STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G308	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CDC INC	204 RILEY RD DELPHI, IN 46923

(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	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: 11/06/13 Facility Number: 000827 Provider Number: 15G308 AIM Number: 100235060 Surveyors: Dennis Austill, Life Safety Code Specialist; Brett Overmyer, Life Safety Code Specialist; Libby Fruth, Life Safety Code Specialist At this Life Safety Code survey, CDC 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 one story facility was determined to be nonsprinklered. The facility has a fire alarm system with smoke detection in corridors, in client rooms and in common living areas. The facility has the capacity for 6 and had a census of 5 at the time of	K010000		

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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	this survey. 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 1.4. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/14/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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K01S018	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 Doors are self-closing or automatic closing in accordance with 7.2.1.8 Exception: Door closing devices are not 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 1 of 4 bedroom doors closed and latched into the door frame. This deficiency could affect the client who resides in that room. Findings include: Based on observation with the Health & Safety Specialist during a tour of the facility from 1:55 p.m. to 2:45 p.m. on 11/06/13, the door for bedroom # 2 failed to close when tested. The door was provided with spring loaded hinges. Based on interview at the time of observation, the Health & Safety Specialist acknowledged the spring loaded hinges were not working and the door did not self close.	K01S018	Tag K0018Upon surveyors leaving a work order was submitted to themaintenance department to fix bedroom #2's door. Work order was completed by themaintenance department on 11-21-2013. All bedroom doors will be assessed forproper closure on a daily basis by group home staff. A checklist of the houseinspection has been updated to include the checking of all doors to proper close. Monitoring will be done a weekly basisby Qualified Supervisor Staff, that doors close proper by doing a visual checkof the doors. Monitoring of checklist will be done a bi-monthly basis by theHealth & Safety Specialist.	11/30/2013

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K01S046	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 multiplug adapters were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 1 of 5 clients in the facility. Findings include: Based on observation with the Health & Safety Specialist during a tour of the facility from 1:55 p.m. to 2:45 p.m. on 11/06/13, bedroom # 1 had a clock plugged into a multiplug adapter. Based on interview at the time of observation, the multiplug adapter was acknowledged by the Health & Safety Specialist.	K01S046	Tag K0046Upon surveyors leaving the multi-plug adapter wasremoved. A surge protected cord was put in place on 11-7-2013 by the Health& Safety Specialist. The house inspection checklist was updated to includethe checking of all plug ins. A visual check of the plugs will be done a weeklybasis by Qualified Supervisor Staff. Monitoring to ensure all plugs are incompliance will be done bi-monthly by Qualified Supervisor Staff and/or Health& Safety Specialist	11/30/2013

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K01S150	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 provisions of 10.3.1. 32.7.5.1, 33.7.5.1 Based on interview and observation, the facility failed to ensure 2 of 2 sets of curtains in the diningroom/office were flame resistant. LSC Section 10.3.1 requires 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. Findings include Based on observation with the Health & Safety Specialist during a tour of the facility from 1:55 p.m. to 2:45 p.m. on 11/06/13, two sets of window curtains were provided in the dining room/office which lacked documentation of flame resistance. Based on interview, it was acknowledged by the Health & Safety Specialist at the time of observation, the curtains were new and documentation of flame resistance for the window curtains was not available and indicated the	K01S150	Tag K0150Upon surveyors leaving the Health & Safety Specialistcontacted Goodwin Fire Equipment to see what was needed to implement safetyimmediately. A checklist was implemented and trained on for staff to ensurethat the curtains will remain flame resistance. Group home staff removedcurtains washed and dried according to label and sprayed with flame retardantagent. Monitoring of the checklist will be done by Group home Supervisor, ifthe curtains needed to be laundered the staff would reapply agent and chart onchecklist. Group home Supervisor will be notified that the curtains have beensprayed with agent. Health & Safety will monitor this also bi-monthly fromhouse inspection checklist and Quality Inspection reports.	11/30/2013

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	curtains would be treated with a flame retardant.			

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K01S155	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility did not have a complete policy to address the fire alarm system being out of service for four hours or more in a 24 hour period to protect 5 of 5 clients. This deficient practice could affect all occupants of the facility if a fire should occur while the fire alarm system was not working. Findings include: Based on a review of the "Fire Watch Policy and Procedure" with the Health & Safety Specialist on 11/06/13 at 2:15 p.m., the following was noted: a. The policy and procedure lacked complete verbiage indicating the fire watch notification would occur when the fire alarm is out of service for "four hours or more in a 24 hour period." Instead , the policy and procedure indicated notification will occur when the fire alarm is out of service for more than four hours. b. The policy and procedure did not	K01S155	Tag K0155Upon surveyors leaving the Health & Safety Specialistupdated the Fire Watch Policy and Procedure. A training of staff was done byGroup Home Supervisor to ensure all staff knows how, when to implement the policy.Monitoring to ensure staff knows how to implement the policy will be donebi-monthly by Qualified Supervisor Staff. Monitoring will be done by QualityInspections and verbal assessment of staff. Health & Safety will beinformed of policy needing updated as needed.	11/30/2013

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	indicate the person conducting the fire watch will be trained and will perform no other duties while conducting the fire watch. Based on interview at the time of record review, the Health & Safety Specialist acknowledged the policy and procedure lacked the verbiage of "four hours or more in a 24 hour period" and the person conducting the fire watch will be trained and will perform no other duties while conducting the fire watch.			