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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G434 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/02/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>JAY-RANDOLPH DEVELOPMENTAL SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>840 PINEVIEW LN<br>WINCHESTER, IN 47394 |
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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: 03/02/12</p> <p>Facility Number: 000948<br/>Provider Number: 15G434<br/>AIM Number: 100244700</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Jay-Randolph Developmental Services 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 not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and common living areas. The facility has a capacity of 6 and had a census of 6 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 Prompt with an E-Score of 0.50.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/06/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> |               |   |                      |

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| K0130   | <p>Based on observation and interview, the facility failed to ensure 6 of 6 portable fire extinguishers were inspected at least monthly and the inspections were documented for 5 of 5 months since the last annual inspection date, including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the home manager on 03/02/12 from 10:10 a.m. to 11:35 a.m., service and inspection tags for the portable fire extinguishers located in the kitchen, the staff office, the living room, the laundry room, and two portable fire</p> | K0130   | Now and in the future, all fire extinguishers will be inspected by staff at least on a monthly basis to ensure that each extinguisher is available and operable. A Record of Inspection will be kept in the home and will be signed and dated by the inspecting staff on a monthly basis. Residential Department Head and Home Manager are responsible. | 03/03/2012   |  |   |  |

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|                    | extinguishers in the garage each bore a service inspection tag indicating the most recent annual inspection was in September 2011, but no monthly checks were documented on the inspection tags for October, November, December 2011, and January and February 2012. Based on interview at the time of observation, the home manager stated there is no written documentation of monthly fire extinguisher inspections for the facility and acknowledged the facility did not perform monthly fire extinguisher inspections from October 2011 through February 2012. |               |   |                      |

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| KS046   | <p>483.470(j)(1)(i)<br/>LIFE SAFETY CODE STANDARD<br/>Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 electrical extension cords were not used as a substitute for fixed wiring. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would affect approximately 2 of 6 clients who reside in the east client sleeping room near the staff office.</p> <p>Findings include:</p> <p>Based on observation with the home manager on 03/02/12 at 11:10 a.m., the east client sleeping room near the staff office had a white twenty foot extension cord connected to a power strip which was in use for a television set. This was verified by the home manager at the time of observation.</p> | KS046   | Now and in the future, extension cords will not be used in the group home. All extension cords are removed. Residential Department Head and Home Manager are responsible. | 03/02/2012   |  |   |  |

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| KS150              | <p>483.470(j)(1)(i)<br/>LIFE SAFETY CODE STANDARD<br/>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 observation and interview, the facility failed to ensure new draperies and curtains were flame resistant in 3 of 4 client sleeping rooms, and in 1 of 2 living rooms. 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 Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects all clients in the facility.</p> <p>Findings include</p> <p>Based on observation on 03/02/12 during a tour of the facility from 10:10 a.m. to 11:35 a.m. with the home manager, the east client sleeping room near the staff office, the west second client sleeping room near the staff office, the north client sleeping room, and the north living room each had white window curtains. Based on an interview with the home manager on 03/02/12 at 11:20 a.m., the curtains in these areas are new and are not flame resistant window curtains.</p> | KS150         | Now and in the future, only flame retardant hanging furnishings such as draperies and /or curtains and decorations will be used in the group home. Residential Department Head and Home Manager are responsible. | 03/05/2012           |