

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G804	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/06/2014
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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 6904 DRY CREEK CT FORT WAYNE, IN 46835
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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
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K010000	<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: 06/06/14</p> <p>Facility Number: 012624 Provider Number: 15G804 AIM Number: 201022150</p> <p>Surveyor: Dennis Austill, 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, in client sleeping rooms and in common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p>	K010000		
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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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K01S029	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.6.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Any hazardous area that is on the same floor as, and is in or about, a primary means of escape or a sleeping room is protected by one of the following means:</p> <p>(a) Protection is an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.18 that has a fire protection rating of not less than ¾ hour. The enclosure is protected by an automatic fire detection system connected to the fire alarm system provided in 32.2.3.4.1.</p> <p>(b) Protection is automatic sprinkler protection, in accordance with 32.2.3.5, and a smoke partition, in accordance with 8.2.4, located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation are self-closing or</p>			

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	<p>automatic closing in accordance with 7.2.1.8. 32.2.3.2.2.</p> <p>Based on observation and interview, the facility failed to ensure the enclosure of 1 of 1 hazardous areas on the same floor that is on the same floor as a primary means of escape was provided with a self closing or automatic closing door. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 06/06/14 at 2:35 p.m. with the Residential Director, the metal door separating the primary means of escape from the garage lacked a door closer. The garage area contained a large quantity of medical supplies such as thirty cardboard boxes of briefs, pull-ups, wipes, pads and cups. Additionally, there were sixteen cardboard boxes and plastic totes with client belongings and six 96 gallon trash containers. Based on interview at the time of observation, the Residential Director acknowledged the door was not provided with a door closer.</p>	K01S029	<p>The contractor was notified of the need for a self closing mechanism to be installed on the door leading to the garage. The self closing mechanism will be added to the door prior to 7-6-14.</p> <p>The residential manager will notify the residential director at the time of the installation. The residential director will complete an inspection of the door to ensure that it meets the requirement for life safety. The resident manager will document the installation of the self closing mechanism on the AWS-Benchmark Residential Maintenance Report for the month of July. Ongoing maintenance reports will be completed monthly and turned into the residential director for review to ensure all self closing mechanisms are fully functions.</p>	07/06/2014			