

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2016
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NAME OF PROVIDER OR SUPPLIER  DAMAR SERVICES INC--MAIN ST	STREET ADDRESS, CITY, STATE, ZIP CODE 411 E MAIN ST PLAINFIELD, IN 46168
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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: 05/02/16</p> <p>Facility Number: 000629 Provider Number: 15G088 AIM Number: 100239570</p> <p>At this Life Safety Code survey, Damar Services Inc.-Main Street 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 two story building with a basement was determined to be nonsprinklered. The facility has a monitored fire alarm system with smoke detection in corridors and all living areas. The facility has a capacity of 6 and had a census of 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,</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 S017 Bldg. 01	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.1.</p> <p>Quality Review completed on 05/05/16 - DA</p> <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>			

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	<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 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, the facility failed to ensure 3 of 6 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 all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Staffing</p>	K S017	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice?</p> <p>1.Fabricated metal door slips to ensure the gapsat the bottom of the doors are no more than 1/8".</p> <p>2.How the facility will identify other residentshaving the potential to be affected by the same deficient practice and whatcorrective action will be taken.</p> <p>1.All doors throughout the house were checked forthe same issue.</p> <p>3.What measures will be put into place or whatsystematic changes the facility will make to ensure that the deficient</p>	05/12/2016

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K S018  Bldg. 01	<p>and Support Manager during a tour of the facility from 12:50 p.m. to 1:15 p.m. on 05/02/16, the following was noted:</p> <p>a. the corridor door to the south bedroom and the corridor door to the southwest bedroom each had a 3/4 inch gap between the top of the door and the door frame which would not resist the passage of smoke.</p> <p>b. a three inch hole was noted in the corridor door to the storage room on the second floor where the door handle assembly had been removed which would not resist the passage of smoke. The latching bolt for the former door handle assembly was still in place to latch the door into the door frame.</p> <p>Based on interview at the time of the observations, the Staffing and Support Manager acknowledged the aforementioned corridor doors were not smoke resistant.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p>		<p>practicedoes not recur.</p> <p>1.Managers, Staff, and Maintenance staff have been trained to look for this issue any time they are in the home.</p> <p>4.How the corrective action will be monitored to ensure the deficient practice will not recur (ie what quality assurance program will be put into place).</p> <p>1.This issue will be added to the list of preventivemaintenance checks that are done monthly.</p> <p>5.By what date the systemic changes will be completed.</p> <p>1.Repair was made on 5/12/16, staff were also trained on the 12th, and the issue was added to the preventivemaintenance checklist immediately.</p>				

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	<p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation, the facility failed to ensure 2 of 6 sleeping room doors would self-close and latch into the door frame. LSC 7.2.1.8 states a door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic closing in accordance with LSC 7.2.1.8.2. LSC 7.2.1.8.2 states in any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:</p> <p>(1) Upon release of the hold-open mechanism, the door becomes self-closing.</p> <p>(2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed.</p> <p>This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Staffing and Support Manager during a tour of the facility from 12:50 p.m. to 1:15 p.m. on</p>	K S018	<p>1.What corrective actions will be accomplished forthose residents found to have been affected by the deficient practice?</p> <p>1.For the first door, the hinges were repaired andthe door's operation was checked. On thesecond, the door frame was adjusted and the door's operation was checked.</p> <p>2.How the facility will identify other residentshaving the potential to be affected by the same deficient practice and whatcorrective action will be taken.</p> <p>1.All bedroom doors in the house were checked forthe same issue, no others were found.</p> <p>3.What measures will be put into place or whatsystematic changes the facility will make to ensure that the deficient practicedoes not recur.</p> <p>1.Managers, Staff, and Maintenance staff have beentrained to look for this issue any time they are in the home.</p> <p>4.How the corrective action will be monitored toensure the deficient practice will not recur (ie what quality assurance programwill be put into place).</p> <p>1.This issue will be added to the list ofpreventive maintenance checks that are done monthly.</p> <p>5.By what date the systemic changes will becompleted.</p>	05/12/2016

