

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G257	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/09/2014
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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 2524 BEECHWOOD CIR FORT WAYNE, IN 46807
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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: 07/09/14</p> <p>Facility Number: 000777 Provider Number: 15G257 AIM Number: 100243390</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Easter Seals ARC of Northeast Indiana 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 Care Occupancies.</p> <p>The two story facility with a basement was not sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors and in common living areas. The facility has a capacity of 5 and had a census of 5 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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K010130	<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 1.0.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>1. Based on observation, record review and interview; the facility failed to ensure monthly fire extinguisher inspections were documented including the date and initials of the person performing the inspections for 3 of 3 portable fire extinguishers. 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. NFPA 10, Standard for Portable Fire Extinguishers, 4-3.1 requires extinguishers shall be inspected monthly. NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. NFPA 10, 4-3.4.2</p>	K010130	<p>All battery operated emergency lights in the home will be tested and the battery operated emergency light on the second floor will be repaired</p> <p>Person Responsible: Maintenance Supervisor</p> <p>Completion Date: August 8, 2014</p> <p>The battery operated lights in all the group homes will be tested annually during a monthly</p>	08/08/2014

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	<p>requires at least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observation and record review of the fire extinguisher inspection/maintenance tags on the fire extinguishers located in the basement, on the ground floor and on the second floor with Maintenance Technician # 1 on 07/09/14 from 11:05 a.m. to 11:35 a.m., there was no documentation on the tags to show the three fire extinguishers in the facility had received a monthly inspection in November 2013. This was acknowledged by Maintenance Technician #1 at the time of observation and record review of each fire extinguisher.</p> <p>2. Based on observation and interview, the facility failed to ensure 5 of 5 interior battery operated 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 an annual test be</p>		<p>preventative maintenance check</p> <p>Person Responsible: Maintenance Supervisor</p> <p>All fire extinguishers in the home will be tested.</p> <p>Person Responsible: Maintenance Supervisor</p> <p>Completion Date: August 8, 2014</p> <p>The fire extinguishers in all the group homes will be tested during each monthly preventative maintenance check</p> <p>Person Responsible: Maintenance Supervisor</p>				

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	<p>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 if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Technician # 1 on 07/09/14 from 11:00 a.m. to 11:14 a.m., a battery powered emergency light was located in the basement, the living room, the kitchen, the office area of the living room and on the second floor. All battery operated lights function properly when tested with the exception of the light on the second floor. Based on an interview with Maintenance Technician # 1 at 11:00 a.m., he stated the facility has not conducted an annual test on the battery operated lights.</p>						

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K01S046	<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>Based on observation and interview, the facility failed to ensure 6 of 6 flexible cords such as an extension cord were not used as a substitute for fixed wiring. LSC 33.2.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 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 could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Technician # 1 on 07/09/14 at 10:55 a.m., there were five extension cords in use and providing power to various light fixtures attached to the ceiling of the basement garage area. At 11:07 a.m., an extension cord was observed in use and providing power to a light at the desk in the office area of the living room. At the time of observations, Maintenance Technician # 1 acknowledged the extension cords were in use and providing power to a light fixtures in the basement and a light on the desk of the</p>	K01S046	<p>The extension cords will be removed from the home</p> <p>Person Responsible: Group Home Supervisor</p> <p>Completion Date: August 8, 2014</p> <p>The Supported Living's Standard operating procedures will be updated to include a policy regarding extension cords in group homes</p> <p>Person responsible: Assistant Director</p> <p>Completion Date: August 8, 2014</p>	08/08/2014
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K01S120	<p>office area.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In addition to the primary route, each sleeping room in facilities that use Exception No. 1 to 32.2.3.5.1 has a second means of escape that consists of one of the following:</p> <p>(a) It is a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape.</p> <p>(b) It is a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to an approved means of escape.</p> <p>(c) It is an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 sq. ft. The width is not less than 24 inches. The bottom of the opening is not more than 44 inches above the floor. Such means of escape is acceptable where one of the following criteria are met:</p> <p>(1) The window is within 20 ft of grade.</p> <p>(2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.</p> <p>(3) The window or door opens onto an exterior balcony. 33.2.2.3</p> <p>Exception No. 1: If the sleeping room has a</p>			
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	<p>door leading directly to the outside of the building with access to grade or to a stairway that meets the requirements of exterior stairs in 33.2.3.1.2, that means of escape is considered as meeting all the escape requirements for the sleeping room.</p> <p>Exception No. 2: A second means of escape from each sleeping room is not required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.</p> <p>Exception No. 3: Existing approved means of escape is permitted to continue to be used.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 4 client sleeping rooms were provided with a secondary means of escape. This deficient practice could affect 4 of 5 clients.</p> <p>Findings include:</p> <p>a. Based on an observation with Maintenance Technician # 1 on 07/09/14 at 12:03 p.m., the ground floor west sleeping room had stacks of storage boxes stored directly in front of the windows and the door leading into the adjacent sleeping room was obstructed by a recliner. This was acknowledged by Maintenance Technician at the time of observation.</p> <p>b. Based on observations with Maintenance Technician # 1 on 07/09/14</p>	K01S120	<p>The storage boxes and the recliner will be moved so that they are no longer blocking exits</p> <p>Person Responsible: Group Home Supervisor</p> <p>Completion Date: August 8, 2014</p> <p>The second story windows have been measured and are 18 feet and 9 inches of grade</p> <p>Person Responsible: Maintenance Supervisor</p> <p>Completion Date: August 8, 2014</p>	08/08/2014

