

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G060	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2015
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NAME OF PROVIDER OR SUPPLIER NORMAL LIFE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 106 ALLENDALE TERRE HAUTE, IN 47802
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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: 06/26/2015</p> <p>Facility Number: 000612 Provider Number: 15G060 AIM Number: 100233640</p> <p>At this Life Safety Code survey, Normal Life of 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>This one story facility was not sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in common living areas and bedrooms. The facility has a capacity of 8 and had a census of 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,</p>	K 0000		
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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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K S014 Bldg. 02	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.08.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Interior wall and ceiling finish is Class A or Class B in accordance with section 10.2, 33.2.3.2. There are no requirements for interior floor finish.</p> <p>Exception: Class C interior wall and ceiling finish is permitted in prompt evacuation capability facilities.</p> <p>Based on observation and interview; the facility failed to have evidence that an outer finish of walls observed in the staff office, living room common area of the home, utility room and a closet near the front entrance had a Class A, Class B or Class C interior finish in this Prompt rated facility to protect 6 of 8 clients. This deficient practice could affect all occupants of the group home.</p> <p>Findings include:</p> <p>During observation on 06/26/2015 between 12:25 P.M. and 1:00 P.M. with the Qualified Intellectual Disabilities Professional (QIDP) the following areas of the home used wood as paneling for walls:</p> <p>The staff office.</p>	K S014	<p>Although there was no evidence at the time of the survey that the wood-paneled areas were finished or treated with a class A, B, or C interior finish, it is thought that this treatment has been completed in the past. These areas will be treated again and the evidence will be maintained with the fire/ Life Safety documents for further review.</p> <p>The Maintenance Coordinator is responsible to see that all wood-paneled areas are finished or treated. A review of all areas of the home will be reviewed and treated as required.</p>	07/27/2015	

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K S046 Bldg. 02	<p>A portion of the living room, dining room area which had wood around an unused fireplace mantle, extending around the corner into the dining room.</p> <p>The walls of a closet in the living room next to the front entrance.</p> <p>Additionally, a portion of a wall in the utility room that extended between the utility room and a furnace room had a plywood pegboard-type panel that had been painted. It was not known if there was drywall behind the pegboard paneling.</p> <p>Interview with the QIDP at the time of the observation indicated there was no documentation available that the wood-paneled areas were finished or treated with a class A, B, or C interior finish.</p> <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>1. Based on observation and interview, the facility failed to ensure 1 of 1 extension cords was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and electrical equipment shall be in accordance with NFPA 70, National Electrical Code.</p>	K S046	The Facility will ensure that utilities comply with Section 9.1. The Residential Manager in each home is responsible for ensuring that no extension cords are being used for any reason in the home. All Residential Managers, QIPD's, and Clinical Supervisors will	07/27/2015

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	<p>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 two residents occupying the northeast bedroom.</p> <p>Findings include:</p> <p>During observation with the Qualified Intellectual Disabilities Professional (QIDP) on 06/26/2015 between 12:25 P.M. and 1:00 P.M. an extension cord providing power to an oscillating fan and a portable radio was being used in the northeast bedroom. The resident of the room was not present at home during the day when it was left plugged into the wall. The QIDP indicated she was not aware the extension cord was being used.</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 1 outlets located in the bathroom between the southwest bedroom and living room, by ensuring the outlet was provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, the National Electrical Code. NFPA 70, Article 210.8, Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units,</p>		<p>receive training concerning their responsibilities to eliminate the use of extension cords in the homes at all times. If at any time additional electrical outlets are essential, The Residential Manager will submit a Maintenance Repair Request to see if the addition of an outlet is possible.</p> <p>The facility will maintain ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms, and kitchens at receptacles intended to serve the counter top surfaces. The GFI outlet that was found to be faulty during the survey was replaced immediately. The Maintenance department conducts a monthly check in each home that includes a test of the GFI receptacles throughout the home. The Safety Committee also conducts a check of the home at least quarterly and includes a check of the GFI receptacles in the home. Any issues that are noted are addressed immediately.</p>	

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K S123 Bldg. 02	<p>requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms, and kitchens at receptacles intended to serve the counter top surfaces. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>During observation with the QIDP on 06/26/2015 between 12:25 P.M. and 1:00 P.M. an electrical outlet in the bathroom located between the southwest bedroom and living room was equipped with a GFCI test button however the circuit did not show any indication of interruption when tested. Interview with the QIDP during the observation indicated the GFCI appeared to not be functioning.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Every bathroom door is designed to allow opening from the outside during an emergency when locked. 32.2.2.5.4, 33.2.2.5.4 Based on observation and interview the facility failed to ensure two of three bathrooms could be opened in an emergency when locked from the inside. This deficiency could affect any resident,</p>	K S123	The facility will insure that every bathroom door knob is the type that can be opened/ unlocked from the outside easily in the case of an emergency. The bathrooms in this home were	07/27/2015

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K S147 Bldg. 02	<p>staff or visitors using those bathrooms.</p> <p>The findings include:</p> <p>During observation with the Qualified Intellectual Disabilities Professional (QIDP) on 06/26/2015 between 12:25 P.M. and 1:00 P.M. it was found the bathrooms located between the southwest bedroom and living room, as well as the bathroom next to the northeast bedroom could be locked by an occupant inside the bathroom. Both bathrooms required a special tool in order to unlock the bathrooms from outside of the room. Interview with the QIDP during the observation indicated she did not know if there was a tool readily available for staff to use, where the tool would be located, or if staff had been trained to immediately located and use the tool in an emergency.</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</p>		recently remodeled and the contractor installed the knobs that were observed during the survey. These knobs have been replaced with those that have a "push button" type of lock that can be unlocked by using a variety of readily available objects such as a pen cap, screwdriver, paper clip, etc. The Maintenance Coordinator is responsible to see that the correct type of door knobs are installed on the bathroom doors at all times.		

