STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G513	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL CRF INC	2375 W US HWY 36 DANVILLE, IN 46122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for the investigation of complaint #IN00106261 which resulted in an Immediate Jeopardy. Complaint #IN00106261: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W102, W104, W406 and W433. Dates of Survey: 4/12/12, 4/13/12, and 4/16/12. Facility Number: 001027 Provider Number: 15G513 AIMS Number: 100245180 Surveyors: Dennis Austill, Life Safety Code Supervisor (4/12/12)-Team Leader Steve Corya, Surveyor Supervisor (4/12/12) Keith Briner, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/23/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation and interview, the facility's governing body failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) plus 3 additional clients (E, F and G). The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to ensure the physical environment of the group home promoted the health and safety of clients A, B, C, D, E, F and G. Findings include: 1. The governing body failed to meet the Condition of Participation: Physical Environment for 7 of 7 clients living in the group home (clients A, B, C, D, E, F and G). The governing body failed to ensure the condition of the home was safe for the clients and free from environmental and fire hazards. Please see W406. 2. The governing body failed to exercise	W0102	Residential CRF staff and administration have monitored the construction project to its completion. The condition of the home has returned to a safe environment free from environmental and fire hazards. Residential CRF will ensure that any construction project in the future will have an outlined agenda before construction occurs.The QMRP and supervisor will monitor the home on a weekly basis to ensure that the home remains safe and free from any environmental and fire hazards.Person Responsible: QMRP and Supervisor	05/16/2012

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	operating direction over the facility to ensure the facility implemented its written policy and procedures to ensure the physical environment of the group home promoted the health and safety of 7 of 7 clients living in the group home (clients A, B, C, D, E, F and G). Please see W104. This federal tag relates to complaint #IN00106261. 9-3-1(a)			

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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 4 of 4 sampled clients (A, B, C and D) plus 3 additional clients (E, F and G), the governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to ensure the physical environment of the group home promoted the health and safety of clients A, B, C, D, E, F and G. Findings include: 1. Observations were done at the group home on 4/12/12 from 7:23 AM through 8:25 AM and 10:00 AM through 12:15 PM. The group home for clients A, B, C, D, E, F and G had two Northern entrances. The first or primary entrance to the front of the group home opened to a foyer or hallway area 15 feet by 10 feet. The area had two resident bedrooms to the East and West of the hallway. The resident bedroom to the West was observed at 7:25 AM. The client bedroom had no carpeting in the bedroom. The	W0104	Residential CRF staff and administrators have monitored the construction project to its completion. The clients living in the group home were moved to Staybridge Suites in Plainfield, Indiana until the home was safe and free of environmental and fire hazards. Residential CRF received approval from the the State Life Safety Code Inspector on April 30, 2012. The client's returned to their home on April 30, 2012.The fire alarm system has been reattached and is in full working order.The fire alarm system was attached and checked by Superior Systems, a local fire alarm system company.A written policy regarding guidelines for when the alarm is not operating has been established.The authority having jurisdiction shall be notified and a fire watch schedule will be completed.Staff will be in-serviced on these procedures. All fire exits are free of any obstacles to ensure all clients can be safely evacuated .All Fire extinguishers will be inspected on a monthly basis and documented with the date and initials of the person performing the inspection.Person Responsible: QMRP and Supervisor	05/16/2012

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	bedroom had carpet padding on the floor with a section measuring 6 feet by 4 feet missing which exposed the wood sub flooring beneath. The missing area created an uneven surface as the wood flooring was depressed below the carpet padding by 3/4 of an inch. The entrance hallway or foyer area opened into an area which had no carpeting. The floor covering was removed leaving exposed plywood sub flooring. The corners of the room had exposed carpet tack strips. The walls did not have drywall or other covering leaving the wall studs exposed. Attached to the wall studs was the home's electrical wiring. The electrical wiring was connected to outlet and light switches which were not covered. The ceiling did not have a covering in that the ceiling was exposed floor joists of the second level (upstairs) flooring. The North wall of the area had a smoke detector wiring unit hanging from the wall (free floating). The area contained a single kitchen sink with exposed plumbing and drain. The area contained a stack of 23 pieces of 4 feet by 8 feet sheets of drywall. The area had a rolled			

