

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G074	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/07/2014
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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 5924 ABBOTT ST FORT WAYNE, IN 46816
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K010000	<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: 02/07/14</p> <p>Facility Number: 000618 Provider Number: 15G074 AIM Number: 100233730</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Easter Seals ARC of Northeast 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.</p> <p>This one story facility was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in common living areas and hard wired single station smoke detectors in the sleeping rooms. The</p>	K010000		
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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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K010130	<p>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 Prompt with an E-Score of 0.9.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/11/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>	K010130	<p>GroupHome staff will remove snow from all paths from all exits of the building PersonResponsible: Group Home SupervisorCompletionDate: March 9, 2014 Thegroup home staff will be trained to keep paths clear from all exits of thebuilding PersonResponsible: QIDPCompletionDate: March 9, 2014 TheQIDP does an observation check on all group</p>	03/09/2014

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K01S147	<p>affect all clients.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Technician # 1 on 02/07/14 from 2:20 p.m. to 2:37 p.m., the exterior walking surface from the living room exit door was covered with seven inches of snow and the exterior walking surface from the men's hall exit door was covered with three inches of snow. Measurement were provided by Maintenance Technician # 1 at the time of observations.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD 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>		homes monthly on an ongoing basis. PersonResponsible: QIDPCompletionDate: March 9, 2014				

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	<p>Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the written fire safety plan. Such instruction is reviewed by the staff not less than every 2 months. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>During the record review process with the Central Files Supervisor on 02/07/13 at 12:30 p.m., the facility failed to provide training records to show all employees have been instructed of their duties and responsibilities, at least every two months, according to the written fire safety plan. Based on an interview with the Central Files Supervisor at the time of record review, she stated she did not keep the training records in her office.</p>	K01S147	<p>Theevacuation plans will be reviewed with the group home staff every two months PersonResponsible: Group Home SupervisorCompletionDate: March 9, 2014 TheQIDP will complete a checklist indicating that all staff have been trained onthe evacuation plans every 2 months for the next 4 months. PersonResponsible: QIDPCompletionDate: March 9, 2014</p>	03/09/2014			

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K01S151	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New upholstered furniture within board and care facilities is tested in accordance with the provisions of 10.3.2(1) and 10.3.3.</p> <p>Exception: Upholstered furniture belonging to the resident in sleeping rooms, provided that a smoke alarm is installed in such rooms. Battery-powered single-station smoke alarms are permitted. 32.7.5.2, 33.7.7.2</p> <p>Based on interview and observation, the facility failed to ensure new upholstered furniture in 1 of 1 living rooms was resistant to cigarette ignition or smoldering. LSC 10.3.2(1) states the components of the upholstered furniture, unless located in rooms or spaces protected by an approved automatic sprinkler system, shall meet the requirements for Class 1 when tested in accordance with NFPA 260, Standard Methods of Tests and Classification System for Cigarette Ignition Resistance of Components of Upholstered Furniture. LSC 10.3.3 states upholstered furniture, unless located in rooms or spaces protected by an approved automatic sprinkler system, shall have limited rates of heat release when tested in accordance with NFPA 266, Standard Method of Test for Fire Characteristics of Upholstered Furniture Exposed to Flaming Ignition Source, or ASTM E 1537, Standard Method for</p>	K01S151	<p><u>K151</u> Another tag was found on the sectional furniture regarding flammability requirements and it is available for inspection. Person Responsible: Group Home Supervisor Completion Date: March 14, 2014 The assistant director must approve all new furniture purchases to ensure that furniture meets Class 1 requirements. Person Responsible: Assistant Director Completion Date: March 14, 2014</p>	03/14/2014

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	<p>Fire Testing of Real Scale Upholstered Furniture Items, as follows: (1) The peak rate of heat release for the single upholstered furniture item shall not exceed 250 kW (kilowatt). (2) The total energy released by the single upholstered furniture item during the first five minutes of the test shall not exceed 40 mJ (millijoule). This deficient practice would affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Technician # 1 on 02/07/14 at 2:23 p.m., the upholstered sectional furniture, chair and ottoman in the living room were new and lacked an attached tag to indicate the furniture provided the Class 1 and/or rates of heat release information. Based on an interview with Maintenance Technician # 1 at the time of observation, no other documentation was available for review.</p>			

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K01S152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) 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 action: and (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>(3) Facilities must meet the requirements of paragraphs (i) (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 conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all clients.</p> <p>Findings include:  Based on review of the fire drills titled "Fire Drill Form" with Central Files</p>	K01S152	The grouphome staff will be retrained to complete fire drills monthly PersonResponsible: QIDPCompletionDate: March 9, 2014 The QIDP willcomplete a checklist monthly for the next 3 months to track that the group homeis completing monthly fire drills PersonResponsible: QIDPCompletionDate: March 9, 2014	03/09/2014	

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	Supervisor on 02/07/14 at 12:30 p.m., fire drill documentation for the first shift of the third quarter 2013 was not available for review. Based on an interview with the Central Files Supervisor at the time of record review, she was already aware the fire drill documentation was missing.			