

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G416	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/29/2015
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 20089 LARK DR SOUTH BEND, IN 46637
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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: 12/29/15</p> <p>Facility Number: 000930 Provider Number: 15G416 AIM Number: 100244540</p> <p>At this Life Safety Code survey, Logan Community Resources 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, common living areas and battery powered smoke detectors in all sleeping rooms. The facility has a generator. The facility has a capacity of 7 and had a census of 7 at the time of this survey.</p>	K 0000		
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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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K S016 Bldg. 01	<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 2.1.</p> <p>Quality Review completed 01/05/16 - DA</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Interior wall and ceiling finish materials in accordance with 10.2 and 10.2.3 is Class A or Class B. 32.2.3.3.2, 33.2.3.3</p> <p>Based on observation, record review and interview; the facility failed to ensure the interior finish in 1 of 1 Basements was rated Class A or Class B for this Slow rated, nonsprinklered facility. This deficient practice could affect all clients and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Program Coordinator on 12/29/15 at 11:14 a.m., there was wood paneling on the stairwell in the basement. Based on interview at the time of observation, the Program Coordinator acknowledged the aforementioned condition and confirmed no documentation was available for review.</p>	K S016	<p>The Director of Maintenance has located fire rated paint product. The product will be purchased and then applied to the wood paneling no later than January 28, 2016.</p> <p>In the future, when completing routine inspections in the residential facilities, maintenance staff will check and note any flammable surfaces/fabrics and resolve any issues if the surface or fabric is not properly treated with a fire rated product.</p> <p>Persons Responsible: Director of Maintenance</p>	01/28/2016

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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 maintain an electrical outlet in 1 of 1 garage. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observations with the Program Coordinator on 12/29/15 at 10:49 a.m., the generator transfer switch had an outlet cover missing. Based on interview at the time of observation, the Program Coordinator acknowledged the aforementioned condition.</p>	K S046	<p>On December 29, 2015, The Program Coordinator completed an electronic SYSAID request to address the missing outlet cover. On December 30, 2015, maintenance staff replaced the outlet cover on the generator transfer switch.</p> <p>In the future, the Program Coordinator will respond in a timely manner by completing an electronic SYSAID request so that maintenance issues, such as but not limited to outlet covers, can be replaced in a timely manner. Additionally, the Program Manager makes routine visits to the home at least on a monthly basis, and will also note any maintenance issues and complete electronic SYSAID requests to address any maintenance issues.</p> <p>Persons Responsible: Program Coordinator, Program Manager, Maintenance Staff</p>	01/28/2016
K S051 Bldg. 01	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in 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</p>			

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	<p>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>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems components and devices, such as, smoke detectors, horn/strobe devices, fire alarm boxes, and fire alarm control equipment was tested annually. LSC 9.6.2.10 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices, such as, smoke detectors, fire alarm boxes, horn/strobe devices, and fire alarm control equipment be tested annually. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Program Coordinator on 12/29/15 at 10:29 a.m., the annual fire alarm inspection documentation noted the horns and strobes were not tested. Based on interview at the time of record review, the Program Coordinator acknowledged the aforementioned condition.</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was maintained in</p>	K S051	<p>The company that completes the fire alarm inspections that includes testing and evaluating the functioning of the horns and strobes as well as the smoke detector sensitivity range completed a follow up visit. Documentation will be provided that records the testing of the horns and strobes. Additionally, documentation will be provided when smoke detectors are tested that include the sensitivity value and the sensitivity range values for each smoke detector. In the future, the Director of Maintenance and the Director of Quality Assurance will both review each report submitted by the company that conducts the fire alarm inspections to ensure that all areas are tested during the inspections and documented including but not limited to horns and strobes and sensitivity ranges for smoke detector sensitivity values. If the documentation is not complete, the company will be asked to provide in a timely manner. Persons Responsible: Director of Maintenance and Director of Quality Assurance</p>	01/28/2016

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	<p>accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity 						