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K S043 Bldg. 01	<p>05/02/16, the following was noted:</p> <p>a. the top two hinges to the corridor door to the northeast bedroom were pulled away from the door frame which caused the bottom of the door to hit the floor and not allow the door to self-close.</p> <p>b. the corridor door to the north bedroom door hit the door frame on the handle side of the door and prevented the door from self-closing.</p> <p>Based on interview at the time of the observations, the Staffing and Support Manager acknowledged the aforementioned corridor doors failed to self-close.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD No door in any means of escape is locked against egress when the building is occupied.</p> <p>Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5.</p> <p>Based on observations and interview, the facility failed to ensure 1 of 2 exit doors were provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. LSC 33.2.2.5.7 requires compliance with LSC 7.2.1.5.4. LSC 7.2.1.5.4 requires where a latch or other similar device is provided, the method of operation of its releasing device must be</p>	K S043	<p>1.Repair was made on 5/12/16, staff were also trained on the 12th, and the issue was added to the preventive maintenance checklist immediately.</p> <p>1.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 1. Dead bolt was replaced with a blank. Door no longer requires a 2 step release. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</p>	05/12/2016			

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K S152  Bldg. 01	<p>obvious, even in the dark. The intention of this requirement is the method of release is one familiar to the average person. Generally, a two-step release, such as a knob and independent dead-bolt is not acceptable. In most occupancies, it is important a single action to unlatch the door be present. This deficient practice affects all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Staffing and Support Manager during a tour of the facility from 12:50 p.m. to 1:15 p.m. on 05/02/16, the front door to the exterior of the facility required a two-step release process to open the door. A door handle and an independent dead bolt with a thumb twist opening device on the inside of the door was the two step release process to open the door. Based on interview at the time of the observations, the Staffing and Support Manager acknowledged the front door required a two-step release process to open the door.</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</p>		<p>taken.</p> <p>1.All exterior doors in the house were checked.</p> <p>3.What measures will be put into place or whatsystematic changes the facility will make to ensure that the deficient practicedoes not recur.</p> <p>1.Managers, Staff, and Maintenance staff have beentrained to look for this issue any time they are in the home.</p> <p>4.How the corrective action will be monitored toensure the deficient practice will not recur (ie what quality assurance programwill be put into place).</p> <p>1.This issue will be added to the list ofpreventive maintenance checks that are done monthly.</p> <p>5.By what date the systemic changes will becompleted.</p> <p>1.Repair was made on 5/12/16, staff were also trained on the 12th, and the issue was added to the preventive maintenancechecklist immediately.</p>				

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	<p>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 under varied conditions on the third shift for 3 of 4 quarters. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill" documentation with the Staffing and Support Manager during record review from 12:20 p.m. to 12:50 p.m. on 05/02/16, fire drills conducted on the third shift on 06/03/15, 09/29/15 and 03/02/16 were conducted at, respectively,</p>	K S152	<p>1. A fire drill will be conducted for 3rd shift at the Main Street group home by 5/18/16. The Manager will conduct a 3rd shift fire drill 1x every quarter thereafter. The documented fire drills will be kept in the fire/tornado drill binder and will be accessible to all needed parties.</p> <p>2. All residents will be assessed annually and during each evacuation drill for their ability to evacuate the home. All fire drills for the home have been completed in accordance with regulatory standards. The evacuation drills are documented on a tracking sheet for each shift and are located in the Fire/Tornado Drill binder located in the home office.</p> <p>3. The Group Home Manager and staff will receive documented training</p>	05/19/2016

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	12:06 a.m., 12:00 a.m. and 12:30 a.m. Based on interview at the time of record review, the Staffing and Support Manager acknowledged the aforementioned third shift fire drills were not conducted under varied conditions.		regarding the regulatory requirements for evacuation drills. The Group Home Manager and QIDP will assign designated times and dates for drills to occur and monitor the completion and documentation of each drill. 4. PQI has added a new indicator to monitor fire drills compliance for greater oversight and monitoring. The Damar safety committee also reviews data regarding fire and tornado drill completion and compliance. 5 Systemic changes will be completed by May 19, 2016.		