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	up carpet with black wiring and a clear plastic sheet in the southern corner of the room. The area was partially separated from the adjacent room to the Southwest by an unfinished wall. The unfinished wall was wall studs attached with exposed electrical wiring and insulation. The area opened with a 6 feet by 4 feet area of linoleum flooring missing with a raised edge around the perimeter of the rip or missing piece. The missing linoleum exposed a depression of sub flooring plywood measuring 3 feet by 4 feet. The sub flooring plywood depression was 1 inch in depth. The area had no coverings on the walls. The walls consisted of the wall studs, exposed wiring, visible gaps to the outside along with the outer paneling/siding of the house. The area had construction supplies including 2 inch by 4 inch boards measuring 8 feet in length, an assortment of electrical cords/wires, a 5 gallon container of roofing sealant, 5 gallon containers of dry wall plaster, and boxes of nails. The second Northern entrance opened to an area 15 feet by 40 feet. The area had no carpeting exposing the			

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	concrete sub flooring. The area had exposed carpet tack strips along the perimeter. The area had a roll of carpet stored behind a couch along the southern most wall. Interview with QMRP-D #1 (Qualified Mental Retardation Professional Designee) on 4/12/12 at 10:00 AM indicated the group home was going through construction. QMRP-D #1 stated, "The construction did not start out like this. It just became this way in the last few days." Confidential Interview A stated the group home was "unsafe for the clients." Confidential Interview A indicated the fire alarm was hanging down on the wall and the sprinkler system was not working. Confidential Interview A indicated the fire exits were blocked and the clients' bedrooms had torn carpet padding. Confidential Interview A stated the home's condition had "multiple fall risks." Confidential Interview A indicated the group home had no functioning kitchen. Confidential Interview A indicated the construction had prevented the clients			

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	from following their routine and programming. Confidential Interview A indicated the floors are bare with exposed nails. **K155** 2. Where a required fire alarm system is out of service for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on observation, interview and record review, the facility's governing body failed to provide a written policy containing procedures to be followed in the event the fire alarm system was to be placed out of service for four hours or more in a 24 hour period to protect all of the clients. LSC 33.7.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. This deficient practice resulted in the potential for harm or death to all clients of the home if they could not be evacuated safely from the home during a fire or other emergency.			

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	Findings include: Based on observation with the QMRP-D on 04/12/12 at 10:30 a.m., the fire alarm system was not functioning. Based on interview with the QMRP-D on 04/12/12 at 10:45 a.m., a fire watch was initiated when the fire alarm system was disabled due to construction/renovation in the home but a written fire watch policy and procedure was not available for review at the facility. Based on review of two fire watch log sheets, a fire watch was documented for 15 minute intervals between 10:00 p.m. and 8:00 a.m. on a daily basis beginning 03/15/12. The QMRP-D indicated the fire watch was only conducted during the sleeping hours and not daily during the hours of 3:00 p.m. to 10:00 p.m. and on the weekends when the clients were in the home and awake. Additionally, the QMRP-D was not sure if the authority having jurisdiction (Indiana State Department of Health and the local fire department) had been notified. **K51** 3. A manual fire alarm system shall be provided in accordance with Section 9.6, 33.2.3.4.1. Exception No 1: Where there are interconnected smoke detectors meeting			

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	the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms. Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction. Based on observation and interview, the facility's governing body failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. LSC Chapter 4.6.12.1 is a general requirement and applies to all occupancies. LSC 4.6.12.1 requires any device or any feature of a required fire detection and alarm system shall be continuously maintained in proper operating condition. This deficient practice could affect all clients, staff, and visitors in the facility. Findings include: Based on observation with the QMRP-D on 04/12/12 at 10:30 a.m., the fire alarm control panel (FACP) located in the east hallway had no power. A pull station and a smoke detector were tested with no alarm. Based on interview at the time of observation, the QMRP-D acknowledged the facility's FACP was not working.			

