STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G527	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 08/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	1553 97TH PL W CROWN POINT, IN 46307

(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	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/13/12 Facility Number: 001041 Provider Number: 15G527 AIM Number: 100245280 Surveyor: W. Chris Greeney, Life Safety Code Specialist At this Life Safety Code survey, ARC of Northwest Indiana 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. This one story facility was not sprinklered. The facility has a fire alarm system with smoke detection in corridors, sleeping rooms and common living areas. The facility has the capacity for 5 and had a census of 5 at the time of this survey. Calculation of the Evacuation Difficulty	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.72. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0130	Based on observation and interview, the facility failed to ensure evidence of monthly fire extinguisher inspections was documented, including the date and initials of the person performing the inspections for 3 of 3 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 residents and staff in the home. Findings include: Based on observation on 08/13/12 between 2:00 p.m. and 2:30 p.m. during a tour of facility with the Area Manager, fire extinguishers located in the bedroom hallway, kitchen and garage each had a tag which documented monthly inspections. Each extinguisher's tag	K0130	To assure further compliance, all fire extinguishers were checked and initialed by maintenance person on site. 9-6To assure further compliance, extinguisher were inspected and updated. Maintenance person responsible for property was verbally reprimanded. 8/14/12	08/13/2012

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	indicated the last inspection was conducted in June 2012. Interview with the Area Manager during the tour indicated it was policy that the inspections occur monthly and there was no evidence the July inspection of any of the three extinguishers occurred.			

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KS032	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In slow and impractical evacuation capability facilities, the primary means of escape for each sleeping room is not exposed to living areas and kitchens. Exception: Buildings equipped with quick-response or residential sprinklers throughout. Standard response sprinklers are permitted for use in hazardous areas in accordance with 33.2.3.2. 32.2.2.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 bedroom corridor doors between the bedrooms and the living room and kitchen area latched securely in the frame when the fire alarm system was tested. This finding could affect 5 of 5 residents in the facility. The findings include: During observation on 8/13/12 at 2:30 p.m. with the Area Manager, the facility's fire alarm system was tested. During the fire alarm test, the self closing door separating the bedroom corridor from the living room and kitchen area failed to close and latch into the door frame. The door released from the magnet on the wall but moved very slowly before stopping short of touching the door frame. The Area Manager during the observation confirmed the self closing door malfunctioned during the test.	KS032	To assure further compliance, door closer was cleaned lubricated and adjusted.9/6To assure compliance, door closer units was cleaned and oiled- all other units were checked and cleaned. 8/14/12.	08/14/2012

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KS046	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1 Based on observation and interview, the facility failed to ensure 2 of 2 kitchen counter electrical outlets were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, the National Electrical Code. NFPA 70, Article 210.8, Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms, and kitchens at receptacles intended to serve the counter top surfaces. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects all residents in the facility. Findings include: Based on observation with the Area Manager on 08/13/12 during a tour of the group home from 2:00 p.m. to 2:30 p.m., the kitchen counter had two electrical outlets within two feet of each side of the kitchen sink. The two outlets were not outlets designed for GFCI protection at the outlet. Observation of the electrical	KS046	To assure further compliance, two standard plugs were replaced with 20amp GFI units. To assure compliance, 2 out 2 electrical appliance plugs were replaced with 20 a GFI units. 8/14/12	08/14/2012

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	panel box indicated no evidence the breakers assigned to those outlets were GFCI protected. This was acknowledged by the Area Manager at the time of observations. Interview with the Area Manager during the observations could not confirm the two outlets were on a GFCI protected circuit.			

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KS120	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: (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. (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. (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: (1) The window is within 20 ft of grade. (2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. (3) The window or door opens onto an exterior balcony. 33.2.2.3 Exception No. 1: If the sleeping room has a door leading directly to the outside of the 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			

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	escape is considered as meeting all the escape requirements for the sleeping room. 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. Exception No. 3: Existing approved means of escape is permitted to continue to be used. Based on observation, record review and interview; the facility failed to ensure a second means of escape that was remotely located from the primary exit was maintained to protect 5 of 5 residents. This finding could affect two residents who are dependent on wheelchairs to evacuate. Findings include: During observation in the home on 8/13/12 from 2:00 p.m. until 2:30 p.m. an evacuation route map posted on a wall in the dining area was reviewed. It documented that the secondary means of escape was out a sliding glass door located on the rear wall of the home. During observation of the exit it was found that there was an eight inch drop off from the threshold of the door to the ground outside. The ground outside the door and throughout the general vicinity of the exit was mostly sand with small	KS120	To assure further compliance, a temporary steel ramp section was placed at rear sliding glass door. (See photos)	08/15/2012

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	weeds. Interview with the Area Manager during the observation indicated a wooden deck used to be attached to the home, but it had been removed and there were plans to replace the deck. It was not known how long the deck had been removed or when the new deck would be installed. Review of F1 Worksheet for Rating Residents completed by facility staff and dated 7/9/12 documented two residents in the home required the use of wheelchairs. The Area Manager also confirmed two residents of the home were dependent on wheelchairs to ambulate and would not be able to use windows in their rooms to escape or transverse the drop off at the sliding glass door to ground level, nor easily negotiate the sand and weeds immediately outside the door to get around to the meeting area in front of the home. The Area Manager indicated there was another alternative which would be to exit through a door in the manager's office. The observation noted however the exit door from the manager's office was located next to the front door of the home which was listed as the primary exit, therefore, the manager's room exit could not be considered remotely located from the primary exit. Additionally that route was not listed on the evacuation route map as a potential exit.			

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KS149	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 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. The findings include: During review of the facility's undated Smoking Policy on 08/13/12 at 1:15 p.m., the policy indicated each home had a designated area where individuals could choose to smoke. Interview with the Area Manager on 08/13/12 during a tour of the home from 2:00 p.m. until 2:30 p.m., indicated the smoking area was in the back of the home outside the sliding glass door exit. During observation of the smoking area, an empty plastic coffee container with no lid was sitting next to the home. The Area Manager indicated it was the receptacle used to dispose of smoking materials. There was no other safety type receptacle located in the area.	KS149	To assure further compliance, safety type ash tray set at smoking area.	08/24/2012