

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 08/17/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130
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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: 08/17/12</p> <p>Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190</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 with a basement was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors and common living areas. The facility has a capacity of 7 and had a census of 7 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 Impractical with an E-score of 5.6.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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KS020	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Interior stairs are enclosed with ½ hour fire barriers, with all openings equipped with smoke-actuated automatic closing or self-closing doors having a fire protection rating comparable to that required for the enclosure. Stairs comply with 7.2.2.5.3. The entire primary means of escape is arranged so that it is not necessary for the occupants to pass from all spaces on that story by construction having not less than a ½ hour fire resistance rating. In buildings of construction other than Type II (000), Type III (200), or Type V (000), the supporting construction is protected to afford the required fire resistance rating of the supported wall. 33.2.2.4.</p> <p>Exception No. 1: Stairs that connect a story at street level to only one other story are permitted to be open to the story that is not at street level.</p> <p>Exception No. 2: Stair enclosures are not required in buildings of three or fewer stories that house prompt or slow evacuation capability facilities protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick response or residential sprinklers. This exception is permitted only if a primary means of escape from each sleeping area still exists that does not pass through a portion of a lower floor, unless that route is separated from all spaces on that floor by construction having a ½ hour fire resistance rating.</p> <p>Exception No. 3: Stair enclosures are not required in buildings of two or fewer stories that house prompt evacuation capability</p>						

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	<p>facilities with not more than eight residents and are protected by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick-response or residential sprinklers. Exception No. 2 to 33.2.2.3 is not used in conjunction with this exception. The exceptions to 33.2.3.4.3 are not used in conjunction with this exception.</p> <p>Exception No. 4: In buildings of three or fewer stories that house prompt or slow evacuation capability facilities protected by an approved automatic sprinkler system in accordance with 33.2.3.5, stairs are permitted to be open at the top most story only. The entire primary means of escape of which the stairs are a part is separated from all portions of lower stairs.</p> <p>IMPRACTICAL Vertical openings are protected so as not to expose a primary means of escape. Vertical openings are considered protected if separated by smoke partitions in accordance with 8.2.4 that prevent the passage of smoke from one story to any primary means of escape on another story. Smoke partitions have a fire resistance rating of not less than ½ hour. Any doors or openings to the vertical opening are capable of resisting fire for not less than 20 minutes. 32.3.1.1, 33.2.3.1.1</p> <p>Exception: Stairs are permitted to be open where complying with Exception No. 2 or Exception No. 3 to 32.2.2.4 and 33.2.2.4. Based on observation and interview, the facility failed to ensure 1 of 1 interior stairway doors would self close and latch into the door frame. This deficient practice could affect all clients in the</p>	KS020	The Environmental Services Manager has scheduled an inspection to be completed by SimplexGrinnell. Items to be inspected will include the door at the top of the basement stairway	09/16/2012

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	<p>facility.</p> <p>Findings include:</p> <p>Based on observation with home manager on 08/17/12 at 12:55 p.m., the door at the top of the basement stairway failed to self close and latch upon activation of the fire alarm system. Furthermore, the basement stairway door had a one inch gap along the entire latching side of the door when the self closer failed to close the door completely. This was acknowledged by the home manager at the time of observation.</p>		<p>where the latch failed to self close upon activation of the fire alarm system. The Maintenance Coordinator will repair the one inch gap along the entire latching side of the door when the door is closed completely. This will ensure the safety of all clients and staff in the facility, and ensure compliance with the NFPA Safety Code.</p>		

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KS051	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on record review and interview, the facility failed to ensure annual inspections were performed for 1 of 1 fire alarm systems including 8 photo electric smoke detectors, 4 horn/strobe devices, 4 fire alarm boxes, and the fire alarm control equipment. LSC 9.6.2.10.1 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, fire alarm boxes, horn/strobe devices, and fire alarm control equipment be tested annually. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Alarm System Annual Inspection Reports in the Simplex/Grinnell Inspection Binder on 08/17/12 at 12:10 p.m. with the home manager, the most recent annual</p>	KS051	The Program Coordinator has been in contact with SimplexGrinnell to replace the missing Inspection Reports. These will be in the SimplexGrinnell Book by the Completion Date with originals sent to the Environment Services Manager. Training has been completed with the new Program Coordinator on the importance of compliance with LSC standards. This will ensure the safety of all clients and staff in the facility, and ensure compliance with the NFPA Life Safety Code.	09/16/2012	

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	inspection report available for review was dated 02/02/11, which was a period of over one year since the last inspection date. This was acknowledged by the home manager at the time of record review.			

