

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G608		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  06/17/2016	
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 132 BERENS ST DYER, IN 46311			
(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			
K 0000  Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/27/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/17/16</p> <p>Facility Number: 001179 Provider Number: 15G608 AIM Number: 100240130</p> <p>At this PSR 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>	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 S017 Bldg. 01	<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 0.2.</p> <p>Quality Review completed on 06/22/16 - DA</p> <p>483.470(j)(1)(i) 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</p>			

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	<p>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 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 06/17/16 at 11:26 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</p>	K S017	<p>Maintenance request will be re-submitted 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 Maintenance request will be have a notation of completion: when and by whom. Responsible person: Ray Giacomini, CFO and Maintenance staff. To ensure future compliance, all of the doors will be inspected monthly. Responsible person: Sheila O'Dell, GH Director &amp; Patti Harris,</p>	07/17/2016

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K S018 Bldg. 01	<p>condition.</p> <p>This deficiency was cited on 04/27/16. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation, the facility failed to ensure 1 of 5 sleeping room doors would latch into the door frame. 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 06/17/16 at 11:26 a.m., a coat hanger was on the corridor side door knob of Bedroom #1 which prevented the door from latching into the</p>	K S018	<p>QIDP.</p> <p>All items including the hanger will be removed from the door knob. Responsible person: Lynetta Stewart-Moore, GH Manager. All staff will be trained that all bedrooms must latch into the door frame and that nothing can be in the way preventing the door from latching into the frame. Responsible person: Lynetta Stewart-Moore, GH Manager. To ensure future compliance, monthly the doors will be inspected that they latch proper into the frame. Responsible person: Sheila O'Dell, GH Director and Patti Harris, QIDP.</p>	07/17/2016	

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	frame. Based on interview at the time of observation, the Group Home Manager acknowledged the aforementioned condition.				