

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  02/28/2012
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NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
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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: 02/28/12</p> <p>Facility Number: 000818 Provider Number: 15G299 AIM Number: 100234990</p> <p>Surveyor: W. Chris Greeney Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Opportunity Enterprises, 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, client sleeping rooms and common living areas. 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 1.25.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/01/12.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

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K0130	<p>Based on observation and interview, the facility failed to ensure monthly fire extinguisher inspections were documented, including the date and initials of the person performing the inspections for 1 of 6 portable fire extinguishers. LSC 101, 4.5.7 states any device, equipment or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 10, Standard for Portable Fire Extinguishers, 4-3.1 requires extinguishers shall be inspected monthly. NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. NFPA 10, 4-3.4.2 requires at least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. This deficient practice could affect all clients and staff in the upper level bedrooms and upper bedroom corridor.</p> <p>Findings include:</p> <p>Based on observation of fire extinguisher inspection/maintenance tags on 02/28/12 between 10:50 am. and 11:35 am during a tour of facility with the Qualified Developmental Disabilities Professional</p>	K0130	The Group Home Manager/Lead Manager will ensure that proper tags are on all fire extinguishers with the date and initials of the person who conducted the monthly inspections. Group Home staff will complete a check one times a day to ensure all tags are properly on the fire extinguishers. To ensure future compliance, the Group Home Manager/ Lead Manager will complete weekly checks to ensure this is being completed properly.	03/29/2012

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	(QDDP), a fire extinguisher located at the end of the main level bedroom corridor had a tag that had been torn off of the extinguisher. The portion that remained with the extinguisher did not contain information regarding the dates and initials of the person who conducted monthly inspections. During an interview at 11:00 am on 02/28/12, the QDDP said one of the residents in the home routinely tears paper. The QDDP said there was no other evidence the extinguisher had the required monthly inspections.			

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KS018	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2.</p> <p>Based on observation and interview, the facility failed to ensure the door to 2 of 3 bedrooms latched securely in the frame when the fire alarm system was tested. This finding affected 4 of 6 residents in the facility.</p> <p>The findings include:</p> <p>During observation on 02/28/12 from 10:50 am to 11:35 am with the Qualified Developmental Disabilities Professional (QDDP), the door to the north bedroom on the main level of the home failed to latch securely in the frame when it self closed. Additionally, the only bedroom in the finished basement did not latch securely into the frame when it self closed. Interview with the facility QDDP on 02/28/12 at 11:05 am confirmed the latches were malfunctioning.</p>	KS018	The Group Home Manager/Lead Manager will ensure the doors are repaired to they latch properly. To ensure future compliance, the QDDPD and Group Home Lead Manager will check all bedroom doors to ensure they are latching properly to the door frame during monthly home visits.	03/29/2012

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KS149	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where smoking is permitted, noncombustible safety type ashtrays or receptacles are provided in convenient locations. 32.7.4.2, 33.7.4.2</p> <p>Based on record review, observation and interview; the facility failed to provide noncombustible safety type ashtrays in the designated smoking area. This finding could affect all residents, staff and visitors to the home.</p> <p>The findings include:</p> <p>During review of the facility's "Smoke-free Workplace" policy dated 6/4/2010 with the Qualified Developmental Disabilities Professional (QDDP) at 10:55 am on 02/28/12, the policy indicated staff who could not take meal breaks away from the facility could smoke in designated areas outside the home. Interview with the QDDP on 02/28/12 at 10:55 am indicated the smoking area was on the back deck outside the kitchen exit. During observation of the deck area on 2/28/12 at 11:00 am, a plastic soft drink container was present sitting on a wooden step leading down off of the deck. The container was filled with water and contained discarded cigarette butts. There was no safety type receptacle located in the area. The QDDP said a</p>	KS149	On 3/5/12 the Group Home Manager placed a noncombustible cigarette receptacle where the smoking area is located at the group home. To ensure future compliance, the Group Home Manager will check the smoking receptacle is located in the smoker's designated location and not moved to an undesignated location.	03/29/2012	

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	noncombustible receptacle had been provided at one time, and did not know where it was located. The QDDP also stated she did not know why the soft drink container was being used.			