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	K53 4. Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms shall be powered from the building electrical system and, when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms shall be installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3. Based on observation and interview, the facility's governing body failed to ensure all smoke alarms were continuously in proper operating condition. LSC Chapter 4.6.12.1 is a general requirement and applies to all occupancies. LSC 4.6.12.1 requires any device or any feature of a required fire detection and alarm system shall be continuously in proper operating condition. This deficient practice could affect all clients, staff, and visitors in the facility. Findings include: See K51 above. The smoke alarms, while installed on all levels of the facility and in common areas, are a component of the facility's fire alarm system and were not			

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	functioning. **K41** 5. Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. 33.2.2.2.1. Based on observation and interview, the facility's governing body failed to ensure 2 of 4 bedrooms had access to a primary means of escape located to provide a safe path of travel to the outside. This deficient practice could affect 3 of 7 clients, staff and visitors in the facility. Findings include**:** Based on observation and interview with the QMRP-D on 04/12/12 at 10:30 a.m., a couch, a dresser and other items were stored in the west hallway leaving a ten inch path to the primary exit for the two west bedrooms. **K40** 6. Doors or paths of travel to a means of escape shall not be less than 28 inches. 33.2.2.5.1 Based on observation and interview, the facility's governing body failed to ensure the path of travel from the bedrooms to a			

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	means of escape was at least 28 inches wide. This deficient practice could affect 3 of 7 clients, staff and visitors in the facility. Findings include: Based on observation and interview with the QMRP-D on 04/12/12 at 10:30 a.m., a couch, a dresser and other items were stored in the west hallway leaving a ten inch path to the primary exit for the two west bedrooms. **K130** 7. Based on observation and interview, the facility failed to ensure 3 of 4 portable fire extinguishers were inspected at least monthly, and the inspections were documented, including the date and initials of the person performing the inspection. LSC 4.5.7 requires any device, equipment or service required for compliance with provisions of this Code shall be thereafter maintained unless the code exempts such maintenance. 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			

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	quick check that an extinguisher is available and will operate. This deficient practice affects all clients, visitors and staff. Findings include: Based on observation with the QMRP-D on 04/12/12 between 10:30 a.m. to 11:00 a.m., the service and inspection tags for the portable fire extinguisher located on the second floor lacked documentation of monthly checks since October 2011 and the service and inspection tags for the portable fire extinguishers located in the living room and near the fire alarm control panel lacked documentation of monthly checks since February 2012. Based on interview during the time of observation, the QMRP-D acknowledged the monthly inspections of the extinguishers were not complete. This federal tag relates to complaint #IN00106261. 9-3-1(a)			

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W0406	483.470 PHYSICAL ENVIRONMENT The facility must ensure that specific physical environment requirements are met. Based on observation and interview, the facility failed to meet the Condition of Participation: Physical Environment for 4 of 4 sampled clients (A, B, C and D) plus 3 additional clients (E, F and G). The facility failed to ensure the physical environment of the group home promoted the health and safety of clients A, B, C, D, E, F and G. This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 3/15/12. The QMRP-D (Qualified Mental Retardation Professional Designee) was notified of the Immediate Jeopardy on 4/12/12 at 12:01 PM regarding the condition of the physical environment for clients A, B, C, D, E, F and G. The facility failed to ensure the group home did not have exposed electrical wiring, exposed electrical outlets, damaged flooring, exposed insulation, exposed wall studs, exposed carpet tack strips, and/or the living space was used for construction material storage.	W0406	Residential CRF staff and administrators have monitored the group homes construction project until its completion. The group home project is complete and the physical environment of the home promotes the health and safety of the clients. The clients living in the group home were moved to Staybridge Suites in Plainfield, Indiana until the homes construction project was complete. Residential CRF received approval from the State Life Safety Code Inspector on April 30, 2012. The clients returned to the home on April 30, 2012.The fire alarm sysytem was reattached and checked by Superior Systems, a local fire alarm company. Residential CRF will ensure that in future planning of construction projects that an outlined agenda for construction is complete before any construction occurs.A written policy regarding guidelines and procedures for when the fire alarm system is not operating will be established.All fire exits are free of obstacles to ensure all clients could be evacuated safely.All fire extinguishers will be inspected on a monthly basis to ensure they are in working order.Person Responsible: QMRP and Supervisor	05/16/2012

