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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G305 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 03/13/2015 |
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| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 205 N MAIN ST SPENCER, IN 47460 |
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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 000 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: 03/13/15</p> <p>Facility Number: 000824 Provider Number: 15G305 AIM Number: 100249060</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Transitional Services Sub, LLC. 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 two story facility with a basement was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, sleeping rooms, common living areas and all levels. The facility has the capacity for 8 and had a</p> | K 000 | | |

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 130 Bldg. 01 | <p>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 Prompt with an E-Score of 1.2.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/20/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | K 130 | The Program Director and Home Manager will be retrained to ensure inspections are completed and documented on each fire extinguisher tag when completing and/or reviewing monthly evacuation reports. Responsible Party: Home Manager, Program Director, Area Director | 04/10/2015 |

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| | <p>the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. This deficient practice affects all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation with Staff #1 between 12:30 p.m. and 1:25 p.m. on 03/13/15, the service and inspection tags for the portable fire extinguishers located in the kitchen, dining room and second floor landing lacked documentation of a monthly check since January 2015 when these fire extinguishers were placed in service. Staff #1 said at the times of observation, the fire extinguisher checks were recorded on the inspection tag when done and there was no other record for a monthly inspection.</p> | | | |