

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G229	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2014
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 307 JOSEPHINE ST MILAN, IN 47031
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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: 02/05/14</p> <p>Facility Number: 000753 Provider Number: 15G229 AIM Number: 100243350</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Res Care Community Alternatives SE IN 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 was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a</p>	K010000		
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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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K010130	<p>capacity of 7 and had a census of 6 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 Prompt with an E-Score of 0.96.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/20/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>	K010130	K130: Clinical Supervisor has been inserviced on completing monthly extinguisher checks and documenting tag (Attachment A). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 2-26-2014	02/26/2014			
	<p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were inspected at least monthly and the inspections were documented for 2 of 3 months since the last annual inspection date, including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing life safety features obvious to the public if not required by the Code to be either maintained or removed. NFPA 10, the Standard for</p>						

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	<p>Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with support assistant # 1 on 02/05/14 from 9:30 a.m. to 11:45 a.m., service and inspection tags for the portable fire extinguishers located in the living room and the water heater room each indicated the most recent annual inspection was 02/27/13, but no monthly checks were documented on the inspection tags for March, April, May, June, July, August, September, October, November, December 2013, and January 2014. Based on interview at the time of observation, support assistant # 1 said there is no written documentation of monthly fire extinguisher inspections for the facility and acknowledged the facility did not perform monthly fire extinguisher inspections since the annual</p>			

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K01S014	<p>inspection date of 02/27/13.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Interior wall and ceiling finish is Class A or Class B in accordance with section 10.2, 33.2.3.2. There are no requirements for interior floor finish.</p> <p>Exception: Class C interior wall and ceiling finish is permitted in prompt evacuation capability facilities.</p> <p>Based on observation and interview, the facility failed to ensure the interior finish in 1 of 5 client sleeping rooms was rated Class A, Class B or Class C for a Prompt rated facility. This deficient practice affects 2 clients who reside in the south client sleeping room.</p> <p>Findings include:</p> <p>Based on observations on 02/05/14 at 10:20 a.m. with support assistant # 1, the south client sleeping room closet had a six inch by six inch area of drywall missing on the east wall. This was verified by support assistant # 1 at the time of observation and acknowledged at the exit conference on 02/05/14 at 11:55 a.m.</p>			K01S014	<p>K0014: Repair estimate has been obtained and approved (Attachment B). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 4-15-2014</p>		04/15/2014

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K01S017	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>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 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</p>						

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	<p>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 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 walls was separated with smoke partitions from the common spaces and corridors in a prompt facility in accordance with 8.2.4. This deficient practice could affect 1 client in the southwest client sleeping room near the living room.</p> <p>Findings include:</p> <p>Based on observation with support assistant # 1 on 02/05/14 at 10:45 a.m., the southwest client sleeping room north wall near the living room had a six foot section of wall with a one half inch gap in the drywall where it met the ceiling. The southwest client sleeping room wall near the living room separating from the ceiling was verified by support assistant # 1 at the time of observation and acknowledged at the exit conference on</p>	K01S017	K0017: Repair estimate has been obtained and approved (Attachment B). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 4-15-2014	04/15/2014			

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K01S018	<p>02/05/14 at 11:55 a.m.</p> <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 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 5 sleeping room doors would close and latch to resist smoke for at least 1/2 hour. This deficient practice could affect two clients who reside in the southwest bedroom near the living room.</p> <p>Findings include:</p> <p>Based on observation with support assistant # 1 on 02/05/14 at 10:40 a.m., the corridor door to the southwest bedroom near the living room failed to latch into the door frame and was missing the strike plate. Furthermore, the southwest bedroom door was not smoke resistant due to a gap one inch wide along the latch side of the door in the closed position. This was verified</p>	K01S018	K0018: Repair estimate has been obtained and approved (Attachment B). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 4-15-2014	04/15/2014			

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K01S041	<p>by support assistant # 1 at the time of observation and at the exit conference on 02/05/14 at 11:55 a.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Every sleeping room and living area has access to a primary means of escape located to provide a safe path of travel to the outside. 33.2.2.2.1.</p> <p>Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape is an interior stair in accordance with 32.2.2.4 and 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. 32.2.2.2.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 exit corridors were provided with a safe path of travel to the outside. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations with support assistant # 1 on 02/05/14 during a tour of the facility from 9:30 a.m. to 11:45 a.m., the living room section of floor extending four feet by two feet in front of the exit door, and the south client sleeping room section of floor extending four feet by two feet in front of the exit door were both rotting and heaving as support assistant # 1 walked over the floor surfaces. This was verified by</p>	K01S041	K0041: Repair estimate has been obtained and approved (Attachment B). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 4-15-2014	04/15/2014			

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K01S148	<p>support assistant # 1 at the time of observations and acknowledged at the exit conference on 02/05/14 at 11:55 a.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1 Based on observation and interview, the facility failed to provide a metal container with a self closing cover for 1 of 1 area where smoking is permitted. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation of the side porch exit smoking location on 02/05/14 at 11:15 a.m. with support assistant # 1, the side porch outside smoking location was provided with an ashtray but lacked a metal container with a self closing cover for discarded smoking material. This was verified by support assistant # 1 at the time of observation and acknowledged at the exit conference on 02/05/14 at 11:55 a.m.</p>	K01S148	K0148: Maintenance request has been completed to purchase container (Attachment C). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 3-7-2014	03/07/2014			

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K01S150	<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 provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p> <p>Based on record review, interview and observation; the facility failed to ensure new draperies and curtains were flame resistant in 7 of 10 rooms. 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.</p> <p>Findings include</p> <p>Based on an interview with support assistant # 1 on 02/05/14 at 9:55 a.m. during record review, there was no record of flame resistance documentation on window curtains throughout the facility. Furthermore, support assistant number one indicated window curtains in all rooms had been replaced over the past year. Based on observations during a tour of the facility with support assistant # 1 on 02/05/14 from 10:10 a.m. to 11:45 a.m., the</p>	K01S150	<p>K0150: Curtains will be removed (Attachment A). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 2-26-2014</p>	02/26/2014			

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	<p>window curtains in the five client sleeping rooms, the television room and the kitchen failed to have attached tags to indicate the window curtains were flame resistant. The lack of flame resistance documentation for window curtains was verified by support assistant # 1 at the time of record review and observation and at the exit conference on 02/05/14 at 11:55 a.m.</p>			