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K S120 Bldg. 01	<p>range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all staff, clients, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Program Coordinator on 12/29/15 at 10:29 a.m., the most recent documentation of a smoke detector sensitivity test failed to include range values for each smoke detector. Based on an interview with Program Coordinator at the time of record review acknowledged the aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In addition to the primary route, each sleeping room in facilities that use Exception No. 1 to 32.2.3.5.1 has a second means of escape that consists of one of the following:</p> <p>(a) It is a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape.</p> <p>(b) It is a passage through an adjacent nonlockable space, independent of and</p>						

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	<p>remotely located from the primary means of escape, to an approved means of escape.</p> <p>(c) It is an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 sq. ft. The width is not less than 24 inches. The bottom of the opening is not more than 44 inches above the floor. Such means of escape is acceptable where one of the following criteria are met:</p> <p>(1) The window is within 20 ft of grade.</p> <p>(2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.</p> <p>(3) The window or door opens onto an exterior balcony. 33.2.2.3</p> <p>Exception No. 1: If the sleeping room has a door leading directly to the outside of the building with access to grade or to a stairway that meets the requirements of exterior stairs in 33.2.3.1.2, that means of escape is considered as meeting all the escape requirements for the sleeping room.</p> <p>Exception No. 2: A second means of escape from each sleeping room is not required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.</p> <p>Exception No. 3: Existing approved means of escape is permitted to continue to be used.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 window in</p>	K S120	On December 29, 2015, The Program Coordinator completed an	01/28/2016	

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K S152 Bldg. 01	<p>Bedroom #1 was maintained as a secondary means of escape. This deficient practice could affect 1 clients.</p> <p>Findings include:</p> <p>Based on observation with the Program Coordinator on 12/29/15 at 11:06 a.m., the Program Coordinator tried to open the window, but the window was stuck closed and failed to open. Based on interview at the time of observation, the Program Coordinator acknowledged the aforementioned condition.</p> <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</p>		<p>electronic SYSAID request to address the stuck window that failed to open. On December 30, 2015, maintenance staff repaired the window so that it will open and is operational.</p> <p>In the future, the Program Coordinator will respond in a timely manner by completing an electronic SYSAID request so that maintenance issues, such as but not limited to windows that will not open/in need of repair so that repair can occur in a timely manner. Additionally, the Program Manager makes routine visits to the home at least on a monthly basis, and will also note any maintenance issues and complete electronic SYSAID requests to address any maintenance issues.</p> <p>Persons Responsible: Program Coordinator, Program Manager, Maintenance Staff</p>		

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	<p>one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities:</p> <p>(iii) File a report and evaluation on each drill:</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective 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>(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 3 of the last 4 calendar quarters. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on record review of the fire drill reports titled "New Drill Report" with the Program Coordinator on 12/29/15 at 10:23 a.m., three consecutive second shift quarter fire drills were performed between 4:55 p.m. and 6:45 p.m. Based on interview at the time of record review, the Program Coordinator acknowledged the aforementioned condition.</p>	K S152	<p>The schedule that has been created to identify when drills should be run will be revised to include more varied times that drills will be run by all shifts of staff. The Program Coordinator will assign specific times for staff to run drills that include, but is not limited evenings after 7PM, on weekends between the hours of 10 AM-4 PM and on various times during the night/sleeping hours. This will ensure that drills are conducted at least quarterly for each shift of personnel under varied conditions.</p> <p>In the future, the Program Coordinator will review the drill documentation in a timely manner to determine if the drill was completed as assigned. If not, it will be reassigned in a timely manner. The Administrative Assistant will continue to track all drills</p>	01/28/2016

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			<p>completed. If drills are not completed as assigned under varied times by all shifts of staff on a quarterly basis, written notification will be provided to the Program Coordinator and the Program Manager in an additional effort to ensure drills are assigned in a timely manner.</p> <p>Persons Responsible: Program Coordinator, Program Manager</p>		