rd floor bathroom doors could be unlocked from the outside during an emergency. This deficient practice could affect anyone locked in the bathroom during a fire or other emergency. Findings include: Based on observations with the Qualified Developmental Disability Professional on 04/15/16 at 12:52 p.m., the 3rd floor bathroom door had a lock that could be operated from inside the bathroom. When tested, the Qualified Developmental Disability Professional was unable to unlock the bathroom door. Based on interview at the time of observation, the Qualified Developmental Disability Professional acknowledged the aforementioned condition.	K S123	A key will be accessible to unlock the bathroom door from the outside. Responsible person: Traci McKinney, Group Home Manager & Maintenance staff. Staff will be trained where the key is to open the bathroom door when locked from the inside in case of a an emergency. They will also be informed where a back up key is located. Responsible person: Traci McKinney, Group Home Manager. To ensure compliance, this will be added to our monitoring system and checked monthly. Responsible person: Tracy Hardesty, QIDP & Sheila O'Dell Group Home Director	04/15/2016
K S152	483.470(j)(1)(i)			

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Bldg. 01	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 procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (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. (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 conduct evacuation drills under varied conditions on each shift for 3 of the last 4 calendar quarters. This deficient practice could affect all clients. Findings include: Based on record review of the fire drill reports titled "Fire/Tornado Drill Report	K S152	Management will be retrained to complete and review for completion of all required fire drills, including drills being completed during varied times. Responsible person: Sheila O'Dell, Group Home Director. All of our clients attend a day program and leave the home by 8:30a Monday-Friday and do not return until 3:30p-4:30p. 1st shift drills are between 7a-3p. Our ability to vary the 1st shift time are	04/15/2016

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	Summary" with the Quality Intellectual Disability Professional on 04/15/16 at 11:40 a.m., three sequential second shift fire drills took place between 7:37 a.m. and 8:10 a.m. for three of the last four quarters. Based on interview at the time of record review, the Quality Intellectual Disability Professional acknowledged the aforementioned condition.		limited. One of the drills were done on a weekend, so that it could be later in the afternoon. We will do more weekend 1st shift drills, so they can be more varied. Responsible person: Traci McKinney, Group Home Manager. A summary sheet will be completed to show which drill have been completed and varied. Responsible person: Traci McKinney, 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 and varied. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QDIP.	