

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G163	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2014
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NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3154 HEAVLIN RD VALPARAISO, IN 46383
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K010000	<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: 05/27/14</p> <p>Facility Number: 000698 Provider Number: 15G163 AIM Number: 100248790</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, In-Pact, 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, in resident sleeping rooms and in common living areas. The facility has a capacity of 5 and had a census of 5 at the time of this survey.</p>	K010000		

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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K010130	<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 0.64.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/02/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers was inspected at least monthly, and the inspections were documented, 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, even if not required by the Code, 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</p>	K010130	<p>All fire extinguishers will be inspected at least monthly with documentation that will include the date of inspection and the initials of the person performing the inspection. Responsible person: Sheila O'Dell, Group Home Director Management staff will be retrained on the monthly fire extinguisher inspection. Responsible person: Sheila O'Dell, Group Home Director All fire escape routes will include the locations of all the extinguishers, so that one does not get over looked. Responsible person: Marcetta Walton, Group Home</p>	06/26/2014

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	<p>the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check 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 observations of fire extinguisher inspection/maintenance tags on 05/27/14 between 10:30 a.m. and 12:00 p.m. during a tour of facility with the Residential Instructor, the inspection/maintenance tag for the portable fire extinguisher located in the kitchen closet underneath the fire alarm panel indicated it's last monthly check was done in March, 2014.</p> <p>Based on interview at the time of observation, Residential Instructor acknowledged the monthly inspection for April, 2014 was missed.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 battery operated, interior emergency lights was 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 functional test be conducted at 30 day intervals and</p>		<p>Manager. To ensure future compliance, inspection of fire extinguisher will be included on our monthly program status report. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QDDP.</p> <p>Maintenance request will be completed to fix &/or replace the battery powered emergency light. Responsible person: Sheila O'Dell, Group Home Director</p> <p>Functional tests of the emergency lighting will conducted on a monthly and on an annual basis. Responsible person: Marcetta Walton, Group Home Manager.</p> <p>Written documentation of these visual inspections will be done and kept in the drill book for review. Responsible person: Marcetta Walton, Group Home Manager. To ensure future compliance, monthly these documents will be reviewed to ensure that the tests were completed and documented. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QDDP</p>				

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K01S014	<p>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 occupants if the facility were required to evacuate in an emergency during a loss of normal power.</p> <p>Findings include:</p> <p>Based on observation on 05/27/14 between 10:30 a.m. and 12:00 p.m. during a tour of facility with the Residential Instructor, there was a battery powered emergency light unit in the kitchen which did not illuminate when the test button was depressed. Based on interview at the time of observation, the Residential Instructor acknowledged the light did not function and was unaware of any testing documentation of a 30 second monthly test or a 90 minute annual test.</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</p>						

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	<p>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, record review and interview; the facility failed to ensure the wood paneling observed in 6 of 9 rooms or common areas had a Class A, Class B or Class C interior finish in this Prompt rated facility to protect 5 of 5 clients. This deficient practice could affect all occupants of the building.</p> <p>Findings include:</p> <p>Based on observations between 10:30 a.m. and 12:00 p.m. on 05/27/14 with the Residential Instructor, 1/4 inch thick wood paneling was observed on the lower half of the walls of the kitchen, front hallway entry, living room, visitor entry and the southwest bedroom. The walls of the southeast bedroom were entirely covered with the 1/4 inch wood paneling. Review of the Life Safety Code book in the home did not reveal any documentation of flame retardant treatment. Based on interview at the time of observation, the aforementioned issue was acknowledged by the Residential Instructor and indicated it was unknown if there was any documentation of a product used to treat the paneling to provide the required interior finish rating.</p>	K01S014	<p>Maintenance request will be completed to treat paneling in the kitchen, front hallway entry, living room, visitor entry and the southwest bedroom with flame retardant. Responsible person: Sheila O'Dell, Group Home Director. The paneling in the kitchen, front hallway entry, living room, visitor entry and the southwest bedroom will have a flame retardant treatment. Responsible person: Maintenance staff. Documentation of the product and rating used for this treatment will be kept in the drill book for review. Responsible person: Maintenance staff and Sheila O'Dell, Group Home Director.</p>	06/26/2014

