

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G608	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2016
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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311
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K 0000 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: 04/27/16</p> <p>Facility Number: 001179 Provider Number: 15G608 AIM Number: 100240130</p> <p>At this Life Safety Code survey, In-Pact 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 was determined to be nonsprinklered. The facility has a fire alarm system with hard wired smoke detection in sleeping rooms, corridors and all living areas. The facility has the capacity for 5 and had a census of 4 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,</p>	K 0000		

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 S014 Bldg. 01	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.2.</p> <p>Quality Review completed on 05/02/16 - DA</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 the interior finish in 1 of 1 Bedroom #3 Closet covered in carpet was rated Class A, Class B or Class C for a Prompt rated facility. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Group Home Manager on 04/27/16 at 11:36 a.m., carpet covered the walls in Bedroom #3 Closet. Based on interview at the time of observation, the Group Home Manager acknowledged the aforementioned condition and confirmed there was no documentation available.</p>	K S014	<p>Maintenance request will be done to have the carpeting removed from the closet in bedroom #3. Responsible person: Sheila O'Dell, GH Director. Maintenance will remove the carpeting from the closet of bedroom #3. Responsible person: Maintenance staff.</p>	05/27/2016
K S017	483.470(j)(1)(i)			

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Bldg. 01	<p>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 facilities, where the group achieves an</p>			

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K S051 Bldg. 01	<p>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 5 client bedrooms would resist the passage of smoke. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Group Home Manager on 04/27/16 at 11:30 a.m., Bedroom #1 contained two separate one eighth inch unsealed penetrations in the door. Based on interview at the time of observation, the Group Home Manager acknowledged the aforementioned condition.</p> <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</p>	K S017	<p>Maintenance request will be completed to close the two gaps in bedroom #1 door to resist smoke. Responsible person: Sheila O'Dell, GH Director. Maintenance will close the two gaps in bedroom #1 door to resist smoke. Responsible person: Maintenance Staff</p>	05/27/2016	

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K S120 Bldg. 01	<p>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 observation and interview, the facility failed to ensure 1 of 1 Bedroom #3 smoke detector would be installed away from a fan that could affect activation. LSC 9.6.1.4 requires fire alarm systems to be installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect staff and at least 1 client.</p> <p>Findings include:</p> <p>Based on observation with the Group Home Manager on 04/27/16 at 11:36 p.m., a smoke detector in Bedroom #3 was located twenty four inches from a ceiling fan. Based on interview at the time of observation, the Group Home Manager acknowledged the aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In addition to the primary route, each sleeping room in facilities that use Exception No. 1 to 32.2.3.5.1 has a second means of</p>	K S051	A work order will be requested to move the smoke detector in bedroom #3 away from the ceiling fan. Responsible person: Sheila O'Dell, GH Director. Alert alarm will come out to move the smoke detector in bedroom #3 from the ceiling fan. Responsible person: Lynetta Stewart.	05/27/2016	

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	<p>escape that consists of one of the following:</p> <p>(a) It is a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape.</p> <p>(b) It is a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to an approved means of escape.</p> <p>(c) It is an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 sq. ft. The width is not less than 24 inches. The bottom of the opening is not more than 44 inches above the floor. Such means of escape is acceptable where one of the following criteria are met:</p> <p>(1) The window is within 20 ft of grade.</p> <p>(2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.</p> <p>(3) The window or door opens onto an exterior balcony. 33.2.2.3</p> <p>Exception No. 1: If the sleeping room has a door leading directly to the outside of the building with access to grade or to a stairway that meets the requirements of exterior stairs in 33.2.3.1.2, that means of escape is considered as meeting all the escape requirements for the sleeping room.</p> <p>Exception No. 2: A second means of escape from each sleeping room is not required</p>			

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K S147 Bldg. 01	<p>where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.</p> <p>Exception No. 3: Existing approved means of escape is permitted to continue to be used.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 client sleeping rooms was provided with a secondary means of escape. This deficient practice could affect no residents because the room was unoccupied.</p> <p>Findings include:</p> <p>Based on observation with the Group Home Manager on 04/27/16 at 11:28 a.m., bedroom #1 contained one window and one door into another bedroom. The bottom of the window opening was 53.5 inches tall. The room was not sprinklered. Based on interview at the time of observation, the Group Home Manager explained the door into another bedroom was sealed shut by maintenance and acknowledged the aforementioned condition.</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</p>	K S120	<p>Maintenance request will be completed to remove the seal from the second door to use as a second egress. Responsible person: Sheila O'Dell, GH Director. Maintenance will remove the seal from the second door to use as a second egress. Responsible person: Maintenance Staff</p>	05/27/2016