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	The facility submitted a 4/13/12 Plan of Removal on 4/13/12. The 4/13/12 plan of removal indicated the following, "Residential CRF removed the [clients A, B, C, D, E, F and G] from the Residential CRF group home on Thursday April 12, 2012, due to the individuals being at risk because of environmental conditions in the home. The client's were moved to [Hotel] in [name of city], Indiana. The clients will remain at the hotel until the group home's renovation project is complete and the living environment is safe at the home." Observations were done at the hotel on 4/13/12 from 8:15 AM through 9:15 AM and on 4/16/12 from 7:30 AM through 8:30 AM. Clients A, B, C, D, E, F and G were observed at the hotel throughout the observation periods. Interview with QMRP-D #1 on 4/13/12 at 8:30 AM indicated clients A, B, C, D, E, F and G had been moved to the hotel the evening of 4/12/12. QMRP-D #1 indicated clients A, B, C, D, E, F and G would remain at the hotel until the group home was determined to be safe to return to. QMRP-D #1 indicated clients A, B, C,			

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	D, E, F and G were participating in active treatment programming at the hotel. The facility's Plan of removal was reviewed on 4/13/12 at 9:00 AM. The Immediate Jeopardy was removed on 4/16/12 at 8:30 AM. It was determined the facility implemented a plan of action to remove the Immediate Jeopardy and the steps taken removed the immediacy of the problem. While the immediate jeopardy was removed on 4/16/12, the facility remained out of compliance at the Condition level in that the facility needed to demonstrate implementation of the safeguards. Findings include: 1. Observations were done at the group home on 4/12/12 from 7:23 AM through 8:25 AM and 10:00 AM through 12:15 PM. The group home for clients A, B, C, D, E, F and G had two Northern entrances. The first or primary entrance to the front of the group home opened to a foyer or hallway area 15 feet by 10 feet. The area had two resident bedrooms to the East and West of the hallway. The			

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	resident bedroom to the West was observed at 7:25 AM. The client bedroom had no carpeting in the bedroom. The bedroom had carpet padding on the floor with a section measuring 6 feet by 4 feet missing which exposed the wood sub flooring beneath. The missing area created an uneven surface as the wood flooring was depressed below the carpet padding by 3/4 of an inch. The entrance hallway or foyer area opened into an area which had no carpeting. The floor covering was removed leaving exposed plywood sub flooring. The corners of the room had exposed carpet tack strips. The walls did not have drywall or other covering leaving the wall studs exposed. Attached to the wall studs was the home's electrical wiring. The electrical wiring was connected to outlet and light switches which were not covered. The ceiling did not have a covering in that the ceiling was exposed floor joists of the second level (upstairs) flooring. The North wall of the area had a smoke detector wiring unit hanging from the wall (free floating). The area contained a single kitchen sink with exposed			

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	plumbing and drain. The area contained a stack of 23 pieces of 4 feet by 8 feet sheets of drywall. The area had a rolled up carpet with black wiring and a clear plastic sheet in the southern corner of the room. The area was partially separated from the adjacent room to the Southwest by an unfinished wall. The unfinished wall was wall studs attached with exposed electrical wiring and insulation. The area opened with a 6 feet by 4 feet area of linoleum flooring missing with a raised edge around the perimeter of the rip or missing piece. The missing linoleum exposed a depression of sub flooring plywood measuring 3 feet by 4 feet. The sub flooring plywood depression was 1 inch in depth. The area had no coverings on the walls. The walls consisted of the wall studs, exposed wiring, visible gaps to the outside along with the outer paneling/siding of the house. The area had construction supplies including 2 inch by 4 inch boards measuring 8 feet in length, an assortment of electrical cords/wires, a 5 gallon container of roofing sealant, 5 gallon containers of dry wall plaster, and boxes			

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	of nails. The second Northern entrance opened to an area 15 feet by 40 feet. The area had no carpeting exposing the concrete sub flooring. The area had exposed carpet tack strips along the perimeter. The area had a roll of carpet stored behind a couch along the southern most wall. Interview with QMRP-D #1 (Qualified Mental Retardation Professional Designee) on 4/12/12 at 10:00 AM indicated the group home was going through construction. QMRP-D #1 stated, "The construction did not start out like this. It just became this way in the last few days." Confidential Interview A stated the group home was "unsafe for the clients." Confidential Interview A indicated the fire alarm was hanging down on the wall and the sprinkler system was not working. Confidential Interview A indicated the fire exits were blocked and the clients' bedrooms had torn carpet padding. Confidential Interview A stated the home's condition had "multiple fall risks." Confidential Interview A indicated the			

