

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G221	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2014
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 59796 PARK SIDE ELKHART, IN 46517
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K020000	<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: 07/25/14</p> <p>Facility Number: 000745 Provider Number: 15G221 AIM Number: 100234850</p> <p>Surveyor: Dennis Austill, 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 32, New Residential Board and Care Occupancies.</p> <p>This one story facility with a basement was fully sprinklered. The facility has a monitored fire alarm system with smoke detection on all levels including in the corridors, in client sleeping rooms and in common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p>	K020000		
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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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K02S018	<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 0.58.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/31/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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 1 of 6 bedroom doors would latch into the door frame. This deficient practice could affect one</p>	K02S018	On the date of the survey, staff contacted maintenance and the doors in the home were adjusted and closed properly. In order to prevent this issue in the future, all doors will be checked on a	07/28/2014

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K02S053	<p>client in the west bedroom on the main floor.</p> <p>Findings include:</p> <p>Based on observation with the House Manager on 07/25/14 from 10:45 a.m. to 11:45 a.m., the door to the west bedroom on the main floor closed but did not latch into the door frame. Based on interview at the time of observation, the House Manager acknowledged the door did not latch.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Approved smoke alarms are provided in accordance with 9.6.2.10, 32.2.3.43.1. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms are installed for all living areas as defined in 3.3.119.</p> <p>Exception: Smoke alarms are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 11 smoke detectors was not located where airflow could prevent the operation of the detectors. LSC 9.6.2.10.1 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors</p>	K02S053	<p>weekly basis by the manager or QIDP and documented. Failure to comply will result in disciplinary action. Person Responsible: QIDP, Res Manager</p> <p>Maintenance staff are in the process of removing the ceiling fan and replacing it with just a light fixture. This will be completed by 8/8/14. In the future, prior to installation of a ceiling fan, maintenance staff will be sure that there are no smoke detectors in the area. Person Responsible: Maintenance</p>	08/05/2014

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K02S152	<p>shall not be located where airflow prevents operation of the detectors. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations on 07/25/14 from 10:45 a.m. to 11:45 a.m. with the House Manager, the smoke detector in the main floor living room was mounted on the ceiling above an operating ceiling fan. Based on interview, this was acknowledged by the House Manager at the time of observation.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities; (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective</p>						

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	<p>action: and</p> <p>(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>Facilities meet the requirements of paragraphs (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the fire drill documentation at 11:00 a.m. on 07/25/14 with the House Manager, there was no record of a fire drill for the second shift of the fourth quarter of 2013. This was acknowledged by the House Manager at the time of record review.</p>	K02S152	The house manager has implemented a fire drill schedule that covers each shift each quarter so that all drills are run on a timely basis. The manager will pass the completed drills to the QIDP who will review and sent to the training coordinator who will track the drills and maintain the files. With all checks in place, this deficient practice will be corrected. Person Responsible: QIDP, Res Manager	08/08/2014			