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	<p>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 observation, record review, and interview, the facility administration failed to have a written fire safety plan to protect 4 of 4 clients. This deficient practice affects two clients.</p> <p>Findings include:</p> <p>Based on observation with the Group Home Manager on 04/27/16 at 11:34 am. then again at 11:36 a.m., Bedroom #1 door contained a locking device. Then again, Bedroom #2 contained a locking device. Based on interview, the Group Home Manager was unable to unlock each resident room door with a key.</p> <p>Based on record review, the written fire safety plan failed to include how staff would unlock the clients bedrooms in an</p>	K S147	<p>Maintenance request will be completed to remove the locks on bedroom doors #1 and #2. Responsible person: Sheila O'Dell, GH Director.</p> <p>Maintenance will remove the locks on bedroom doors #1 and #2. Responsible person: Maintenance Staff. All staff will be trained to on unlock any doors that could be lock in an emergency. Responsible person: Patti Harris, QIDP. To ensure future compliance, monthly doors will be checked that key are available in an emergency. Responsible person: Sheila O'Dell, GH Director & Patti Harris, QIDP.</p>	05/27/2016

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K S148 Bldg. 01	<p>emergency.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Group Home Manager on 04/27/16 at 11:18 a.m., there were at least 30 cigarette butts on the ground in the designated staff smoking area. Based on interview at the time of observation, the Group Home Manager acknowledged the aforementioned condition.</p>	K S148	<p>A self-closing cover ashtray will be purchased. Responsible person: Sheila O'Dell, GH Director. Staff who are the smokers will go out to clean up the grounds of cigarette butts. Responsible person: Lynetta Stewart, GH Manager. All staff will be trained on where to smoke and how to dispose of their cigarette butts. Responsible person: Lynetta Stewart, GH Manager. To ensure future compliance, monthly the grounds will be monitored for deficient practice. Responsible person: Lynetta Stewart, GhManager.</p>	05/27/2016			
K S152 Bldg. 01	<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>						

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	<p>(2) The facility must -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities:</p> <p>(iii) File a report and evaluation on each drill:</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(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 2 of the last 4 calendar quarters. This deficient practice could affect all clients.</p> <p>Findings include: Based on record review of the fire drill reports titled "In-pact Site Drill Report" with the Group Home Manager on 04/27/16 at 10:54 a.m., there was no documentation for a first shift fire drill for the third quarter of 2015. Also, there was no documentation for a third shift fire drill for the third and fourth quarter of 2015. Based on interview at the time of record review, the Group Home Manager acknowledged the lack of</p>	K S152	<p>Manager/staff will be retrained to complete and review for completion of all required fire drills, including 1st, 2nd & 3rd shift drill during each quarter within 90 days. Responsible person: Patti Harris, QIDP. An extra third shift drill will be completed. Responsible person: Lynetta Stewart, Group Home Manager. A summary sheet will be completed to show which drill have been completed, when and by who. Responsible person: Lynetta Stewart, Group Home Manager. To ensure future compliance, monthly the drills will be reviewed to ensure completion of all required drills for each shift, each quarter. Responsible person: Sheila O'Dell, Group Home Director & Patti Harris, QIDP.</p>	05/27/2016			

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K S155 Bldg. 01	<p>documentation.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy for the protection of 6 of 6 clients indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during</p>	K S155	The fire watch policy will be updated to include contacting the local fire department to inform them our power is out and that the home is under a fire watch. Responsible person: Sheila O'Dell, GH Director. Management staff and staff will be trained on the policy. Responsible person: Sheila O'Dell, GH Director & Patti Harris, QIDP.	05/27/2016

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	<p>a malfunction of the building fire alarm system. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Policy on Fire Watch" with the Group Home Manager on 04/27/16 at 11:01 a.m., the facility's documentation provided for a plan of action when the fire alarm system was out of service for more than four hours in a twenty four hour period but was not complete. The procedure did not include all elements required such as; the contacting the local fire department. Based on an interview record review, the Group Home Manager acknowledged the aforementioned condition.</p>				