

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G693	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC-ARC AVE (105)	STREET ADDRESS, CITY, STATE, ZIP CODE 2968 E ARC AVE BLDG 105 VINCENNES, IN 47591
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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 Dates: 05/17/12</p> <p>Facility Number: 002937 Provider Number: 15G693 AIM Number: 200333060</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Knox County ARC – ARC Ave. 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>This one story facility was sprinklered. The facility has a fire alarm system with smoke</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.

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	<p>detection in the corridors, sleeping rooms, and common living areas. The facility has a capacity of eight and had a census of eight 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 Impractical with an E-Score of 6.4.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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KS043	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD No door in any means of escape is locked against egress when the building is occupied.</p> <p>Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5.</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 exterior exit doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.4 which states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. Doors shall be operable with not more than one releasing operation. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on observations on 05/17/12 between 10:00 a.m. and 10:15 a.m. with the Residential</p>	KS043	<p>Plan of Correction: The deadbolts will be removed from all exterior doors leaving only one lock on each door. Preventive Action: Maintenance will be retrained that all exterior doors must have only one lock. Monitoring: Maintenance will monitor that all exterior doors only have one lock. Date to Be Completed By: June 16, 2012 Responsible Party: Vice President of Program Services</p>	06/16/2012			

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	Services Office Coordinator, all four entrance/exit doors were equipped with two latching devices, a latching door handle, and a separate deadbolt lock on each door. This was acknowledged by the Residential Services Office Coordinator at the time of each observation.			

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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 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</p> <p>Based on record review and interview, the facility failed to ensure there was a fire safety plan in place for the safety of 8 of 8 clients. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on record review on 05/17/12 at 9:45 a.m. with the Residential Services Office Coordinator present, the facility's Emergency Action Plan did not have a fire safety plan included. This was acknowledged by the</p>	KS147	<p>Plan of Correction: A fire safety plan will be added to the facility's Emergency Action Plan Preventive Action: The Office Coordinator will be retrained to ensure each location has a fire safety plan. Monitoring: The Office Coordinator will monitor that each location has a fire safety plan. Date to Be Completed By: June 16, 2012 Responsible Party: Director of Residential Services</p>	06/16/2012	

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	Residential Services Office Coordinator at the time of record review.			