

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G524	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FOUR RIVERS RESOURCE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 538 S BELL ST SULLIVAN, IN 47882
---	--

(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: 02/10/12</p> <p>Facility Number: 001038 Provider Number: 15G524 AIM Number: 100245060</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Four Rivers Resource Services, 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 not 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G524	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FOUR RIVERS RESOURCE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 538 S BELL ST SULLIVAN, IN 47882
---	--

(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>detection in the corridors, sleeping rooms, and common living areas. The facility has a capacity of seven and had a census of seven 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 1.16.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/14/12.</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: 15G524		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/10/2012	
NAME OF PROVIDER OR SUPPLIER FOUR RIVERS RESOURCE SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 538 S BELL ST SULLIVAN, IN 47882			
(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			
KS147	<p>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 ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 7 of 7 residents. Such instruction is reviewed by the staff not less than every two months. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on interview during review</p>	KS147	<p>There was a written evacuation plan in place; however, it was being reviewed as often as required. Effective and beginning with the February monthly routine house meeting, the review of this evacuation plan will be done at each subsequent monthly house meeting and changes or revisions will be made, as needed, on an on-going basis. The plan, changes and revisions, and review of such will be the responsibility of the Community Living Coordinator.</p>	02/10/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G524	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FOUR RIVERS RESOURCE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 538 S BELL ST SULLIVAN, IN 47882
---	--

(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>of the facility's Fire Protection Plan on 02/10/12 at 1:30 p.m., the Qualified Mental Retardation Professional Director (QMRPD) indicated employees are instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of any resident, however, the QMRPD indicated such instructions are not reviewed by the staff every two months. The most recent review of the Fire Protection Plan by staff was on 09/02/11, and previous to that date the only time the Plan was reviewed by staff during the past twelve months was on 04/16/11. The facility was lacking written documentation of a fire drill for the second shift during the fourth quarter (October, November, and December) of 2011.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G524		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/10/2012	
NAME OF PROVIDER OR SUPPLIER FOUR RIVERS RESOURCE SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 538 S BELL ST SULLIVAN, IN 47882			
(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			
KS152	<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 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill book on 02/10/12 at 1:15 p.m. with the Qualified</p>	KS152	The Community Living Coordinator is now assigning specific shift staff to complete and document drills on certain days/months/shifts. The Coordinator will monitor the documentation to assure that these drills were complete and accurate and that there were no problems that need to be addressed further.	02/10/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G524	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FOUR RIVERS RESOURCE SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 538 S BELL ST SULLIVAN, IN 47882
---	--

(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
--------------------	--	---------------	---	----------------------

	Mental Retardation Professional Director (QMRPD) present, the facility did have fifteen documented fire drills since January of 2011, however, there was no documented fire drill conducted during the second shift (evening) of the fourth quarter (October, November, and December) of 2011. This was acknowledged by the QMRPD at the time of record review.			
--	---	--	--	--