

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G801	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/04/2015
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NAME OF PROVIDER OR SUPPLIER  ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6712 MACKEY CT 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
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K 0000  Bldg. 01	<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: 06/04/2015</p> <p>Facility Number: 012599 Provider Number: 15G801 AIM Number: 201023260</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</p>	K 0000		
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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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K 0130 Bldg. 01	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.68.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 fire extinguishers requiring a 12-year hydrostatic test was emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation and interview on 06/04/15 at 9:23 a.m. and then again at 9:45 a.m., the Residential Manager acknowledged the front entrance extinguisher and the basement extinguisher hydrostatic date was last documented in 2007 on each extinguisher.</p>	K 0130	<p>The extinguishers were replaced on 6/11/15 The director contacted the company responsible for the maintenance of the extinguisher and they came out to the home and swapped the faulty extinguisher with properly maintained extinguishers Staff will monitor for the extinguisher company to complete tasks as required during inspections Person Responsible: Director</p>	06/11/2015			