

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
---	---

(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
K 0000 Bldg. 01	<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: 08/20/15</p> <p>Facility Number: 001018 Provider Number: 15G504 AIM Number: 100239810</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 in the corridors, in client 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> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,</p>	K 0000		

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: 15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
---	---

(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
K S017 Bldg. 01	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.6.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those of 1¾ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2.</p> <p>Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
---	---

(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>the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms are separated from escape routes by walls and doors that are smoke resistant.</p> <p>No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 clients slept in a room provided with a door which would close and latch securely in the door frame. This deficient practice could affect one client.</p> <p>Findings include:</p> <p>Based on observation on 08/20/15 at 11:46 a.m. with the Qualified Intellectual Disability Professional, Bedroom #5 failed to latch when tested. Based on interview at the time of observation, the Qualified Intellectual Disability Professional acknowledged the aforementioned condition.</p>	K S017	<p>A maintenance request was filled out to fix bedroom door #5 so it will self close and latch into the door frame securely. Responsible person: Sheila O'Dell, GH Director. Maintenance will fix bedroom door #5 so that it will self close and latch into the door frame securely. Responsible person: Maintenance staff & Marcetta Walton, Group Home Manager. All the sleeping room doors on both levels were checked and they all self closed and latched securely into the door frames. Responsible person: Marcetta Walton, Group Home Manager. Monthly, all sleeping room doors will be checked to ensure that they all self close and latch securely into the door frames. Responsible person: Traci Hardesty, QIDP & Sheila O'Dell, Group Home Director.</p>	09/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
---	---

(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
K S046 Bldg. 01	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 multiplugs were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and all clients.</p> <p>Findings include:</p> <p>Based on observation with Qualified Intellectual Disability Professional on 08/20/15 at 11:32 a.m. then again 11:42 a.m., a multiplug was discovered powering an air conditioner, lamp, and air freshener in the Living Room and powering computer equipment in the Basement office. Based on interview at the time of observation, the Qualified Intellectual Disability Professional acknowledged each aforementioned condition.</p>	K S046	<p>All extension cords/multiplug have been removed and/or replaced with surge protectors that are directly plugged into the outlet. Responsible person: Marcetta Walton, GH Manager. All management staff will be retrained that extension cord will not be used as a substitute for fixed wiring. Responsible person: Sheila O'Dell, GH Director. All staff will be retrained that extension cord will not be used as a substitute for fixed wiring. Responsible person: Marcetta Walton, GH Manager. To ensure future compliance, the home will be inspected that no extension cords are being used monthly. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP.</p>	09/04/2015
K S051 Bldg. 01	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
---	---

(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
K S150	<p>accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on observations and interview, the facility failed to ensure 1 of 2 levels was provided with manual fire alarm boxes. LSC 9.6.2.3 requires manual fire alarm boxes shall be provided near the natural path to exit an area. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Qualified Intellectual Disability Professional on 08/20/15 at 11:47 a.m., two bedrooms were located in the basement. The basement was not provided with a manual fire alarm box. Based on an interview at the time of observation, the Qualified Intellectual Disability Professional acknowledged the aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p>	K S051	<p>Alert alarm was contacted and a work order was put in to install an additional pull station by the basement exterior exit door. Responsible person: Sheila O'Dell, GH Director. All management staff were trained that all exits require manual fire alarm boxes/pull stations near the natural path to exit an area. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, the homes will be inspected that all pathways to an exits have an alarm box/pull station. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP.</p>	09/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
---	---

(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
Bldg. 01	<p>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 draperies and curtains were flame resistant. LSC Section 10.3.1 requires that 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 staff, visitors, and all clients.</p> <p>Findings include:</p> <p>Based on observation with the Qualified Intellectual Disability Professional on 08/20/15 at 11:26 a.m., the Kitchen and Living Room had curtains. Based on interview at the time of observation, the Qualified Intellectual Disability Professional was unable to provide documentation of flame resistance for either the Kitchen or Living Room curtains.</p>	K S150	<p>Maintenance request will be completed to treat the curtains in the dining room and Kitchen with a flame retardant spray. Responsible person: Sheila O'Dell, Group Home Director. The curtains in the living room and Kitchen 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>	09/04/2015
K S155 Bldg. 01	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410
---	---

(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>period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 5 of 5 clients. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and interview with the Qualified Intellectual Disability Professional on 08/20/15 at 11:44 a.m., the facility did have a written fire watch policy and procedure for a fire alarm system failure but it did not address all components of LSC Section 9.6.1.8. Specifically, the plan did not state the person conducting the fire watch shall be trained and shall be assigned no other duties during that time.</p>	K S155	<p>The policy was reword for clarity that the staff dedicated to fire watch is only to perform the fire watch as their only duty during that time. It was also clarified that the staff is trained on the fire watch policy. Responsible person: Sheila O'Dell, GH Director. Management staff and staff will be trained on the policy. Responsible person: Sheila O'Dell, GH Director & Traci Hardesty, QIDP.</p>	09/04/2015