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	group home had no functioning kitchen. Confidential Interview A indicated the construction had prevented the clients from following their routine and programming. Confidential Interview A indicated the floors are bare with exposed nails. **K155** 2. Where a required fire alarm system is out of service for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 The immediate jeopardy began on 03/15/12 when facility documentation of a fire watch was initiated when the fire alarm system was disabled due to construction/renovation in the home. The Qualified Mental Retardation Professional Designee (QMRP-D) was informed of the immediate jeopardy on 04/12/12 at approximately 11:45 a.m. Based on observation, interview and record review, the facility failed to			

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	provide a written policy containing procedures to be followed in the event the fire alarm system was to be placed out of service for four hours or more in a 24 hour period to protect all of the clients. LSC 33.7.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. This deficient practice resulted in the potential for harm or death to all clients of the home if they could not be evacuated safely from the home during a fire or other emergency. Findings include: Based on observation with the QMRP-D on 04/12/12 at 10:30 a.m., the fire alarm system was not functioning. Based on interview with the QMRP-D on 04/12/12 at 10:45 a.m., a fire watch was initiated when the fire alarm system was disabled due to construction/renovation in the home but a written fire watch policy and procedure was not available for review at the facility. Based on review of two fire watch log sheets, a fire watch was documented for 15 minute intervals between 10:00 p.m. and 8:00 a.m. on a daily basis beginning 03/15/12. The QMRP-D indicated the fire watch was only conducted during the sleeping hours and not daily during the hours of 3:00 p.m. to 10:00 p.m. and on the weekends			

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	when the clients were in the home and awake. Additionally, the QMRP-D was not sure if the authority having jurisdiction (Indiana State Department of Health and the local fire department) had been notified. **K51** 3. A manual fire alarm system shall be provided in accordance with Section 9.6, 33.2.3.4.1. Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms. Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. LSC Chapter 4.6.12.1 is a general requirement and applies to all occupancies. LSC 4.6.12.1 requires any device or any feature of a required fire detection and alarm system shall be continuously maintained in proper operating condition. This deficient			

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	practice could affect all clients, staff, and visitors in the facility. Findings include: Based on observation with the QMRP-D on 04/12/12 at 10:30 a.m., the fire alarm control panel (FACP) located in the east hallway had no power. A pull station and a smoke detector were tested with no alarm. Based on interview at the time of observation, the QMRP-D acknowledged the facility's FACP was not working. **K53** 4. Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms shall be powered from the building electrical system and, when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms shall be installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3. Based on observation and interview, the facility failed to ensure all smoke alarms were continuously in proper operating condition. LSC Chapter 4.6.12.1 is a general requirement and applies to all occupancies. LSC 4.6.12.1 requires any			

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	device or any feature of a required fire detection and alarm system shall be continuously in proper operating condition. This deficient practice could affect all clients, staff, and visitors in the facility. Findings include: See K51 above. The smoke alarms, while installed on all levels of the facility and in common areas, are a component of the facility's fire alarm system and were not functioning. **K41** 5. Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. 33.2.2.2.1. Based on observation and interview, the facility failed to ensure 2 of 4 bedrooms had access to a primary means of escape located to provide a safe path of travel to the outside. This deficient practice could affect 3 of 7 clients, staff and visitors in the facility. Findings include**:** Based on observation and interview with			

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	the QMRP-D on 04/12/12 at 10:30 a.m., a couch, a dresser and other items were stored in the west hallway leaving a ten inch path to the primary exit for the two west bedrooms. **K40** 6. Doors or paths of travel to a means of escape shall not be less than 28 inches. 33.2.2.5.1 Based on observation and interview, the facility failed to ensure the path of travel from the bedrooms to a means of escape was at least 28 inches wide. This deficient practice could affect 3 of 7 clients, staff and visitors in the facility. Findings include**:** Based on observation and interview with the QMRP-D on 04/12/12 at 10:30 a.m., a couch, a dresser and other items were stored in the west hallway leaving a ten inch path to the primary exit for the two west bedrooms. **K130** 7. Based on observation and interview, the facility failed to ensure 3 of 4 portable fire extinguishers were inspected at least monthly, and the inspections were			

