

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
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NAME OF PROVIDER OR SUPPLIER TANGRAM INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 GREENBROOK DR GREENFIELD, IN 46140
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K 000 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: 03/04/15</p> <p>Facility Number: 000846 Provider Number: 15G328 AIM Number: 100243990</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Tangram 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 was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 6 and had a census of 6 at the</p>	K 000		

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 130 Bldg. 01	<p>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 Slow with an E-Score of 3.96.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/06/15.</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 3 of 3 portable fire extinguishers were inspected at least monthly and the inspections were documented for 11 of 12 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 Extinguishers, Chapter 4-3.4.2 requires at</p>	K 130	Staff conduct monthly safety fire drills at the home. During these drills, staff will now be required to check the portable fire extinguishers and document said checks on the accompanying tags. In order to ensure that these monthly checks occur, the Program Manager will conduct routine audits of the safety fire drill documentation and the portable fire extinguisher tags. Program Manager will correct any instances of staff failure to complete the proper checks. In a further effort to ensure compliance, the Program	04/03/2015

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	<p>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 03/04/15 from 11:15 a.m. to 12:50 p.m., service and inspection tags for the portable fire extinguishers located in the staff office, the living room, and the laundry room each bore a service inspection tag indicating the most recent annual inspection was 03/14/14, but no monthly checks were documented on the inspection tags for April, May, June, July, August, September, October, November, December of 2014, and January and February of 2015. 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 inspections from April 2014 through</p>		<p>Manager will document the aforementioned audits on a spreadsheet that can then be reviewed by the Director of Compliance and Risk Management during her internal on-site audits. The Director of Compliance and Risk Management will also review this documentation during her quarterly internal on-site audits.</p>		

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K 046 Bldg. 01	<p>February 2015. This was acknowledged by the home manager at the exit conference on 03/04/15 at 12:50 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 6 of 11 rooms were not using electrical extension cords as a substitute for fixed wiring. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations and interview on 03/04/15 during a tour of the facility with the home manager from 11:15 a.m. to 12:50 p.m., the north client sleeping room #2, the north client sleeping room #1, the living room, the staff office, and the south client sleeping room #3 each had a ten foot long thin wired brown or</p>	K 046	The Program Manager at the home has already removed the extension cords and plugged applicable items into fixed outlets in the walls. To ensure that this does not recur, the Program Manager will discuss with staff the importance of not using extension cords in the home. In addition, the Director of Compliance and Risk Management will review safety issues at the home during her quarterly internal on-site audits.	04/03/2015	

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K 147 Bldg. 01	<p>white extension cord in use to power television sets, lights, and a refrigerator. This was verified by the home manager at the time of observations and at the exit conference on 03/04/15 at 12:50 p.m.</p> <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 administration failed to periodically instruct and keep employees informed with respect to their duties and responsibilities under the written emergency plan not less than every 2 months to protect 6 of 6 clients. A copy of the plan is readily available at all times within the facility. This deficient practice</p>	K 147	Staff conduct monthly safety fire drills at the home. In order to ensure that these monthly drills occur as required, the Program Manager will conduct routine audits of the safety fire drill documentation. Additionally, each client has an Individual Emergency Preparedness Plan (IEPP), which includes any special instructions for fire	04/03/2015			

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	<p>would affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on record review of the Emergency Safety Skills Drill Reports on 03/04/15 at 11:15 a.m. with the home manager, the only documentation indicating employees were periodically instructed and kept informed with respect to their duties and responsibilities were the Emergency Safety Skills Drill Reports. Based on a review of Emergency Safety Skills Drill Reports with the home manager on 03/04/15 at 11:15 a.m., there was a period of four months between fire drills dating from the fire drill conducted on 10/22/14 at 1:30 a.m. to the fire drill conducted on 02/23/15 at 12:20 p.m. Based on an interview with the home manager on 03/04/15 at 11:25 a.m., the home manager indicated there was no other documentation available for review to indicate employees were periodically instructed and kept informed with respect to their duties and responsibilities between the four month period dating from 10/22/14 and 02/23/15. The lack of two month updates for employees during the period between 10/22/14 and 02/23/15 was acknowledged by the home manager at the exit conference on 03/04/15 at 12:50 p.m.</p>		<p>procedures. Staff are required to review these instructions at least every other month. In the home, there is a review sheet that staff sign to document their review.</p> <p>These documents are maintained separately from the fire drill documentation and may not have been reviewed by the Surveyor. The Program Manager will also review these IEPPs and the review sign-off sheet to ensure that staff have reviewed at least every two (2) months. In a further effort to ensure compliance, the Program Manager will document the aforementioned audits on a spreadsheet that can then be reviewed by the Director of Compliance and Risk Management during her internal on-site audits. The Director of Compliance and Risk Management will also review this documentation during her quarterly internal on-site audits. Finally, staff will be instructed to fax the completed drill forms to the Director of Compliance and Risk Management after the drills have been done. Staff will then be required to enter the drill information into Tangram's internal client database, CASPer. Monthly reviews of CASPer will be done to ensure that safety fire drills are completed in a timely manner.</p>		

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K 152 Bldg. 01	<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 - (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 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 quarterly on each shift for 4 of the last 4 calendar quarters and 3 of 3 shifts over the past year. This deficient practice could affect all clients.</p> <p>Findings include:</p>	K 152	Staff conduct monthly safety fire drills at the home. In order to ensure that these monthly drills occur as required, the Program Manager will conduct routine audits of the safety fire drill	04/03/2015	

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	Based on a review of Fire Drill Reports on 03/04/15 with the home manager at 11:15 a.m., there was no record of a fire drill conducted on first, second, and third shift for the first quarter of the year 2014 or 2015, a third shift fire drill for the third quarter of the year 2014, or a first and second shift fire drill for the fourth quarter of the year 2014. This was verified by the home manager at the time of record review and the home manager confirmed there were no other records to indicate the missed fire drills were conducted at the exit conference on 03/04/15 at 12:50 p.m.		documentation. Additionally, each client has an Individual Emergency Preparedness Plan (IEPP), which includes any special instructions for fire procedures. Staff are required to review these instructions at least every other month. In the home, there is a review sheet that staff sign to document their review. These documents are maintained separately from the fire drill documentation and may not have been reviewed by the Surveyor. The Program Manager will also review these IEPPs and the review sign-off sheet to ensure that staff have reviewed at least every two (2) months. In a further effort to ensure compliance, the Program Manager will document the aforementioned		

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