

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC	STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842
--	---

(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
K 0000 Bldg. 01	<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: 09/10/15</p> <p>Facility Number: 000714 Provider Number: 15G181 AIM Number: 100234680</p> <p>At this Life Safety Code survey, Child Adult Resource Services 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 two story facility with a basement was determined to be nonsprinklered. The facility has a monitored fire alarm system with hard wired smoke detection in corridors, living areas and all levels. The facility has a capacity of 6 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		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC	STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842
--	---

(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
K 0130 Bldg. 01	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.5.</p> <p>Quality Review on 09/14/15 - DA</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 interior emergency lights was 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 requires a thirty second functional test be conducted at 30 day intervals and an annual test be 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 second floor occupants if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p>	K 0130	<p>Emergency and Exit Lighting Equipment activation test (illumination for at least 30 seconds) is completed by C.A.R.S. on a monthly basis (last test for facility#714 was on 9/8/2015). Emergency and Exit Lighting Equipment power test (emergency lighting for at least 90 minutes)is completed by C.A.R.S. on an annual basis (last test for facility #714 was on 9/17/2015). Original copies of the test reports are kept at C.A.R.S. Corporate office in Rockville. Effective October 1, 2015 – Maintenance will continue to complete testing for Emergency and Exit Lighting Equipment activation test (illumination for at least 30 seconds) each month and power test (emergency lighting for at least 90 minutes)annually. Effective October 1, 2015 – Original copy of the Emergency and Exit Lighting Equipment Testing Report will continue to be filed and maintained at C.A.R.S. Corporate office in Rockville. A copy of these reports will now be filed within facility #714. A section in facility #714 Drill Book will be</p>	10/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC	STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842
--	---

(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
K S017 Bldg. 01	<p>Based on observation and interview on 09/10/15 at 1:15 p.m., the Lead Staff acknowledged a monthly or an annual 1 ½ hour duration test had not been performed on the second floor battery powered emergency light.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those of 1¼ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2.</p> <p>Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is</p>		designated for these Testing Reports. Quality Assurance will review facility #714 Drill Book each month to ensure testing has been completed and copies of the testing reports are present within the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC	STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842
--	---

(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>no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms are separated from escape routes by walls and doors that are smoke resistant.</p> <p>No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.</p> <p>Based on observation and interview the facility failed to ensure 1 of 2 first floor bedroom doors was smoke resistant. This deficient practice could affect 1 of 6 clients.</p> <p>Findings include:</p> <p>Based on observation and interview on 09/10/15 at 1:04 p.m., the Lead Staff acknowledged there were two holes near the door handle of the back bedroom door.</p>	K S017	<p>On September 19, 2015 – the two holes near the door handle of the back bedroom door was fixed by C.A.R.S. Maintenance. Effective October 1, 2015 – Maintenance will continue to complete a formal walk-thru of all group homes (which includes facility #714) on a monthly basis. During this walk-thru an Inspection Monthly Report will be completed for each site location. This walk-thru will consist of checking light fixtures, door handles, emergency lights, smoke detectors, water temperatures, and other items within the facility. Any</p>	10/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC	STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842
--	---

