

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G331	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350
---	---

(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: 01/07/13</p> <p>Facility Number: 000849 Provider Number: 15G331 AIM Number: 100243820</p> <p>Surveyors: Joe L. Brown, Jr., Life Safety Code Specialist &amp; Robert Sutton, Life Safety Code Specialist Trainee.</p> <p>At this Life Safety Code survey, Parents and Friends, 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</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G331		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  PARENTS AND FRIENDS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350			
(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			
	<p>Care Occupancies.</p> <p>This one story facility with a basement was not sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, in the living areas, and battery operated smoke detectors in the client sleeping rooms. The facility has a capacity of 6 and had a census of 6 at the time of this survey.</p> <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 0.3.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/11/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G331	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G331	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  PARENTS AND FRIENDS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350		
(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	
K0130	<p>Based on observation and interview, the facility failed to ensure 3 of 3 interior emergency lights were tested and the records of the testing maintained. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires a functional test be conducted at 30 day intervals and an annual test be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the facility were required to evacuate in an emergency during a loss of</p>	K0130	<p>In order to ensure this standard is met now and in the future, the maintenance department will develop and implement a new form that will be completed on a monthly basis. The maintenance department will conduct tests on a monthly basis for 60 seconds and on an annual basis for 1 1/2 hours to make sure the emergency lighting in the facility continually works. Documentation will be kept on a monthly and annual basis. (maintenance department responsible)</p>	02/06/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G331	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  PARENTS AND FRIENDS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350		
(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	
	<p>normal power.</p> <p>Findings include:</p> <p>Based on observation and interview with the Residential Director during a tour of the facility from 11:15 a.m. to 1:00 p.m. on 01/07/13, the facility has three battery powered emergency lights which worked when tested. Based on interview with the Residential Director on 01/07/13 at the time of observations, the facility does not perform an annual 1 ½ hour duration test for each battery powered light and the facility does not provide a thirty second monthly test for each battery powered light, so the facility did not have a written record of monthly or annual battery powered emergency light testing.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G331	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350
---	---

(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
KS046	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 electric receptacles in the hallway and 1 of 1 electric receptacles in the basement were provided with covers. LSC 9.1.2 refers to NFPA 70, National Electrical Code. NFPA 70, 1999 Edition, Article 370-25, Covers and Canopies, states "In completed installations each box shall have a cover, faceplate or fixture canopy." This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation and interview with the Residential Director during a tour of the facility from 11:15 a.m. to 1:00 p.m. on 01/07/13, the electric receptacle in the hallway above the linen closet was missing the cover plate. Further observation revealed the</p>	KS046	<p>In order for this citation to be met now and in the future, maintenance will inspect the home for any equipment that may be broken or unsafe in the homes on a weekly basis. For this particular citation, the extension cord was removed from the bedroom and there was a surge protector placed in the kitchen for the two small appliances that were in use. In addition the cover plate was replaced. (maintenance department responsible)</p>	02/06/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G331		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  PARENTS AND FRIENDS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350			
(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			
	<p>electrical receptacle in the basement wall behind the refrigerator and the freezer was missing the electric receptacle cover plate. Based on observation and interview with the Residential Director on 01/07/13, she stated that she was unaware that the cover plates were missing.</p> <p>2. Based on observation and interview with the Residential Director during a tour of the facility from 11:15 a.m. to 1:00 p.m. on 01/07/13, the facility failed to ensure 2 of 2 electrical extension cords or multiplug adapters 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 all residents, staff, and visitors.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G331	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  PARENTS AND FRIENDS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1709 FARRAND AVE LA PORTE, IN 46350		
(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	
	<p>Findings include:</p> <p>Based on observation and interview with the Residential Director during a tour of the facility from 11:15 a.m. to 1:00 p.m. on 01/07/13, resident room # 3 had a five feet extension cord connected to two televisions. Further observation revealed there was a six plug adapter being used to connect a coffee pot and radio. Based on interview at the time of observation with the Residential Director on 01/07/13, she acknowledged there were extension cords being used in the facility.</p>				