STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE SOUTHEAST INDIANA	16613 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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: 05/21/12 Facility Number: 011595 Provider Number: 15G749 AIM Number: 200905630 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Res Care Southeast Indiana 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. This one story facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, client sleeping rooms and common living areas. The facility has a capacity of 4 and had a census of 4 at the time of this survey.	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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	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 2.25. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/24/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0130	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 3 of 3 portable fire extinguishers were inspected at least monthly, and the inspections were documented, including the date and initials of the person performing the inspection. LSC 4.6.12.2 in General Requirements, requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff. Findings include: Based on observations during a tour of the facility with maintenance worker # 1 on 05/21/12 from 10:00 a.m. to 11:55 a.m., service and inspection tags for the two portable fire extinguishers located in the staff office and one portable fire extinguisher located near the front exit door bore service inspection tags	K0130	The Operations Manager SGL and the Program Coordinator will ensure the staff inspect the fire extinguishers service and inspection tags, for the two portable fire extinguishers. One located in the staff office and the other near the front exit door. Documenting the date of the inspections on the attached inspection tags. This will be done once a month. This will ensure the extinguishers in the home are in compliance with LSC Standards. SimplexGrinnell will perform annual inspections of the extinguishers and the Environmental Services Manager will follow-up on scheduling needed for recharging/replacement of extinguishers as necessary.	06/20/2012

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	indicating there was no monthly check conducted since the annual inspection conducted on 10/12/11. This was verified by maintenance worker # 1 at the time of observations.			

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KS017	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD 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. 32.2.3.6.1 and 32.2.3.6.2. Exception No. 1: In prompt evacuation capability facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 32.2.3.6.4. 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 32.2.3.5 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 32.2.3.6.4. 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 the sleeping area is sufficient to awaken staff that might be sleeping. No louvers or operable transoms or other air			

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	passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.			
	Based on observation and interview, the facility failed to ensure 2 of 4 sleeping room doors were capable of resisting smoke for at least 1/2 hour. NFPA 101, LSC 2000 Edition, in 8.2.4 requires doors in smoke barriers to be in accordance with NFPA 80, 1999 Edition, the Standard for Fire Doors and Windows. NFPA 80, Section 2-3.1.7 requires the clearance between the edge of the door and the frame not exceed 1/8 inch for wood doors. This deficient practice could affect one client in the southeast bedroom and one client in the northeast bedroom. Findings include: Based on observation with maintenance worker # 1 on 05/21/12 during a tour of the facility from 10:00 a.m. to 11:55 a.m., the corridor door to the southeast client sleeping room was not smoke resistant due to a gap 1/2 inch wide along the latch side of the closed door. Furthermore, the northeast client sleeping room lacked a door. This was verified by maintenance worker # 1 at the time of observations.	KS017	A. The Environmental Services Manager will schedule with the Environmental Coordinator to repair the corridor door to the southeast client sleeping room and eliminate the half inch wide gap along the latch side of the closed door. This will ensure the safety of all clients and staff in the facility, and ensure compliance with the NFPA Life Safety Code.B. The Environmental Services Manager will schedule with the Environmental Coordinator to install the new corridor door in the northeast client sleeping room. This will ensure the safety of all clients and staff in the facility, and ensure compliance with the NFPA Life Safety Code.	06/20/2012

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KS051	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6. 32.2.3.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 manual fire alarm systems was continuously in proper operating condition. LSC Chapter 4.6.12.1 is a general requirement and applies to all occupancies. LSC 4.6.12.1 requires that any device or any feature of a required fire detection and alarm system shall be continuously maintained in proper operating condition. This deficient practice could affect all clients, staff, and visitors in the facility. Findings include: Based on observation on 05/21/12 at 11:30 a.m. with maintenance worker # 1, the fire alarm system panel lights "System Trouble" and "Disarmed" were illuminated. Based on interview with maintenance worker # 1 on 05/21/12 at 11:35 a.m., the fire alarm system is an addressable panel and maintenance worker # 1 was not properly trained to either test the fire alarm system or reset the fire alarm panel. This was verified by maintenance worker # 1 at the time of observation and acknowledged by the	KS051	The Environmental Services Manager has contacted the Program Coordinator about scheduling an inspection and repair of the fire alarm panel that lights "System Trouble" and "Disarmed". SimplexGrinnell has already been to the home on May 29, 2012 and is scheduled to return after some research, as they are unsure why the system is not resetting so that it can be tested on a routine basis. The Program Coordinator was not available on May 21, 2012 as he was with the client's at their Day Program. The normal Environmental Coordinator was off. Maintenance Worker # 1 who was sent to attend to the surveyor and normally does not maintain this group home was unfamiliar with their codes. The Fire Watch will continue to done until the issue is resolved and is back in ready mode. This will ensure the safety of all the clients and staff in the facility, and ensure compliance with the NFPA Life Safety Code.	06/20/2012

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	residential coordinator on a telephone interview on 05/21/12 at 12:25 p.m.			

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KS155	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 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 Based on observation and interview, the facility failed to ensure a fire watch was initiated for 1 of 1 manual fire alarm systems out of service. This deficient practice could affect all clients, staff, and visitors in the facility. Findings include: Based on observation on 05/21/12 at 11:30 a.m. with maintenance worker # 1, the fire alarm system panel lights "System Trouble" and "Disarmed" were illuminated. Based on interview with maintenance worker # 1 on 05/21/12 at 11:45 a.m., there was no documentation the fire alarm system contractor, the residential coordinator, or the home manager of the facility documented the fire alarm system being out of service and a initiating a fire watch in the facility. Based on a telephone interview with the residential coordinator on 05/21/12 at	KS155	The Environmental Services Manager has put a written policy in place containing procedures to be followed in the event the Fire Alarm System is placed out of service for 4 or more hours in a 24 hour period. See attached Fire Watch Prodical. This is to ensure the safety of all clients and staff in the facility, and ensure compliance with the NFPA Life Safety Code. Due to the Program Coordinator not following policy and notifying the service contractor immediately and initiating the Fire Watch Prodical. The Operations Manager SGL is following up with an In Service.	06/20/2012

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	12:35 p.m., the residential coordinator stated it was not known the fire alarm system was out of service in the facility and the group home manager would be contacted immediately to initiate a fire watch. Furthermore, the fire alarm system contractor would be contacted immediately to repair the fire alarm system. The fire watch not being initiated in the facility due to the fire alarm system being out of service was acknowledged by the residential coordinator on a telephone interview on 05/21/12 at 12:25 p.m.			