

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2012
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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143
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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: 06/29/12</p> <p>Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Res Care Community Alternatives SE IN 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, client sleeping rooms and common living areas. The facility has a capacity of 6 and had a census of 5 at the time of this survey.</p>	K0000	Please See Attached POC	
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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 2.45.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/05/12.</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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were inspected at least monthly, and that the inspections were documented, 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 observations during a tour of the facility with the home manager on 06/29/12 from 10:00 a.m. to 11:00 a.m., service and inspection tags for the two portable fire extinguishers located in the dining room/kitchen bore service inspection tags indicating there was no monthly check conducted for December</p>	K0130	<p>The Operations Manager SGL and the Program Coordinator will ensure the staff inspect the fire extinguishers service and inspection tags, for the two portable fire extinguishers. Two located in the dining room / kitchen areas. Documenting the date of the inspections on the attached inspection tag. This will be done once a month. This will ensure the extinguishers in the home are in compliance with Life Safety Code Standards. SimplexGrinnell will perform annual inspections of the extinguishers and the Environmental Services Manager will follow-up on scheduling needed for recharging/replacement of extinguishers as necessary.</p>	07/29/2012

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	2011, January, February, March, April, and May of 2012. The annual inspection was conducted 09/07/2011. This was verified by the home manager at the time of the observations.			

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KS147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available 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 person 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 no 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 record review and interview, the facility administration failed to periodically instruct and keep employees informed with respect to their duties and responsibilities under the written emergency plan at least every two months to protect 5 of 5 clients. A copy of the plan is readily available at all times within the facility. This deficient practice would affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on review of the Emergency Evacuation Drill Plan and State Fire Marshall Fire Regulations Policy on 06/29/12 at 9:45 a.m. with the home</p>	KS147	The Administration has put into effect a plan that the QA team will oversee. Ensuring that the Operations Manager SGL, instructs the Program Coordinator periodically in the event of a fire, so that staff responses are well informed with respect to their duties and responsibilities whenever any resident with unusual needs is admitted to the home. QA will follow up with the Program Coordinator / staff on a monthly basis, ensuring that documentation / drills are done. Also that required documentation is turned in and meets Life Safety Code Standards. This will ensure the safety of 5 of 5 clients and all staff.	07/29/2012			

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	<p>manager, there was no documentation indicating employees were periodically instructed and kept informed with respect to their duties and responsibilities under the written plan over the past year. Based on an interview with the home manager on 06/29/12 at 10:00 a.m., there was no evidence available for review to indicate staff were periodically instructed and kept informed with respect to their duties and responsibilities under the either the Emergency Evacuation Drill Plan or the State Fire Marshall Regulations Policy over the past year.</p>			

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KS152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>The facility must -</p> <ul style="list-style-type: none"> <li>(i) Actually evacuate clients during at least one drill each year on each shift;</li> <li>(ii) Make special provisions for the evacuation of clients with physical disabilities;</li> <li>(iii) File a report and evaluation on each drill;</li> <li>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</li> <li>(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.</li> </ul> <p>Facilities meet the requirements of paragraphs (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>Based on record review and interview, the facility failed to conduct fire drills at least quarterly on 2 of 3 shifts during the past year. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Emergency Evacuation Drill Reports with the home manager on 06/29/12 at 9:20 a.m., there</p>	KS152	The Operations Manager SGL will ensure that the Program Coordinator develops and follows a schedule conducting Fire Drills at least quarterly for each shift of personnel and under varied conditions. This will ensure that all personnel on all shifts are trained to perform assigned tasks and are familiar with the use of the facility's emergency and disaster plans and procedures. The Program Coordinator will submit copies of Fire Drills	07/29/2012			

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	was no evidence of a first shift fire drill for the fourth quarter of the year 2011, or a first and third shift fire drill for the first quarter of the of the year 2012. Based on a review of the Emergency Evacuation Drill Reports by the home manager and interview on 06/29/12 at 9:30 a.m., it was confirmed there was no other evidence available for review to indicate the missed fire drills were conducted.		performed to the QA Team for review. The QA Team will ensure the schedule for Fire Drills is in compliance with Life Safety Code Standards.	