

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350
---	---

(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	<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: 11/24/14</p> <p>Facility Number: 000849 Provider Number: 15G331 AIM Number: 100243820</p> <p>Surveyor: Brett Overmyer, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Parents and Friends, 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.</p> <p>This one story facility with a basement was not sprinklered. The facility has a monitored fire alarm system with smoke detection on all levels including in the corridors, in the living areas and in the client sleeping rooms. The facility has a capacity of 6 and had a census of 5 at the</p>	K010000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/24/2014	
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350			
(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			
K01S029	<p>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 .28.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/03/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Any hazardous area that is on the same floor as, and is in or abuts, a primary means of escape or a sleeping room is protected by one of the following means:</p> <p>(a) Protection is an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than ¾ hour.</p> <p>(b) Protection is automatic sprinkler protection, in accordance with 32.2.3.5, and a smoke partition, in accordance with 8.2.4, located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation is self-closing or automatic closing in accordance with 7.2.1.8. 33.2.3.2.2.</p> <p>Based on observation and interview, the</p>	K01S029	To ensure immediate compliance	12/11/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/24/2014	
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350			
(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			
K01S046	<p>facility failed to ensure 1 of 1 hazardous areas was protected by a self closing or automatic closing fire door in accordance with 7.2.1.8. This deficient practice was also documented on 2013 survey report and facility failed to repair the deficiency. This deficient practice could affect all residents ' staff and visitors in the home.</p> <p>Findings include:</p> <p>During observation with the maintenance staff on 11/24/14 between 09:00 a.m. and 09:20 a.m. the attached garage was found to contain a commercial lawn mower with a 10 gallon capacity of fuel, weed eater, extra chairs, and paper products. The maintenance staff further indicated the materials stored in the garage were for use in all the group homes owned by the agency. The door from the living area to the garage connected to a hallway by the front exit of the home. That door between the garage and the hallway was rated at 1.5 hours but was not a self-closing or automatic closing door. The maintenance staff acknowledged the aforementioned deficiency.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p>		<p>of this citation, an automatic door closure was purchased and installed on 12/10/14. The maintenance staff and the Program Director tested the door several times to ensure proper operation. Due to this being the only home with an abutting garage, no additional individuals have been identified as at risk. The automatic closure will be monitored two times weekly for a period of one month by the maintenance staff and the Program Director to ensure continued proper operation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/24/2014	
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350			
(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			
	<p>Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 4" x 4" electric box in the basement laundry room area was provided with a cover plate. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, the National Electrical Code. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. Article 370-25, Covers and Canopies, states "In completed installations each box shall have a cover, faceplate or fixture canopy." This deficient practice could affect one client, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Staff during a tour of the facility on 11/24/14 from 9:20 a.m. to 10:00 a.m. , the 4" x 4" electrical box in the ceiling of the basement laundry room was missing the cover plate which exposed the electric wiring. Based on interview at the time of observation, the maintenance staff acknowledged the electrical box was missing the cover plate which exposed the electric wiring.</p>	K01S046	<p>To ensure this citation is corrected immediately the maintenance staff has purchased and installed a cover plate for the electrical box. To ensure systemic compliance of this citation all staff will be trained to report missing face plates on electrical boxes to the maintenance staff immediately by phone and through the Maintenance Request Form. The maintenance staff will inspect all homes for missing face plates and will repair as necessary. Additionally, inspection of electrical boxes will be added to the Monthly Group Home Inspection form and the maintenance staff will examine all electrical boxes during his monthly Group Home Inspections on an ongoing basis. Repairs will be made as needed.</p>	12/19/2014			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G331	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/24/2014
NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350		
(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	