

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 Certification Survey and Environmental Preoccupancy survey for a temporary replacement home was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(J).</p> <p>Survey Date: 04/13/12</p> <p>Facility Number: 000617 Provider Number: 15G073 AIM Number: 100233770</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code and Environmental Preoccupancy survey, Easter Seals ARC of Northeast Indiana 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 and with 410 IAC 9,</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(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
	<p><b>Community Residential Facilities for Persons with Developmental Disabilities.</b></p> <p>The two story facility with a basement was not sprinklered. The facility has smoke detectors that are interconnected with smoke detection on all levels including the corridors, common living areas and the sleeping rooms. The facility has a capacity of 8 and had a census of 8 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 Slow with an E-Score of 4.5.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/19/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(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
KS018	<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>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.</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 sleeping room doors would self close and latch into the door frame. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Technician # 1 and the Qualified Developmental Disabilities Professional on 04/13/12 from 11:50 a.m. to 12:28 p.m., all five sleeping room doors lacked a self closing device. Additionally, the first floor west sleeping room door was a pocket type door that slide into the wall. This door did not latch into the door frame. Also, the second</p>	KS018	<p>A designated fire watch person has been implemented as of 4/13/12. This individual has no client responsibilities or other duties. This individual monitors the home's interior and exterior and documents accordingly on a fire watch checklist every 15 minutes. The fire watch person is in place at all times client(s) are present. The checklist is monitored by the supervisor. All clients will be relocating to apartments at the IPFW student housing campus located at 4110 Crescent Avenue building H Fort Wayne IN 46815. The relocation date is scheduled for May 9 th , 2012. We will be renting two apartment units. Each unit has 4 bedrooms and 2 bathrooms, a living area and kitchen. One unit will house the female clients and the other will house the male clients. BDDS has been notified and a temporary license will be issued. F1's will be updated. An</p>	05/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	floor southeast sleeping room door could not be closed. Based on an interview with Maintenance Technician # 1 at the time of observation, she believes the house must have shifted causing the door to hit the door frame.		evacuation plan will be in place at the time of the move. All clients will participate in a fire and tornado drill within 24 hours of the move. A fire extinguisher will be placed in the kitchen. Person responsible: Director of Residential Services Completion date: 5/9/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(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
KS020	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Interior stairs are enclosed with ½ hour fire barriers, with all openings equipped with smoke-actuated automatic closing or self-closing doors having a fire protection rating comparable to that required for the enclosure. Stairs comply with 7.2.2.5.3. The entire primary means of escape is arranged so that it is not necessary for the occupants to pass from all spaces on that story by construction having not less than a ½ hour fire resistance rating. In buildings of construction other than Type II (000), Type III (200), or Type V (000), the supporting construction is protected to afford the required fire resistance rating of the supported wall. 33.2.2.4.</p> <p>Exception No. 1: Stairs that connect a story at street level to only one other story are permitted to be open to the story that is not at street level.</p> <p>Exception No. 2: Stair enclosures are not required in buildings of three or fewer stories that house prompt or slow evacuation capability facilities protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick response or residential sprinklers. This exception is permitted only if a primary means of escape from each sleeping area still exists that does not pass through a portion of a lower floor, unless that route is separated from all spaces on that floor by construction having a ½ hour fire resistance rating.</p> <p>Exception No. 3: Stair enclosures are not required in buildings of two or fewer stories that house prompt evacuation capability</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(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