(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
K S147 Bldg. 01	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		discrepancies will be fixed and corrected immediately and reported to the Director of Industrial Operations. If a discrepancy cannot be fixed immediately – the Director of Industrial Operations will be notified so repairs can be scheduled to be fixed by a professional. Original copy of the Inspection Monthly Report will be filed and maintained at C.A.R.S. Corporate office in Rockville. Director of Industrial Operations will review and follow up on all Inspection Monthly Reports on a weekly/monthly basis to ensure repairs are being fixed in a timely manner.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/08/2015
NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842		
(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>Based on observation, record review and interview, the facility administration failed to include portable space heaters in the written fire safety plan to protect 6 of 6 clients. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Lead Staff on 09/09/15 during the tour from 12:38 p.m. to 1:15 p.m., there was a portable space heater in the front bedroom, basement and storage room on the second floor. Based on a record review and interview with the Lead Staff at the time of observation, the written fire safety plan did not address the proper use and safety precautions when using a portable space heater.</p>	K S147	<p>On September 9, 2015 – the space heaters located in the front bedroom, basement and storage room on the second floor were removed by C.A.R.S. Maintenance. On September 21, 2015 – a Space Heater Procedure was created based on safety information found on the NFPA website. This procedure will be filed and maintained at each C.A.R.S. site (which includes facility #714) within the site's Drill Book. The Space Heater Procedures includes information regarding safety, storage, use and training of space heaters. On September 24, 2015 – C.A.R.S. Adult Management Team was trained on the new Space Heater Procedure. Adult Program Coordinators will in turn train direct care staff at their respective Day Service sites by September 30, 2015. On October 1, 2015 – Quality Assurance will train all residential staff on the new Space Heater Procedure. Effective October 1, 2015 – Space Heater training will be incorporated within the Annual In-service that every C.A.R.S. employee is required to complete. Members of the C.A.R.S. Management Team will oversee direct care staff to (1) ensure staff are implementing the appropriate space heater procedures (2) assess staff's ongoing training needs in regards to space heaters. Overseeing may include but is not limited to:</p>	10/01/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/08/2015
NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842		
(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	
K S150 Bldg. 01	<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 new draperies and curtains at 2 of 2 windows 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 Lead Staff on 09/10/15 from 12:50 p.m. to 1:00 p.m., new curtains were hung at the windows</p>	K S150	<p>(a) Direct observation of direct care staff (b) Interviewing direct care staff to analyze their knowledge in regards to space heater procedures. Based on what information members of C.A.R.S. Management Team has gathered by overseeing direct care staff – it will determine if staff person(s) need further training in space heater procedures.</p> <p>On September 9, 2015 – the curtains that were hung in the windows in the living room were taken down by C.A.R.S. Maintenance. On September 21, 2015 – the curtains that were hung in the front bedroom were taken down by C.A.R.S. Maintenance. On September 21, 2015 – Director of Industrial Operations placed an order from a vendor that sells curtains that meets the NFPA 701 standards. The curtain in the windows in the living room and the front bedroom will be replaced as soon as the new curtains arrive. On September 24, 2015 – C.A.R.S. Adult Management Team was trained on the requirement of buying draperies, curtains or other similar loosely hanging</p>	10/01/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC	STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842
--	---

(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
K S155 Bldg. 01	<p>in the living room and the front bedroom. Based on an interview with Lead Staff at the time of observations, she was unable to provide documentation to confirm the curtains were flame resistant.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD 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>furnishings and decorations needing to be flame resistant and meet NFPA 701 standards. On October 1, 2015 – Quality Assurance will train all residential staff that purchasing curtains or other similar loosely hanging furnishings and decorations will require approval from either the Senior Residential Manager, Director of Industrial Operations and/or Designee to ensure these items are flame resistant and meet NFPA 701 standards. Effective October 1, 2015 – When Senior Residential Manager, Director of Industrial Operations and/or Designee reviews the request to purchase curtains or other similar loosely hanging furnishings and decorations – before purchase, a review of the product will be completed to ensure the product is flame resistant and meets NFPA 701 standards. Manufacturer paperwork of the product will be filed and maintained at both C.A.R.S. Corporate Office in Rockville and at the facility site.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/08/2015	
NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC				STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842			
(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>9.6.1.8 Based on record review and interview, the facility failed to protect 6 of 6 clients by providing a 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. LSC, Section A.9.6.1.8 explains the individual conducting the fire watch should be specially trained in fire prevention, in the use of fire extinguishers, in notifying the fire department, in sounding the building fire alarm and in understanding the particular fire safety situation for public education purposes This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on record review and interview on 09/10/15 at 12:35 a.m., the Lead Staff acknowledged the fire watch policy did not indicate the person conducting the fire watch shall be properly "trained" in the duties and responsibilities of a fire watch.</p>	K S155	<p>On November 6, 2014 – staff were trained on the Fire Watch During Prolonged Utility Outage Policy & Procedure as part of the Winter Safety Residential In-service. On September 21, 2015 – the Fire Watch During Prolonged Utility Outage Policy& Procedure was updated to identify when residential staff will be trained on Fire Watch procedures. The policy& procedure was also updated to identify who is to be notified after 24 hours of utility outage and who is to be notified when utility is restored. On October 1, 2015 – Quality Assurance will train all residential staff on the Fire Watch During Prolonged Utility Outage Policy & Procedure as well as completing and documenting Fire Watch procedures. Effective October 1, 2015 – Residential staff will be trained on the Fire Watch During Prolonged Utility Outage Policy & Procedure as well as completing and documenting Fire Watch procedures twice a year – once in the Spring during Summer Safety Residential In-service and again in the Fall during Winter Safety Residential In-service. Members of the C.A.R.S. Management Team will oversee direct care staff to (1) ensure staff are implementing the appropriate fire watch procedures (2) assess staff's ongoing training needs in regards to fire watch during</p>	10/01/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G181	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 09/08/2015
NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCE SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 442 VINE ST CLINTON, IN 47842		
(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>prolonged utility outage. Overseeing may include but is not limited to: (a) Direct observation of direct care staff (b) Interviewing direct care staff to analyze their knowledge in regards to fire watch procedures. Based on what information members of C.A.R.S. Management Team has gathered by overseeing direct care staff – it will determine if staff person(s) need further training on fire watch procedures.</p>		