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	documented, including the date and initials of the person performing the inspection. LSC 4.5.7 requires any device, equipment or service required for compliance with provisions of this Code shall be thereafter maintained unless the code exempts such maintenance. 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 that an extinguisher is available and will operate. This deficient practice affects all clients, visitors and staff. Findings include: Based on observation with the QMRP-D on 04/12/12 between 10:30 a.m. to 11:00 a.m., the service and inspection tags for the portable fire extinguisher located on the second floor lacked documentation of monthly checks since October 2011 and the service and inspection tags for the portable fire extinguishers located in the living room and near the fire alarm control panel lacked documentation of monthly checks since February 2012. Based on interview during the time of observation, the QMRP-D acknowledged the monthly inspections of the			

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	extinguishers were not complete. This federal tag relates to complaint #IN00106261. 9-3-7(a)			

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W0433	483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote mobility in areas used by clients. Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C, D) plus 3 additional clients (E, F and G), the facility failed to ensure the flooring in the group home promoted the mobility of the clients A, B, C, D, E, F and G. Findings include: Observations were done at the group home on 4/12/12 from 7:23 AM through 8:25 AM and 10:00 AM through 12:15 PM. The group home for clients A, B, C, D, E, F and G had two Northern entrances. The first or primary entrance to the front of the group home opened to a foyer or hallway area 15 feet by 10 feet. The area had two resident bedrooms to the East and West of the hallway. The resident bedroom to the West was observed at 7:25 AM. The client bedroom had no carpeting in the bedroom. The bedroom had carpet padding on the floor with a section measuring 6 feet by 4 feet missing which exposed the wood sub	W0433	Residential will ensure that all floor surfaces and floor coverings promote mobility in areas used by clients. All the carpeting and linoleum in the group home has been put down. All the rooms have floor coverings at this time. The QMRP and Supervisor will check the home on a weekly basis to ensure that floor coverings are on the floor and that it promotes safe mobility for the clients.Person Responsible: QMRP and Supervisor	05/16/2012

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	flooring beneath. The missing area created an uneven surface as the wood flooring was depressed below the carpet padding by 3/4 of an inch. The entrance hallway or foyer area opened into an area which had no carpeting. The floor covering was removed leaving exposed plywood sub flooring. The corners of the room had exposed carpet tack strips. The area contained a stack of 23 pieces of 4 feet by 8 feet sheets of drywall. The area had a rolled up carpet with black wiring and a clear plastic sheet in the southern corner of the room. The area was partially separated from the adjacent room to the Southwest by an unfinished wall. The area opened with a 6 feet by 4 feet area of linoleum flooring missing with a raised edge around the perimeter of the rip or missing piece. The missing linoleum exposed a depression of sub flooring plywood measuring 3 feet by 4 feet. The sub flooring plywood depression was 1 inch in depth. The area had construction supplies including 2 inch by 4 inch boards measuring 8 feet in length, an assortment			

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	of electrical cords/wires, a 5 gallon container of roofing sealant, 5 gallon containers of dry wall plaster, and boxes of nails. The second Northern entrance opened to an area 15 feet by 40 feet. The area had no carpeting exposing the concrete sub flooring. The area had exposed carpet tack strips along the perimeter. The area had a roll of carpet stored behind a couch along the southern most wall. Client E's record was reviewed on 4/12/12 at 4:30 PM. Client E's 9/22/11 High Risk Fall Plan indicated, "[Client E] has a history of falls with and without injury...." The High Risk Fall Plan indicated throw rugs and objects should be removed from the floor to prevent fall risks. Interview with QMRP-D #1 (Qualified Mental Retardation Professional Designee) on 4/12/12 at 10:00 AM indicated the group home was going through construction. QMRP-D #1 stated, "The construction did not start out like this. It just became this way in the last few days." QMRP-D #1 indicated clients A, B, C, D, E, F and G needed additional			

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	assistance while walking in the home due to the condition of the house. QMRP-D #1 indicated client E had a fall risk protocol due to history of falls. Confidential Interview A stated the group home was "unsafe for the clients." Confidential Interview A indicated the fire exits were blocked and the clients' bedrooms had torn carpet padding. Confidential Interview A stated the home's condition had "multiple fall risks." Confidential Interview A indicated the construction had prevented the clients from following their routine and programming. Confidential Interview A indicated the floors are bare with exposed nails. This federal tag relates to complaint #IN00106261. 9-3-7(a)			