

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G266	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2016
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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K 0000 Bldg. 02	<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: 03/24/16</p> <p>Facility Number: 000786 Provider Number: 15G266 AIM Number: 100248990</p> <p>At this Life Safety Code survey, Transitional Services Sub, LLC 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 sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, sleeping rooms, and common living areas. The facility has a capacity of eight and had a census of seven at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K 0000		

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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K S051 Bldg. 02	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.08.</p> <p>Quality Review completed on 03/29/16 - DA</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6. 32.2.3.4.1. Based on record review, observation and interview; the facility failed to ensure documentation for the testing of 1 of 1 fire alarm systems components and devices, such as, smoke detectors, horn/strobe devices, fire alarm boxes, and fire alarm control equipment was complete and accurate. LSC 9.6.2.10 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices, such as, smoke detectors, fire alarm boxes, horn/strobe devices, and fire alarm control equipment be tested annually. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire alarm system annual inspection report on 03/24/16 at 12:00 p.m. with the Program Director present, the annual fire alarm</p>	K S051	<p>Tri-State Fire Protection, INC. is scheduled to come back to the Belmont Group Home prior to 4/23/16 to complete their inspection to ensure they have an itemized list of all devices tested, including location, type of device, visual/functional test, and pass/fail result. Tri-State Fire Protection will also ensure that all eight smoke detectors are tested. TSI Maintenance has reviewed with Tri-State Fire Protection the requirements for survey's so they for next years inspection. Responsible Parties: Tri-State Fire Protection, INC., Maintenance, Program Director, Program Coordinator</p>	04/23/2016

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K S149 Bldg. 02	<p>system inspection report from Tri State dated 01/14/16 was the equivalent of a cover page with only the number of devices installed and tested on the list. The report did not include an itemized check list of all devices tested, including, location, type of device, visual/functional test, and pass/fail result. Furthermore, the number of smoke detectors listed as installed and tested was five, however, during a tour of the facility with the Program Director, there were a total of eight smoke detector installed in the facility. This was acknowledged by the Program Director at the time of record review and observation.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where smoking is permitted, noncombustible safety type ashtrays or receptacles are provided in convenient locations. 32.7.4.2, 33.7.4.2 Based on observation and interview, the facility failed to provide a noncombustible container which cigarette butts can be disposed of for 1 of 1 areas where smoking occurs. This deficient practice could affect clients and staff while around the back porch area where smoking occurs.</p> <p>Findings include: Based on observation on 03/24/16 at</p>	K S149	The five gallon bucket has been removed from the Belmont Group Home and Replaced with an approved smoke tower for clients and staff to put their cigarette butts in. The Direct Support Profession (DSP's), Program Coordinator (PC) and Program Director (PD) were retrained on 3/24/16 in regards to the appropriate smoking tower being utilized and in place at all times at the Belmont Group Home. The PD and PC were retrained again on 4/6/16 regarding smoking	04/10/2016

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	12:35 p.m. during a tour of the facility with the Program Director, there was an open five gallon bucket with over 50 cigarette butts at the back porch area where smoking occurs. The Program Director said the back porch area was the only designated smoking area.		towers. The PD and PC will inspect the smoking tower a couple of times a month to ensure it is working properly and being utilized. The PD and PC will replace the smoking tower as needed to ensure there is always a fire retardant smoking tower being utilized and in working order. Responsible Parties: Direct Support Professionals, Program Director, Program Coordinator and Area Director		