

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G558	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6341 FOREST AVE HAMMOND, IN 46324
---	---

(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
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: 001072 Provider Number: 15G558 AIM Number: 100235500</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 with a basement was not sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in common living areas, and in all client sleeping rooms. The facility has a capacity of 5 and had a census of 4 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G558	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6341 FOREST AVE HAMMOND, IN 46324
---	---

(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
K010130	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 1.28.</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>	K010130	<p>Functional tests of the emergency lighting will be conducted on a monthly and on an annual basis. Responsible person: Starr Frohock, Group Home Manager. Written documentation of these visual inspections will be done and kept in the drill book for review. Responsible person: Starr Frohock, 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 &amp; Elaina Blystone, QDDP</p>	06/26/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G558		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  05/27/2014	
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6341 FOREST AVE HAMMOND, IN 46324			
(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			
K01S043	<p>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 2:00 p.m. and 2:45 p.m. during a tour of facility with the Residential Instructor, there was a battery powered emergency light unit in the living room which functioned when tested. Based on interview at the time of observation, the Residential Instructor 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 No door in any means of escape is locked against egress when the building is occupied.</p> <p>Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5. Based on observation and interview, the</p>	K01S043	A maintenance request will be completed to remove the door	06/26/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G558	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  05/27/2014
NAME OF PROVIDER OR SUPPLIER  IN-PACT INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6341 FOREST AVE HAMMOND, IN 46324		
(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>facility failed to ensure 1 of 3 exit doors was provided with a releasing device having a obvious method of operation and readily operated under all lighting conditions. LSC 33.2.2.5.7 requires compliance with LSC 7.2.1.5.4. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one that is familiar to the average person. Generally, a two step release, such as a knob and independent dead-bolt, is not acceptable. In most occupancies, it is important a single action unlatch the door. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observation with the Residential Instructor on 05/27/14 from 2:00 p.m. to 2:45 p.m., the front exit door had a lockable door knob and an independent dead-bolt. Based on an interview at the time of observation, the Residential Instructor acknowledged the front door was provided with two releasing devices.</p>		<p>knob lock. Responsible person: Sheila O'Dell, Group Home Director Management will be retrained that all exit doors only have a single action step to unlock the doors. Responsible person, Group Home Director To ensure future compliance, monthly the exit doors will be inspected for single step unlocking device. Responsible person: Sheila O'Dell, Group Home Director &amp; Elaina Blystone, QDDP.</p>		