

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G709	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/18/2012
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 55737 REEVES DR OSCEOLA, IN 46561
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	<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: 07/18/12</p> <p>Facility Number: 003862 Provider Number: 15G709 AIM Number: 200460470</p> <p>Surveyor: W. Chris Greeney, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, AWS 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 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.</p>	K0000		

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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	<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 3.2.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/25/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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KS147	<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 person 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 no 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> <p>Based on observation and interview, the facility failed to ensure staff had access to a written plan for protecting 4 of 4 clients in the event of fire. The plan is to be reviewed not less than every two months by staff and kept readily available at all times within the facility. This deficiency affects all clients, staff and visitors.</p> <p>Findings include:</p> <p>During observation on 07/18/12 between 9:30 a.m. and 10:30 a.m. the Qualified Mental Retardation Professional (QMRP) and direct care staff (DCS) #1 searched for emergency procedures in various binders but could not locate them.</p>	KS147	AWS has a group home emergency policy for protecting clients in case of fire. This policy is located in the home's policy book and is readily accessible to staff. This policy was in place at the time of the survey. All staff have been re-trained on the location of the policy which is readily accessible in case of emergency. A return demonstration that included the location of the policy and review of the procedures have been completed to ensure the effectiveness of the training. The emergency procedures plan has been added to the monthly house meeting agendas to ensure regular review of the plan. The monthly house meetings will be	08/17/2012			

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	Interview during the observation at 10:20 a.m. with the QMRP and DCS #1 indicated they remember seeing them but could not locate them and confirmed they were not readily accessible. During interview on 7/18/12 at 11:30 a.m. with the Residential Director (RD) at the facility's main office, the RD produced a copy of the procedures and indicated that they should have been readily accessible in the home.		reviewed by the director.		

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KS148	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1</p> <p>Based on observation, record review and interview; the facility's administration failed to adopt specific smoking regulations that guided staff in determining where smoking was permitted and how to dispose of discarded smoking materials. This deficiency could affect all clients, staff and visitors in the home.</p> <p>Findings include:</p> <p>During observation in the home on 7/18/12 from 9:30 a.m. until 10:30 a.m. with the Qualified Mental Retardation Professional, an empty coffee can with a plastic lid was found on the back patio. The plastic lid had a large hole cut out of the center and discarded cigarette butts were observed in the bottom of the can. Interview with the Qualified Mental Retardation Professional during the observation indicated it was the smoking area and the can was used for discarded smoking material. Review on 7/18/12 at 11:30 a.m. of an undated "Smoking Policy" found the policy specified the facility provided a "non-smoking environment to all its employees and clients." It further stated, "One exception</p>	KS148	<p>The smoking policy was revised to include the proper disposal of smoking materials in noncombustible safety type receptacles and the permitted smoking area. The noncombustible smoking receptacles have been purchased and are being used. All staff have been trained on the policy revision. The Residential Manager and the QMRP work out of the home and have completed spot checks to ensure compliance with the training. These observations are being documented and turned into the director for review.</p>	08/17/2012			

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	to this rule will be residential clients that live in group homes." The policy did not provide any guidance or direction for the exception. Interview with the Residential Director at 11:30 a.m. on 7/18/12 indicated the policy was not more specific.				

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KS149	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where smoking is permitted, noncombustible safety type ashtrays or receptacles are provided in convenient locations. 32.7.4.2, 33.7.4.2</p> <p>Based on observation and interview, the facility failed to provided noncombustible safety type receptacles for discarded smoking materials. This deficiency could affect all clients, staff and visitors in the home.</p> <p>Findings include:</p> <p>During observation in the home on 7/18/12 from 9:30 a.m. until 10:30 a.m. with the Qualified Mental Retardation Professional, an empty coffee can with a plastic lid was found on the back patio. The plastic lid had a large hole cut out of the center and discarded cigarette butts were observed in the bottom of the can. Interview with the Qualified Mental Retardation Professional during the observation indicated the can was the only receptacle used to contain discarded smoking materials.</p>	KS149	<p>Noncombustible safety type receptacles have been purchased and are in use for disposal of smoking materials. All staff have been trained on the use of the receptacles. The Residential Manager and the QMRP work out of the home and have completed spot checks to ensure compliance with the training. These observations are being documented and turned into the director for review.</p>	08/17/2012			