	<p>facilities with not more than eight residents and are protected by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick-response or residential sprinklers. Exception No. 2 to 33.2.2.3 is not used in conjunction with this exception. The exceptions to 33.2.3.4.3 are not used in conjunction with this exception.</p> <p>Exception No. 4: In buildings of three or fewer stories that house prompt or slow evacuation capability facilities protected by an approved automatic sprinkler system in accordance with 33.2.3.5, stairs are permitted to be open at the top most story only. The entire primary means of escape of which the stairs are a part is separated from all portions of lower stairs.</p> <p>IMPRACTICAL Vertical openings are protected so as not to expose a primary means of escape. Vertical openings are considered protected if separated by smoke partitions in accordance with 8.2.4 that prevent the passage of smoke from one story to any primary means of escape on another story. Smoke partitions have a fire resistance rating of not less than ½ hour. Any doors or openings to the vertical opening are capable of resisting fire for not less than 20 minutes. 32.3.1.1, 33.2.3.1.1</p> <p>Exception: Stairs are permitted to be open where complying with Exception No. 2 or Exception No. 3 to 32.2.2.4 and 33.2.2.4.</p> <p>Based on observation and interview, the facility failed to enclose 1 of 2 interior stairs was enclosed in one half hour construction with self closing</p>	KS020	A designated fire watch person has been implemented as of 4/13/12. This individual has no client responsibilities or other duties. This individual monitors the home's interior and exterior and documents accordingly on a	05/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  04/13/2012
NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815		
(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	
	<p>doors. This deficient practice could affect any client evacuated from the second floor and any clients near the stairs during an emergency situation.</p> <p>Finding include:</p> <p>Based on observation with Maintenance Technician # 1 and the Qualified Developmental Disabilities Professional on 04/13/12 at 12:05 p.m., the set of stairs leading to the second floor lacked a door at either the top or bottom of the stairs. Additionally, the bottom section was an open to the living room without construction having a half hour fire resistance rating. This was acknowledged by Maintenance Technician # 1 at the time of observation.</p>		<p>fire watch checklist every 15 minutes. The fire watch person is in place at all times client(s) are present. The checklist is monitored by the supervisor. All clients will be relocating to apartments at the IPFW student housing campus located at 4110 Crescent Avenue building H Fort Wayne IN 46815. The relocation date is scheduled for May 9 th , 2012. We will be renting two apartment units. Each unit has 4 bedrooms and 2 bathrooms, a living area and kitchen. One unit will house the female clients and the other will house the male clients. BDDS has been notified and a temporary license will be issued. F1's will be updated. An evacuation plan will be in place at the time of the move. All clients will participate in a fire and tornado drill within 24 hours of the move. A fire extinguisher will be placed in the kitchen. Person responsible: Director of Residential ServicesCompletion date: 5/9/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  04/13/2012
NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815		
(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	
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>1. Based on observation and interview, the facility failed to ensure 1 of 3 wet location client care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all 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 where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any client in the kitchen near the sink.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Technician # 1 and</p>	KS046	<p>A designated fire watch person has been implemented as of 4/13/12. This individual has no client responsibilities or other duties. This individual monitors the home's interior and exterior and documents accordingly on a fire watch checklist every 15 minutes. The fire watch person is in place at all times client(s) are present. The checklist is monitored by the supervisor. All clients will be relocating to apartments at the IPFW student housing campus located at 4110 Crescent Avenue building H Fort Wayne IN 46815. The relocation date is scheduled for May 9 th , 2012. We will be renting two apartment units. Each unit has 4 bedrooms and 2 bathrooms, a living area and kitchen. One unit will house the female clients and the other will house the male clients. BDDS has been notified and a temporary license will be issued. F1's will be updated. An evacuation plan will be in place at the time of the move. All clients will participate in a fire and tornado drill within 24 hours of the move. A fire extinguisher will be placed in the kitchen. A work order has been submitted to replace two kitchen outlets with GFCI receptacles. A surge protector will be purchased to replace the extension cord that</p>	05/09/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  04/13/2012	
NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST				STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815			
(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			
	<p>the Qualified Developmental Disabilities Professional on 04/13/12 at 11:35 a.m., the kitchen had two electrical receptacles on the wall within three feet of the sink. After looking in the breaker box, Maintenance Technician # 1 confirmed the two receptacles lack GFCI protection.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords, such as an extension cord was not used as a substitute for fixed wiring. LSC 33.2.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all clients in the living room in the event of an emergency.</p> <p>Findings include:</p>		was in use powering the VCR/DVD player. Person responsible: Director of Residential Services Completion date: 5/9/12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Based on an observation with Maintenance Technician # 1 and the Qualified Developmental Disabilities Professional on 04/13/12 at 11:50 a.m., a regular light weight extension cord was in use and providing power for a VCR/DVD player in the living room. This was confirmed by Maintenance Technician # 1 at the time of observation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  04/13/2012
NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815		
(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	
KS051	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on observation and interview, the facility failed on ensure 1 of 1 fire alarm systems with interconnected smoke detectors had at least one manual fire alarm box per floor. This deficient practice could affect all occupants.</p> <p>Finding include:</p> <p>Based on observation with Maintenance Technician # 1 and the Qualified Developmental Disabilities Professional (QDDP) on 04/13/12 at 12:20 p.m., the facility lacked a manual fire alarm box on all levels of the house. This was confirmed by Maintenance Technician # 1 at the time of observations.</p>	KS051	<p>A designated fire watch person has been implemented as of 4/13/12. This individual has no client responsibilities or other duties. This individual monitors the home's interior and exterior and documents accordingly on a fire watch checklist every 15 minutes. The fire watch person is in place at all times client(s) are present. The checklist is monitored by the supervisor. All clients will be relocating to apartments at the IPFW student housing campus located at 4110 Crescent Avenue building H Fort Wayne IN 46815. The relocation date is scheduled for May 9 th , 2012. We will be renting two apartment units. Each unit has 4 bedrooms and 2 bathrooms, a living area and kitchen. One unit will house the female clients and the other will house the male clients. BDDS has been notified and a temporary license will be issued. F1's will be updated. An</p>	05/09/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(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
			evacuation plan will be in place at the time of the move. All clients will participate in a fire and tornado drill within 24 hours of the move. A fire extinguisher will be placed in the kitchen. Person responsible: Director of Residential Services Completion date: 5/9/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(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
KS120	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In addition to the primary route, each sleeping room in facilities that use Exception No. 1 to 32.2.3.5.1 has a second means of escape that consists of one of the following:</p> <p>(a) It is a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape.</p> <p>(b) It is a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to an approved means of escape.</p> <p>(c) It is an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 sq. ft. The width is not less than 24 inches. The bottom of the opening is not more than 44 inches above the floor. Such means of escape is acceptable where one of the following criteria are met:</p> <p>(1) The window is within 20 ft of grade.</p> <p>(2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.</p> <p>(3) The window or door opens onto an exterior balcony. 33.2.2.3</p> <p>Exception No. 1: If the sleeping room has a door leading directly to the outside of the building with access to grade or to a stairway that meets the requirements of exterior stairs in 33.2.3.1.2, that means of escape is considered as meeting all the escape</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(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
	<p>requirements for the sleeping room.</p> <p>Exception No. 2: A second means of escape from each sleeping room is not required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.</p> <p>Exception No. 3: Existing approved means of escape is permitted to continue to be used.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 client sleeping rooms was provided with a secondary means of escape. This deficient practice could affect 2 of 8 clients.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Technician # 1 and the Qualified Developmental Disabilities Professional on 04/13/12 at 11:55 a.m., the two windows designed to open in the first floor west sleeping room measured eighteen inches wide. Measurements were provided by Maintenance Technician # 1 at the time of observation.</p>	KS120	<p>A designated fire watch person has been implemented as of 4/13/12. This individual has no client responsibilities or other duties. This individual monitors the home's interior and exterior and documents accordingly on a fire watch checklist every 15 minutes. The fire watch person is in place at all times client(s) are present. The checklist is monitored by the supervisor. All clients will be relocating to apartments at the IPFW student housing campus located at 4110 Crescent Avenue building H Fort Wayne IN 46815. The relocation date is scheduled for May 9 th , 2012. We will be renting two apartment units. Each unit has 4 bedrooms and 2 bathrooms, a living area and kitchen. One unit will house the female clients and the other will house the male clients. BDDS has been notified and a temporary license will be issued. F1's will be updated. An evacuation plan will be in place at the time of the move. All clients will participate in a fire and tornado drill within 24 hours of the move. A fire extinguisher will be</p>	05/09/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G073	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 INWOOD DR FORT WAYNE, IN 46815
---	---

(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
			placed in the kitchen. Person responsible: Director of Residential Services Completion date: 5/9/12	