

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G306	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 RANCH RD CONNERSVILLE, IN 47331
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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
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 Date: 01/16/13</p> <p>Facility Number: 000825 Provider Number: 15G306 AIM Number: 100243840</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Residential CRF Inc. 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 smoke detection in the corridors, common living areas, and battery operated smoke detectors in all client sleeping rooms. The facility has a capacity of 6 and had a census of 6 at the time of this survey.</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>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 0.35.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/17/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0130	<p>Based on observation and interview, the facility failed to ensure 3 of 3 portable fire extinguishers were inspected at least monthly and the inspections were documented for 3 of 4 months since the annual inspection date, including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with maintenance worker # 1 from 10:00 a.m. to 11:20 a.m. on 01/16/13, service and inspection tags for the portable fire extinguishers located in the kitchen, the garage, and the West Hall each bore service inspection tags</p>	K0130	<p>K 130: NFPA 101 Miscellaneous: Inspection of portable fire extinguishers. A memo was sent out to the group home detailing instructions that portable fire extinguishers must be inspected monthly to assure they are available and operable. In addition , staff were inserviced that the inspection tag must be initialed to document such inspection. Further staff were instructed to notify superviosr immediately if any extinguishers were found to be defective. Memo was sent to the group home on February 5, 2013. Group home supervisor will also check fire extinguishers as part of their monthly home inspection to assure that house staff are performing required checks. In addition, QMRP will also perform random checks when in the facility to assure that appropriate safety measures, including extinguisher checks are being completed. This procedure will also be implemented for other group homes within the Residential CRF, Inc. ownership. Completed: February 15, 2013 Responsible: House staff, Supervisor, QMRP</p>	02/15/2013			

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	indicating the most recent annual inspection was in August 2012 but no monthly checks were documented on the inspection tags for September, November, or December 2012. Based on an interview with the home manager on 01/16/2013 at 10:50 a.m., there was no written documentation of monthly fire extinguisher inspections for the facility and acknowledged the facility did not perform monthly fire extinguisher inspections for September, November, or December 2012.			