

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2014
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NAME OF PROVIDER OR SUPPLIER  JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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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: 08/18/14</p> <p>Facility Number: 001193 Provider Number: 15G656 AIM Number: 100446910</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Jay-Randolph Developmental Services 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 hard wired smoke detection in the corridors, in sleeping rooms and in common living areas. The facility has a capacity of 6 and had a census of 5 at the time of this survey.</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>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 0.9.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 interior emergency lights were tested annually and the records of the testing maintained. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires a functional test be conducted at 30 day intervals and an annual test be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully</p>	K010130	Now, and in the future, the Maintenance staff will perform an annual 1.5 hour duration test for the battery powered lights in all group homes. Both the Home Managers, and the Maintenance staff will schedule and perform testing annually. To	09/17/2014			

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K01S014	<p>operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on observation with the Group Home Manager on 08/18/14 from 1:05 p.m. to 1:37 p.m., four battery powered emergency lights were located throughout the facility. Based on interview with Group Home Manager at the time of observations, the facility does not perform an annual 1 ½ hour duration test for the battery powered lights.</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 1 of 1 hallways had at least a Class C interior finish.</p>	K01S014	<p>ensure that the testing is done annually, scheduling and reports will be sent to the Residential Department Head upon completion.</p> <p>Residential Department Head, Home Managers and Maintenance staff responsible.</p> <p>Now, and in the future, all wood paneling areas</p>	09/17/2014			

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K01S147	<p>This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observation with the Group Home Manager on 08/18/14 at 1:32 p.m., the bottom one third of the walls in the hallway was covered with wood paneling. Based on an interview with the Group Home Manager at the time of observation, she was unable to provide documentation to confirm the wood paneling provided at least a Class C finish.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised</p>		<p>in group homes will be coated with at least a Class C interior finish (see attachment). We will recoat the finish of the hallway with the product on the attachment. Documentation will be provided of application. Residential Department Head and Maintenance responsible To be completed by September 17, 2014</p>	

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K01S150	<p>whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review and interview, the facility administration failed to have a complete fire safety plan to protect 5 of 5 clients. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>During the record review process with the Group Home Manger on 08/18/14 at 1:25 p.m., the facility did have a written fire safety plan but the plan did not address activation of the fire alarm in the event of a fire emergency. This was acknowledged by the Group Home Manager at the time of record review.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p>	K01S147	<p>Now, and in the future, the facility will ensure evacuation procedures and fire safety plans are review at least every 2 months.</p> <p>Now, and in the future, the facility will ensure that the written fire safety plan addresses activation of the fire alarm in the event of a fire emergency.</p> <p>Residential Department Head, QIDP and Home Manager responsible.</p>	09/17/2014			

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	<p>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 interview and observation, the facility failed to ensure new draperies and curtains in 1 of 4 sleeping rooms were flame resistant. 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 Method of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects all clients.</p> <p>Finding include:</p> <p>Based on observations with Group Home Manager on 08/18/14 at 1:32 p.m., curtains hung at the windows in the center west sleeping room lacked an attached documentation to confirm they were flame resistant. Based on an interview with the Group Home Manager at the time of observations, she was unaware there were curtains in this sleeping room and was unable to provide documentation to confirm the curtains were flame resistant.</p>	K01S150	<p>Now and in the future, only flame retardanthe hanging furnishings such as draperies and /or curtains and decorations will be used in all of the group homes. HomeManager and Residential Department Head are responsible. All new hanging furnishings will have an attached document that ensures the furnishings are flame resistant.</p>	09/17/2014

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K01S152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all clients.</p> <p>Findings include:  Based on review of the fire drill reports titled Evacuation Drill Report with the</p>	K01S152	Now and in the future, the facility will hold evacuation drills at least quarterly for each shift of personnel. The attached Evacuation Drill Schedule is	09/05/2014			

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	Group Home Manager on 08/18/14 at 1:05 p.m., documentation of a third shift fire drill for the second quarter of 2014 was not available for review. Based on an interview with the Group Home Manager at the time of record review, she confirmed this fire drill was not conducted.		currently being followed to ensure compliance. Evacuation Drill reports are reviewed by the Home Manager and submitted monthly to the QIDP. Group Home Staff, Home Manager, QIDP responsible		