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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G390 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/14/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>AWS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>825 MENDLESON DR<br>RICHMOND, IN 47374 |
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|--------------------|--|---------------|---|----------------------|
| K0000              | <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: 11/14/12</p> <p>Facility Number: 000904<br/>Provider Number: 15G390<br/>AIM Number: 100233320</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, AWS 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 in all client sleeping rooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> | K0000         |   |                      |

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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|  | <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.0.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/16/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> |   |   |   |  |   |  |

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| KS017  | <p>483.470(j)(1)(i)<br/>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 6 sleeping room doors was capable of resisting fire and smoke for at least 1/2 hour. This deficient practice could affect one client in the southeast bedroom.</p> <p>Findings include:</p> <p>Based on observation with the qualified mental retardation professional on 11/14/12 at 11:50 a.m., the corridor door to the first southeast client sleeping room was not smoke resistant due to a three inch diameter area of door missing in the center of the door. This was verified by the qualified mental retardation professional at the time of observation.</p> | KS017   | <p><b>Corrective action for resident(s) found to have been affected</b><br/> <b>A new door has been ordered and will replace the broken door. The installation is scheduled for 11/29/12.</b><br/> <b>How facility will identify other residents potentially affected and what measures taken</b><br/> <b>No other consumers were affected by the broken door.</b><br/> <b>Measures or systemic changes facility put in place to ensure no recurrence</b><br/> <b>Doors will be checked each time a home inspection occurs, at least monthly.</b><br/> <b>How corrective actions will be monitored to ensure no recurrence</b><br/>                     The director will visit the home on 11/30/12 to ensure the door has been replaced. Home inspections are done monthly by the team leader. These will be turned into the Group Home Manager, signed off on by the</p> | 11/30/2012           |   |

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|                    |  |               | QDDP and forwarded to the director to ensure compliance and follow up on any items found deficient.             |                      |