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KS053	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms are powered from the building electrical system and when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms are installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3.</p> <p>Exception No 1: Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system.</p> <p>Exception No. 2: Where buildings are protected throughout by an approved automatic sprinkler system, in accordance with 32.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms.</p> <p>Based on record review and interview, the facility failed to ensure 8 of 8 smoke detectors, tested by a qualified service technician, were within their listed and marked sensitivity range. LSC Section 9.6.2.10.1 refers to NFPA 72, National</p>	KS053	The Program Coordinator has been in contact with SimplexGrinnell to replace the missing Inspection Reports. These will be in the SimplexGrinnell Book by the completion date with originals sent to the Environmental	09/16/2012			

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	<p>Fire Alarm Code. NFPA 72, at 7-3 requires testing to be in accordance with Section 7-3, Inspection and Testing Frequency. NFPA 72, 7-3.2.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:</p> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method</p>		<p>Services Manager. The two year sensitivity test record was in the original for the report date 2/02/11 at the office, please see attached. This will ensure compliance with the NFPA Life Safety Code.</p>				

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	<p>acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.</p> <p>The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients in the facility including staff, and visitors.</p> <p>Findings include:</p> <p>Based on a review of Fire Alarm System Inspection Reports with the home manager on 08/17/12 at 12:20 p.m., there were no Sensitivity Test Reports available for review in the Simplex/Grinnell Inspection Binder. Furthermore, the only records available for review were Fire Alarm System Inspection Reports dated 02/02/11 and 08/02/09 indicating annual functional tests were performed on all fire alarm system components. The lack of a two year sensitivity test record was acknowledged by the home manager at the time of record review.</p>				

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KS147	<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 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 periodically instruct and keep employees informed with respect to their duties and responsibilities under the written emergency plan not less than every 2 months to protect 7 of 7 clients. A copy of the plan is readily available at all times within the facility. This deficient practice would affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on review of the Fire Evacuation Plan Policy and Emergency Evacuation Drill Reports on 08/17/12 at 11:55 a.m.</p>	KS147	The Administration has put into effect a plan that the QA Team will oversee. Ensuring that the Operations Manager SGL, instructs the Program Coordinator periodically in the event of fire, so that staff responses are well informed with respect to their duties and responsibilities whenever any resident with unusual needs is admitted to the home. QA will follow up with the Program Coordinator / Staff on a monthly basis, ensuring that documentation / drills are done. Also that required documentation is turned in and meets Life Safety Code Standards. This will ensure the safety of 7 of 7 clients and all staff.	09/16/2012			

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	with the home manager, there was no documentation indicating employees were periodically instructed and kept informed with respect to their duties and responsibilities under the plan from 08/11/11 through 01/20/12. Based on an interview with the home manager on 08/17/12 at 12:10 p.m., the home manager indicated there was no other documentation available for review to indicate employees were periodically instructed and kept informed with respect to their duties and responsibilities under the Fire Evacuation Plan Policy between 08/11/11 through 01/20/12.				

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KS152	<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 at least quarterly on 3 of 3 shifts during the past year. This deficient practice affects all clients in the facility.</p> <p>Findings include: Based on a review of the Emergency Evacuation Drill Reports with the home</p>	KS152	The Operations Manager SGL will develop and implement a process for evaluating all emergency drills under varied conditions. The drills will be completed by the Program Coordinator with input from the home staff. The drills will be kept on file in the home and a copy in the Quality Assurance Office. This will ensure the safety of all the clients in the facility. The Operations Manager SGL will	09/16/2012			

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	manager on 08/17/12 at 11:35 a.m., there was no evidence of a first shift, second shift or third shift fire drill for the fourth quarter of the year 2011. Based on a review of the Emergency Evacuation Drill Reports by the home manager and interview on 08/17/12 at 11:45 a.m., it was confirmed there was no other evidence available for review to indicate the missed fire drills were conducted.		periodically review the home files to ensure the drills and evaluations are completed. To meet the requirements of the NFPA Life Safety Code.		