

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G321	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/22/2014
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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 335 WESTERN ROW DILLSBORO, IN 47018
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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: 01/22/14</p> <p>Facility Number: 000839 Provider Number: 15G321 AIM Number: 100244000</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Res Care Community Alternatives SE IN 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 fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including in the basement, in the corridors, in common living areas and hard wired smoke detectors in all</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>client sleeping rooms. The facility has a capacity of 7 and had a census of 7 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 1.375.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/30/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were inspected at least monthly and the inspections were documented for 10 of 10 months since the last annual inspection date, including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 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</p>	K010130	<p>PROVIDER'S PLAN OF CORRECTIONK130: Clinical Supervisor has been inserviced on completing monthly extinguisher checks and documenting tag (Attachment A). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 2-10-2014</p>	02/10/2014			

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	<p>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.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the home manager on 01/22/14 from 11:00 a.m. to 1:00 p.m., service and inspection tags for the portable fire extinguishers located in the kitchen and at the base of the basement stairs each bore a service inspection tag indicating the most recent annual inspection was 02/27/13, but no monthly checks were documented on the inspection tags for March, April, May, June, July August, September, October, November, and December 2013. Based on interview at the time of observation, the home manager stated there is no written documentation of monthly fire extinguisher inspections for the facility and acknowledged the facility did not perform monthly fire extinguisher</p>			

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	inspections for March, April, May, June, July August, September, October, November, and December 2013. This was verified by the home manager at the exit conference on 01/22/14 at 1:15 p.m.			

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K01S017	<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 the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved</p>						

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	<p>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 sleeping room doors was capable of resisting smoke for at least 1/2 hour. This deficient practice could affect two clients who reside in bedroom # 6.</p> <p>Findings include:</p> <p>Based on observation with the home manager on 01/22/14 at 12:10 p.m., the corridor door to client sleeping room # 6 was not smoke resistant due to a gap one inch wide along the latch side of the door in the closed position. This was verified by home manager at the time of observation and at the exit conference on 01/22/14 at 1:15 p.m.</p>	K01S017	K0017: Maintenance requested has been submitted to repair door (Attachment B). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 3-15-2014	03/15/2014	

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K01S041	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Every sleeping room and living area has access to a primary means of escape located to provide a safe path of travel to the outside. 33.2.2.2.1.</p> <p>Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape is an interior stair in accordance with 32.2.2.4 and 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. 32.2.2.2.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 rooms and 1 of 2 corridors were provided with a safe path of travel to the outside. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations with home manager on 01/22/14 during a tour of the facility from 11:50 a.m. to 1:00 p.m., the south client bathroom section of floor extending four feet by eight inches next to the bathtub and the open television room corridor section of floor near the staff office entrance, extending four feet by one foot in the center of the egress corridor, were both rotting and heaving as the home manager walked over the floor surfaces. The south client bathroom section of rotting floor next to the bathtub and the open television room</p>	K01S041	K0041: Maintenance requested has been submitted to repair floors, walk thru with contractor completed 2-4-14, written estimate to be obtained 2-11-14(Attachment B). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 3-31-2014	03/31/2014			

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K01S046	<p>corridor section of rotting floor near the staff office were verified by the home manager at the time of observations and at the exit conference on 01/22/14 at 1:15 p.m.</p> <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 1 of 3 bathrooms was provided with ground fault circuit interrupter (GFCI) protection against electric shock near an electrical outlet. NFPA 101, 33.2.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8, Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms, and kitchens at receptacles intended to serve the counter top surfaces. Note: Moisture can reduce the contact resistance of the body and electrical insulation is more subject to failure. This deficient practice affects all clients who would use the north client bathroom.</p> <p>Findings include:</p>	K01S046	K0046: Maintenance requested has been submitted to install GFI outlet (Attachment B). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 3-1-2014	03/01/2014

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	Based on observation on 01/22/14 at 12:30 p.m. with the home manager, the north client bathroom had an electric outlet behind the corridor door, three feet from the hand wash sink which was not provided with a ground-fault circuit interrupter. Furthermore, the main electric panel in the basement was checked and the electric receptacle in the north client bathroom located three feet from the hand wash sink was not provided with GFCI protection to prevent electric shock. This was verified by the home manager at the exit conference on 01/22/14 at 1:15 p.m.			

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K01S053	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms are powered from the building electrical system and when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms are installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3.</p> <p>Exception No 1: Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system.</p> <p>Exception No. 2: Where buildings are protected throughout by an approved automatic sprinkler system, in accordance with 32.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms.</p> <p>Based on record review and interview, the facility failed to ensure 15 of 15 smoke detectors were tested for sensitivity by a qualified service technician every alternate year. 9.6.2.10.1 refers to NFPA 72, National</p>	K01S053	K0053: Sensitivity Testing was completed on 1-26-12 (Attachment C). This will ensure the safety of all consumers at the site and will also comply with the NFPA Life Safety Code. Completion Date: 2-10-2014	02/10/2014

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	<p>Fire Alarm Code. NFPA 72, 7-3.2.1 states detector sensitivity shall be checked within 1 year of 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, 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 areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method.</li> <li>(2) Manufacturer's calibrated sensitivity test instrument.</li> <li>(3) Listed control equipment arranged for the purpose.</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range.</li> <li>(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction</li> </ol> <p>Detectors found to have sensitivity</p>			

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K01S150	<p>outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.</p> <p>The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all occupants in the facility including staff, and visitors.</p> <p>Findings include:</p> <p>Based on a review of Fire Alarm System Reports of Inspection with the home manager on 01/22/14 at 11:00 a.m., the only Sensitivity Test Report available for review was dated 02/08/11, which was a period over the two year testing interval requirements. The lack of a current smoke detector test for the fifteen smoke detectors in the facility was verified by the home manager at the exit conference on 01/22/14 at 1:15 p.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD 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 new draperies and curtains were flame resistant for 7 of</p>	K01S150	K0150: Curtains will be removed (Attachment B). This will ensure the safety of all consumers at the site and will also comply with the	02/10/2014

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	<p>12 rooms. LSC Section 10.3.1 requires 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 all clients in the facility.</p> <p>Findings include</p> <p>Based on an interview with the home manager on 01/22/14 at 11:10 a.m. during record review, there was no record of flame resistance documentation for window curtains throughout the facility. Furthermore, the home manager indicated a number of room window curtains had been replaced over the past year. Based on observations during a tour of the facility with the home manager on 01/22/14 from 11:55 a.m. to 1:00 p.m., the window curtains in client room # 1, client sleeping room # 3, client sleeping room # 7, the living room, the kitchen, the staff office, and the television room failed to have attached tags to indicate the window curtains were flame resistant. The lack of flame resistant documentation for window curtains was verified by the home manager at the</p>		NFPA Life Safety Code. Completion Date: 2-10-2014				

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