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K01S147	<p>from 11:20 a.m. to 11:24 a.m., both second floor sleeping rooms had two windows with the same measurements. According to Maintenance Technician # 1 at the time of observation, the width measurement for each window was seventeen and one half inches. Additionally, Maintenance Technician # 1 did not confirm the windows were within 20 feet of grade.</p> <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 persons 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 not 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 Based on record review and interview, the facility administration failed to have a written fire safety plan to protect 5 of 5 clients which included procedures for the</p>	K01S147	The charcoal lighter fluid will be moved away from any flammable material	08/08/2014			

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	<p>storage and handling of flammable liquids such as charcoal lighter fluid, the use of portable electric space heaters, testing of new upholstered furniture in clients rooms per the requirements of NFPA 266, Standard Method of Test for Fire Characteristics of Upholstered Furniture Exposed to Flaming Ignition Source or ASTM E 1537, Standard Method for Fire Testing for Real Scale Upholstered Furniture Items or the provision of smoke detectors, use of extension cords, and requirements for flame resistant curtains. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>a. Based on observation with Maintenance Technician # 1 on 07/09/14 at 11:10 a.m., there was an oil filled space heater in the closet of the ground floor west sleeping room. Based on interview with Maintenance Technician # 1 at the time of observation, he was unaware of the space heater and could not provide documentation for the proper use of the space heater.</p> <p>b. Based on observation with Maintenance Technician # 1 on 07/09/14 at 11:39 a.m., two containers of charcoal lighter fluid were stored in the main room of the unsprinklered basement. One container was stored on the floor next to</p>		<p>Person Responsible: Group Home Supervisor</p> <p>Completion Date: August 8, 2014</p> <p>The portable space heater will be removed from the home</p> <p>Person Responsible: Group Home Supervisor</p> <p>Completion Date: August 8, 2014</p> <p>The supported living's standard operating procedures will be updated to include a policy regarding flammable fluids, portable space heaters, extension cords, flame resistant curtains, and upholstered furniture in group homes</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: August 8, 2014</p>	

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K01S150	<p>bags of charcoal and numerous boxes of holiday decorations. The remaining container was stored on a shelving unit near the loosely hung fabric without flame resistant documentation that was hung from the ceiling of the basement. Based on an interview with Maintenance Technician # 1 at the time of observation, the charcoal lighter fluid should not have been stored in the basement.</p> <p>During the record review process with Maintenance Technician # 1 on 07/09/14 at 10:43 a.m., he confirmed the facility failed to have a written fire safety plan available for review to provide guidance for the use of curtains and hanging fabrics, extension cords, combustible liquid storage and portable space heaters.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p>			
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	<p>Based on interview and observation, the facility failed to ensure new draperies and curtains in 3 of 3 sleeping rooms were flame resistant. LSC Section 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Method of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects all clients.</p> <p>Finding include:</p> <p>Based on observations with Maintenance Technician # 1 on 07/09/14 from 10:57 p.m. to 11:24 a.m., curtains or loosely hung fabric were hung in the following locations:</p> <ul style="list-style-type: none"> <li>a. loosely hung fabric was hung from the ceiling in the main room of the basement,</li> <li>b. curtains were hung at windows in living room and the office area of the living room,</li> <li>c. curtains were hung at the windows in the first floor west sleeping room,</li> <li>d. curtains were hung at the windows in the second floor north and south sleeping rooms.</li> </ul> <p>Based on an interview with Maintenance Technician #1 at the time of observations, he was not able to confirm nor provide documentation to confirm the</p>	K01S150	<p>The loose fabric in the basement will be treated with flame retardant spray</p> <p>Person Responsible: Group Home Supervisor</p> <p>Completion Date: August 8, 2014</p> <p>The curtains in the living room, office area, and bedrooms will be treated with a flame retardant spray</p> <p>Person Responsible: Maintenance Supervisor</p> <p>Completion Date: August 8, 2014</p> <p>The supported living's standard operating procedures will be updated to include a policy regarding flame resistant curtains and drapery</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: August 8, 2014</p>	08/08/2014

