

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2012
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD OSCEOLA, IN 46561
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(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
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: 09/05/12</p> <p>Facility Number: 003863 Provider Number: 15G713 AIM Number: 200462800</p> <p>Surveyor: W. Chris Greeney, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, AWS 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 32, New Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and common living areas. The facility has a capacity of 4 and had a census of 4 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 Slow with an E-Score of 2.04.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/06/12.</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>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers in the home was readily accessible at all times. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1-6.3 requires extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from an area. This deficient practice affects all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the House Manager on 09/05/12 at 11:40 a.m., a fire extinguisher was found to be attached to a wall in the home's attached garage. A ladder was folded up and stored against the wall with the top of the ladder extending from above the extinguisher down to the floor immediately in front, blocking access to</p>	K0130	All staff have been re-trained on maintaining accessibility of the fire extinguishers. The house manager and QMRP are completing periodic spot checks to ensure that the training was effective. The management staff also complete a monthly house walk thru. This form has been revised to include monitoring the accessibility of the fire extinguishers. The maintenance walk thru form will be used to document the spot checks and will be turned into the director to ensure compliance.	10/05/2012	

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	the extinguisher. There were also two brooms, a dustpan and a step stool located on both sides of the extinguisher leaning up against the wall. Interview with the House Manager during the tour indicated staff were trained not to store items around fire extinguishers and those items should not have been there.				