

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G206	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 4318 BADENSTRASSE JASPER, IN 47546
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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: 07/25/12</p> <p>Facility Number: 000734 Provider Number: 15G206 AIM Number: 100234100</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Community Alternatives SW 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 was sprinklered. The facility has a fire alarm system with smoke</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>detection in the corridors, sleeping rooms, and common living areas. The facility has a capacity of eight and had a census of eight 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 07/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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KS046	<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 electrical outlets in 1 of 3 wet locations, such as a kitchen, were equipped with properly working ground-fault circuit-interrupter (GFCI) protection. NFPA 101, 33.2.5.1 requires utilities comply with Section 9.1. 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, the 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 could affect all clients, as well as staff and visitors.</p> <p>Findings include:</p>	KS046	The Environmental Services Manager had the two electric receptacles on the wall in the kitchen that was within two feet of the sink taken care of. The receptacle to the right of the sink which was provided with a GFCI was found to be overloaded with appliances plugged into it causing it to amp, tripping the test button. One appliance was moved to another plug returning the GFCI to normal load and use. A GFCI was installed to the left of the sink, ensuring compliance with LSC Standards.	08/08/2012			

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	Based on observation on 07/25/12 at 11:10 a.m. during a tour of the facility with the Properties Coordinator, the kitchen had two electric receptacles on the wall within two feet of the sink. The receptacle to the right of the sink was provided with a GFCI receptacle, however, the test button on the receptacle could not be depressed, furthermore, the circuit did not break when tested with a GFCI tester. The receptacle to the left of the sink was not provided with a GFCI receptacle and there was no GFCI breaker in the breaker box. This was acknowledged by the Properties Coordinator at the time of observation.				

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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 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> <p>Based on record review and interview, the facility failed to ensure there was a correct and complete fire safety plan in place, furthermore, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients. This deficient practice could affect all clients.</p>	KS147	The Administration has put into effect a plan that the QA Team will oversee/ ensuring that the Operations Manager SGL, instructs the Program Coordinator periodically in the event of fire, so that staff responses are well informed with respect to their duties and responsibilities whenever any resident with unusual needs is admitted to the home. QA will follow up with the Program Coordinator / staff on a monthly basis, ensuring that documentation / drills are done. Also that required documentation is turned in and meets Life Safety Code Safety Standards. This will ensure the safety of 8 of 8 clients and all staff.	08/24/2012	

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	<p>Findings include:</p> <p>Based on record review on 07/25/12 at 10:45 a.m. with the Properties Coordinator present, the facility's "ADDENDUM TO FIRE DRILL PROCEDURE" was very vague, a bit contradictory, and written in a way to have staff determine the size of a fire. At "B. Suppression" it said "Your first priority is the safety of the individuals. Call the fire department first. If the fire is small enough to fight (lower than your waist,) use the fire extinguisher to put it out. If you have any doubt that you can fight the fire for any reason, call 911 immediately and evacuate the home." Several of the following issues of the ADDENDUM TO FIRE DRILL PROCEDURE were not included, but not limited to: Lack of R.A.C.E. (Rescue, Alarm, Contain, and Evacuate and/or Extinguish) with more detail. Use of alarms, response to alarms, more in depth on isolation of fire, more in depth on evacuation of facility to areas of refuge. Also, the Properties Coordinator said employees are not instructed and</p>						

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	kept informed with respect to their duties and responsibilities under a plan for special staff response, including fire protection procedures needed to ensure the safety of any client. The facility was lacking written documentation of fire drills for the first shift (day) during the second quarter of 2012, and the second shift (evening) during the third quarter of 2011.			

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KS152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(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 -</p> <p>(i) Actually evacuate clients during at least 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.</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 2 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of the facility's</p>	KS152	The Operations Manager SGL will develop and implement a process for evaluating all emergency drills under varied conditions. The drills will be completed by the Program Coordinator with input from the home staff. The drills will be completed by the Program Coordinator with input from the home staff. The drills will be kept on file in the home and a copy in the Quality Assurance Office. This will ensure the safety of all	08/24/2012			

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	<p>fire drills in the Emergency Evacuation Drills book on 07/25/12 at 10:30 a.m. with Properties Coordinator present, the facility lacked documentation fire drills were conducted during the following shifts and quarters:</p> <p>a. First shift (day) of the second quarter (April, May, and June) of 2012.</p> <p>b. Second shift (evening) of the third quarter (July, August, and September) of 2011. There was a documented fire drill for 08/17/11 during the second shift of the third quarter of 2011, however, the fire drill had a time of 11:40 with no a.m. or p.m. included.</p> <p>Based on interview at the time of record review, the Properties Coordinator acknowledged the lack of documented fire drills during the previously mentioned shifts and quarters, furthermore, the Properties Coordinator indicated the time of 11:40 regardless of a.m. or p.m. was not a second shift fire drill, it had to be either a first or third shift fire drill.</p>		<p>the clients in the facility. The Operations Manager SGL will periodically review the homes files to ensure the to ensure the drills and evaluations are completed. To meet the requirement of the NFPA Life Safety Code.</p>				