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	<p>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 administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 6 of 8 clients which is amended, or revised, whenever any resident with unusual needs is admitted to the home. Such instruction is reviewed by the staff at least every two months. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Review of "Fire Drill" documentation on 06/26/2015 at 11:15 A.M., indicated lapses in staff fire safety training times were more than the two months allowed as evidenced by the lack of any record of fire drills for the 11:00 P.M. to 7:00 A.M. shift during the third quarter (July through September) of 2014. The records also indicated a lapse in training for the 7:00 A.M. to 3:00 P.M. shift</p>	K S147	<p>The facility has a written monthly drill schedule and protocol that is provided to the Residential Manager that outlines when drills are to take place, including each shift, so that at least one drill is conducted one each shift at least every three months. Unless there is inclement weather during the drill, all residents are evacuated from the home during each drill conducted at the home on all shifts. Each home also has an evacuation plan that includes the designation of a "safe meeting place" during the drill in order to provide consistent training to both staff and individuals in the home.</p> <p>The Residential Manager has received training concerning their responsibilities to insure that staff training in emergency procedures and fire drills is completed in at least a monthly basis.</p> <p>The Clinical Supervisor tracks the completion of emergency drills and evacuations on a monthly basis. If any discrepancies are noted they are reported to the Program Manager for follow up with the Residential Manager.</p>	07/27/2015	

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K S150 Bldg. 02	<p>during the fourth quarter (October through December) of 2014. Interview with the Qualified Intellectual Disabilities Professional on 6/26/2015 at 11:45 A.M. indicated there was no other fire drill documentation or other fire safety staff training documentation available during these time frames.</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> <p>Based on interview and observation, the facility failed to ensure draperies and curtains were flame resistant. LSC Section 10.3.1 requires that draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect all occupants staff and visitors in the home.</p> <p>Findings include</p> <p>During observation on 6/26/2015 between 12:25 P.M. and 1:00 P.M. with the Qualified Intellectual Disabilities Professional (QIDP) curtains or draperies</p>	K S150	<p>The Safety Committee reviews the timely completion of and issues noted during fire and storm drill on at least a quarterly basis. The Program Manager is responsible for submitting, reviewing and following up on recommendation with the Safety Committee.</p> <p>The curtains or draperies used as window coverings in the living room, dining room, northeast bedroom and southwest bedroom will be replaced with window coverings that indicate that they are flame resistant. The Residential Manager is responsible for purchasing and maintaining the furnishing in the home. All Residential Managers have received training on their responsibilities to insure that the window coverings purchased for the home indicate that they are flame resistant. The Safety Committee conducts at least a quarterly check of each home. Checking the window coverings and drapes for an indication of flame resistance will be added to the checklist. The Program Manager is responsible to insure</p>	07/27/2015

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K S152 Bldg. 02	<p>were used as window coverings in the living room, dining room, northeast bedroom and the southwest bedroom. There were no indication on the tags that the fabrics used were flame-resistant. Interview with the QIDP during the observation indicated it was unknown when the curtains were installed.</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: (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,</p>			K S152	that this check is conducted at least quarterly.		07/27/2015

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	<p>the facility failed to ensure fire and evacuation drills were provided for each shift for 2 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Review of "Fire Drill" documentation on 06/26/2015 at 11:15 A.M., indicated no evidence of fire drills for the 11:00 P.M. to 7:00 A.M. shift during the third quarter (July through September) of 2014, and for the 7:00 A.M. to 3:00 P.M. shift during the fourth quarter (October through December) of 2014. Interview with the Qualified Intellectual Disabilities Professional on 6/26/2015 at 11:45 A.M. indicated there was no other fire drill documentation available for these time frames.</p>		<p>The facility has a monthly drill schedule that is provided to the Residential Manager that outlines when drills are to take place, including each shift, so that at least one drill is conducted one each shift at least every three months. Unless there is inclement weather during the drill, all residents are evacuated from the home during each drill conducted at the home on all shifts.</p> <p>The Residential Manager has received training concerning their responsibilities to insure that staff training in emergency procedures and fire drills is completed in at least a monthly basis.</p> <p>The Clinical Supervisor tracks the completion of emergency drills and evacuations on a monthly basis. If any discrepancies are noted they are reported to the Program Manager for follow up with the Residential Manager. The Safety Committee reviews the timely completion of and issues noted during fire and storm drill on at least a quarterly basis. The Program Manager is responsible for submitting, reviewing and following up on recommendation with the Safety Committee.</p>		