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K01S120	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In addition to the primary route, each sleeping room in facilities that use Exception No. 1 to 32.2.3.5.1 has a second means of escape that consists of one of the following:</p> <p>(a) It is a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape.</p> <p>(b) It is a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to an approved means of escape.</p> <p>(c) It is an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 sq. ft. The width is not less than 24 inches. The bottom of the opening is not more than 44 inches above the floor. Such means of escape is acceptable where one of the following criteria are met:</p> <p>(1) The window is within 20 ft of grade.</p> <p>(2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.</p> <p>(3) The window or door opens onto an exterior balcony. 33.2.2.3</p> <p>Exception No. 1: If the sleeping room has a door leading directly to the outside of the</p>			
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	<p>building with access to grade or to a stairway that meets the requirements of exterior stairs in 33.2.3.1.2, that means of escape is considered as meeting all the escape requirements for the sleeping room.</p> <p>Exception No. 2: A second means of escape from each sleeping room is not required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.</p> <p>Exception No. 3: Existing approved means of escape is permitted to continue to be used.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 5 bedrooms were provided with a secondary means of escape. This deficient practice could affect 3 of 5 clients within the facility.</p> <p>Findings include:</p> <p>Based on observation with the Residential Instructor on 05/27/14 from 10:30 a.m. to 12:00 p.m., the east, southeast and southwest bedrooms were not provided with a secondary means of escape. The rooms lack a door or hall providing a way of unobstructed travel to the outside of the dwelling that is independent of and remotely located from the primary means of escape. The rooms also lacked an outside window that provides a clear opening of not less than 5.7 square feet. The windows were single hung windows with a clear</p>	K01S120	A maintenance request will be completed to assess the east, southeast and southwest bedroom windows for removal, enlarge opening and replacement. Responsible person: Sheila O'Dell, Group Home Director Estimate will be gotten for removal, enlarge opening and replacement of outside window for secondary means of escape. Responsible person: Maintenance staff The east, southeast and southwest bedroom window will have a clear opening of not less than 5.7 square feet. Responsible person: Maintenance staff. To ensure future compliance, all bedroom windows will be checked to have a clear opening of not less than 5.7 square feet. Responsible person: Maintenance staff	06/26/2014

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K01S123	<p>opening of four square feet. Based on interview, the aforementioned condition was acknowledged by the Residential Instructor.</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</p> <p>Based on observation and interview, the facility failed to provide a key or tool for the operable lock for 1 of 3 bathroom doors. This deficient practice could affect 1 of 5 clients in the facility if they locked themselves in the bathroom and staff could not reach them during an emergency.</p> <p>Findings include:</p> <p>Based on observation on 05/27/14 from 10:30 a.m. to 12:00 p.m. with the Residential Instructor, the southwest bedroom bathroom door was equipped with a lock which was operable from inside the bathroom. A tool provided by the Residential Instructor did not unlock the bathroom door. Based on interview,</p>	K01S123	<p>A maintenance request will be filled out to replace southwest bedroom bathroom door knob &/or to provide a key or tool to open the door from the outside. Responsible person: Sheila O'Dell, Group Home Director. The door knob will be replace &/or provide a key/tool to open the door from the outside. Responsible person: Maintenance staff. To ensure future compliance, an extra key/tool will be made available to all staff. Responsible person: Marcetta Walton, Group Home Manager. To ensure future compliance, monthly the door will be checked to ensure the key/tool is available at all times. Responsible person: Sheila O'Dell, Group Home Director & Traci Hardesty, QDDP.</p>	06/26/2014

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K01S150	<p>the Residential Instructor indicated the tool was the only device available to open the door.</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 new curtains 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 Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect all clients in the facility.</p> <p>Findings include</p> <p>Based on observations made between 10:30 a.m. and 12:05 p.m. on 05/27/14 with the Residential Instructor, new window curtains which lacked documentation of flame resistance were provided in the living room. Based on interview, it was acknowledged by the Residential Instructor at the time of</p>	K01S150	<p>Maintenance request will be completed to treat the curtains in the living room with a flame retardant spray. Responsible person: Sheila O'Dell, Group Home Director. The curtains in the living room will have a flame retardant treatment. Responsible person: Maintenance staff. Documentation of the product and rating used for this treatment will be kept in the drill book for review. Responsible person: Maintenance staff and Sheila O'Dell, Group Home Director</p>	06/26/2014	

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	observation, the curtains were purchased this past February and documentation of flame resistance for the window curtains was not available.				