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K01S151	<p>curtains and loosely hanging fabric were flame resistant.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New upholstered furniture within board and care facilities is tested in accordance with the provisions of 10.3.2(1) and 10.3.3.</p> <p>Exception: Upholstered furniture belonging to the resident in sleeping rooms, provided that a smoke alarm is installed in such rooms. Battery-powered single-station smoke alarms are permitted. 32.7.5.2, 33.7.7.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 4 sleeping rooms where upholstered furniture was present were provided with battery operated smoke detectors in this nonsprinklered facility. Testing of upholstered furniture in clients rooms shall meet the requirements of NFPA 266, Standard Method of Test for Fire Characteristics of Upholstered Furniture Exposed to Flaming Ignition Source or ASTM E 1537, Standard Method for Fire Testing for Real Scale Upholstered Furniture Items or the clients room shall be provided with a smoke detector. This deficient practice could affect all clients in the facility.</p>	K01S151	<p>Smoke detectors will be installed in the bedrooms with upholstered furniture</p> <p>Person Responsible: Maintenance Supervisor</p> <p>Completion Date: August 8, 2014</p> <p>The smoke detectors in all the group homes will be tested during a monthly preventative maintenance check</p> <p>Person Responsible:</p>	08/08/2014

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K01S152	<p>Findings include:</p> <p>Based on observation with Maintenance Technician # 1 on 07/09/14 at 11:13 a.m. to 11:24 a.m., upholstered furniture was present in the ground floor west and both second floor sleeping rooms without a smoke detector being provided. Additionally, documentation was not available for the testing of the upholstered furniture. Based on interview with Maintenance Technician # 1 at the time of observations, smoke detectors were not provided in the sleeping rooms.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities:</p>		<p>Maintenance Supervisor</p> <p>The supported living's standard operating procedures will be updated to include a policy regarding upholstered furniture in group homes</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: August 8, 2014</p>	

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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 2524 BEECHWOOD CIR FORT WAYNE, IN 46807
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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
K01S155	<p>(iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (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.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 2 of the last 4 calendar quarters. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of the fire drill reports titled Easter Seals ARC of Northeast Indiana with Maintenance Technician # 1 on 07/09/14 at 10:30 a.m., documentation of a third shift fire drill for the first quarter of 2014 or a third shift fire drill for the third quarter of 2013 were not available for review. Based on an interview with Maintenance Technician # 1 at the time of record review, he was unable to confirm these fire drills were conducted.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p>	K01S152	<p>The supported living drill schedule will be updated to include quarterly fire and tornado drills on each shift. The schedule will include the specific hour that staff should run the drill</p> <p>Person Responsible: Assistant Director Supported Living</p> <p>Completion Date: August 8, 2014</p> <p>The QIDP will review drill forms to ensure that they were run correctly</p> <p>Person Responsible: QIDP</p> <p>Completion Date: August 8, 2014</p>	08/08/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G257	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/09/2014
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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 2524 BEECHWOOD CIR FORT WAYNE, IN 46807
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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
	<p>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.</p> <p>9.6.1.8</p> <p>Based on record review and interview, the facility failed to protect 5 of 5 residents by providing a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on an interview with Maintenance Technician # 1 during the record review process on 07/09/14 at 10:45 a.m., the facility was unable to provide a written policy and procedure for an impaired fire alarm system.</p>	K01S155	<p>The supported living's standard operating procedures will be updated to include an impaired fire alarm policy.</p> <p>Person Responsible: Assistant Director</p> <p>Completion Date: August 8, 2014</p>	08/08/2014