

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G485	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/05/2012
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 403 HAWTHORNE AVE GOSHEN, IN46526
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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: 01/05/12</p> <p>Facility Number: 000999 Provider Number: 15G485 AIM Number: 100239770</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, ADEC, 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>	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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K0130	<p>This one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection on in the corridors, client sleeping rooms and common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 4.475.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/12/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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	<p>1. Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers were located in areas where they were readily accessible. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1-6.3 requires extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from an area. This deficient practice affects all clients, visitors and staff in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the home manager on 01/05/12 at 3:35</p>	K0130	<p>On 1/6/12 NOBI was contaced to inspect the door that failed to close. They came to the facility and found that there was a loose wire. This wire was secured and the doors continued to close. In order to make sure that the equipment remains in proper working order a weekly test will be run to make sure the dpprs close and latch. If there are any problems Nobi will be immediately contacted to repair the problem. Failure to comply will result in disciplinary action. On 1/24/12 the fire extinguisher will be moved into the hall where it will not be blocked by laundry materials. In order to ensure that there are no further problems of blocking the extinguisher, three times per week the manager ill inspect the extinguisher to make sure it is not blocked. PERSON RESPONSIBLE: Res Manager, QDDP</p>	01/24/2012	

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	<p>p.m., access to one fire extinguisher located in the laundry room of the facility was blocked by a clothes hamper, laundry basket and a mop bucket. The home manager stated at the time of the observation, the items blocking the extinguisher were recently placed there by a service man.</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 corridor smoke barrier doors would close and latch into the door frame to keep the door closed during a fire. LSC 4.6.12.2. requires existing life safety features obvious to the public, if not required by the Code to be maintained or removed. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation on 01/05/12 at 3:30 p.m. with the home manager, the two smoke barrier</p>				

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	doors for the resident sleeping room corridors did not self close or latch into the door frame with the activation of the fire alarm system. Three attempts were conducted with two different alarm pull stations with neither door closing or latching during any of the tests. The home manager stated at the time of observation, she was surprised the doors did not release because they were recently inspected.				

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KS147	<p>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</p> <p>Based on observation and interview, the facility failed to provide a written plan for protecting 8 of 8 clients in the event of fire by providing an emergency policy and procedure manual which is readily available in the event of any emergency. The plan is to be reviewed not less than every two months by staff and kept readily available at all times within the facility. This deficiency affects all clients, staff and visitors.</p> <p>Findings include:</p>	KS147	All emergency procedures are kept both on the desktop of the computer and in the home as a hard copy that is either affixed to an emergency proceedure board or emergency proceedure book. A hard copy of these items was available at the home at the time of the survey. All facility staff will be trained to locate the hard copy of the proceedures so that in the event of an amergency all will know where to retrieve them.	01/24/2012	

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	Based on observation at 1:35 p.m. on 01/05/12 with the home manager, the emergency policies and procedures were located on the facility's computer. No contingency was made in the event a power outage should occur rendering the manual no longer readily available. The home manager stated at the time of observation, she was certain the computer had no battery back up in the event of an emergency, to maintain access to the policies and procedures.				