

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2015
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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
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K 0000 Bldg. 02	<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: 04/29/15</p> <p>Facility Number: 000818 Provider Number: 15G299 AIM Number: 100234990</p> <p>At this Life Safety Code survey, Opportunity Enterprises, 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 with a basement was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in client sleeping rooms and in common 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		

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. 02	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.64.</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> <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</p>			

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	<p>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 and interview, the facility failed to ensure 1 of 3 sleeping room doors were capable of resisting smoke for at least 1/2 hour. LSC 8.2.3.2.1(a) states door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with NFPA 80, Standard for Fire Doors and Fire Windows. NFPA 80, Standard for Fire Doors and Fire Windows, 1999 Edition, states the clearance under the bottoms of doors shall be in accordance with Table 1-11.4. Table 1-11.4 states the maximum clearance for a fire rated swinging door with fire hardware shall be 3/4 inch between the bottom of the door and the floor where no sill exists. This deficient practice could affect at least two clients</p>	K S017	<p>The aforementioned door will be replaced with a 30 minute fire resistant door, which will be installed with no greater than a 3/4 of an inch gap at the bottom threshold. To ensure this deficient practice does not reoccur, the Group Home Director will monitor this, along with other life safety codes, in a monthly facility check. Documentation of these facility checks will be maintained by the Group Home Director or the Executive Assistant.</p>	05/29/2015

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K S053 Bldg. 02	<p>and staff.</p> <p>Findings include:</p> <p>Based on observations with the Director of Group Homes during a tour of the facility from 9:00 a.m. to 10:45 a.m. on 04/29/15, a one and 1/2 inch clearance was noted in the twenty minute fire rated swinging lower level door bedroom door between the bottom of the door and the floor where no sill exists. Based on interview at the time of the observations, the Director of Group Homes acknowledged the clearance at the bottom of the aforementioned bedroom door was greater than 3/4 inch and was not enclosed with a separation of twenty minute fire resistive construction.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms are powered from the building electrical system and when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms are installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3.</p> <p>Exception No 1: Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with</p>			

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	<p>approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system.</p> <p>Exception No. 2: Where buildings are protected throughout by an approved automatic sprinkler system, in accordance with 32.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms.</p> <p>Based on record review and interview, the facility failed to ensure the smoke detector sensitivity test documentation for 10 of 10 smoke detectors was up to date. LSC 9.6.2.10.1 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 7-3.2 requires testing be accordance with Table 7-3.2 Testing Frequencies. Table 7-3.2 at 7-3.2.15(i) Smoke Detectors - Sensitivity (The requirements of 7-3.2.1 shall apply). NFPA 72, at 7-3.2.1 states Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended,</p>	K S053	<p>On May 6th, a sensitivity inspection was completed by Shambaugh and Sons fire protection company. To ensure this deficient practice does not reoccur, the Group Home Director or the Executive Assistant will monitor all record and documentation of any fire alarm system checks and sprinkler system checks, performed by Shambaugh and Son, or any other contracted fire protection company. In addition, the Group Home Director will monitor this, along with other life safety codes, in a monthly facility check. Documentation of these facility checks will be maintained by the Group Home Director or the Executive Assistant.</p>	05/28/2015

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	<p>records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method, (2) Manufacturer's calibrated sensitivity test instruments (3) Listed control equipment arranged for the purpose, (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside the listed sensitivity range, (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or be replaced.</p> <p>NOTE: The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p> <p>This deficient practice could affect all clients, staff, and visitors.</p>			

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K S152 Bldg. 02	<p>Findings include:</p> <p>Based on interview during record review with the Director of Group Homes on 04/29/15 at 10:15 a.m., the most recent smoke detector sensitivity test documentation available to review occurred 01/11/13. The Director of Group Homes acknowledged the 01/11/13 smoke detector sensitivity test documentation had occurred more than two years ago and was not up to date.</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 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</p>			
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	<p>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 1 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> <p>Based on a review of Fire Drill Reports on 04/29/15 with the Director of Group Homes at 9:45 a.m., there was no record of fire drills conducted on first, second, and third shift for the 3rd quarter of 2014. This was verified by the Director of Group Homes at the time of record review and the Director of Group Homes confirmed there were no other records to indicate the missed fire drills were conducted.</p>	K S152	Evacuation drills will be conducted a minimum of once per quarter for each shift. The GHM will schedule these drills and see that they are completed. Once a drill is conducted, the drill form will be signed by the staff on shift and will include information on the client's in the home as far as their level of participation/assistance required in the dill. Once these forms are completed,they will be turned into the Executive Assistant to Programs. She/he will add this drill tracking to a checklist of monthly action items and will ensure that all drills are conducted within the regulatory timeframes.	05/18/2015			