

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G665	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/08/2014
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NAME OF PROVIDER OR SUPPLIER  LIFE DESIGNS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2701 FAIRLAWN AVE COLUMBUS, IN 47203
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K010000	<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: 10/08/14</p> <p>Facility Number: 001115 Provider Number: 15G665 AIM Number: 100235410</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Life Designs 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 two story facility with a basement was fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, common living areas, and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 7 and had a census of 7 at the</p>	K010000		

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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K01S018	<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 Prompt with an E-Score of 1.15.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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 1 of 5 sleeping room doors was provided with a latch or other mechanism suitable for keeping the door closed. This deficient practice</p>	K01S018	To correct the deficient practice, the door frame will be fixed to include latching hardware. To ensure the deficient practice does not continue, the Maintenance Supervisor will train the Team Manager and Network	11/07/2014

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K01S147	<p>could affect two clients who reside in the first basement client sleeping room.</p> <p>Findings include:</p> <p>Based on observation with the home manager on 10/08/14 at 1:45 p.m., the first basement client sleeping room door lacked latching hardware which prevented the door from latching into the door frame. This was verified by home manager at the time of observation and acknowledged at the exit conference on 10/08/14 at 2:00 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,</p>	K01S147	<p>Director(ND)/ QDDP on procedures related to maintenance requests. To provide ongoing monitoring, the Team Manager will include all household maintenance needs on the TM Weekly Report, which is submitted to the ND/Q and CEO for review. The Maintenance Supervisor and Quality Assurance Director fill do spot inspections as part of the irregular checks of all residences. The CEO will meet regularly with the maintenance supervisor to ensure all identified needs are resolved.</p> <p>To correct the deficient practice,</p>	11/07/2014	

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	<p>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 7 of 7 clients. A copy of the plan is readily available at all times within the facility. This deficient practice would affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on record review of the Fire Drill Reports on 10/08/14 at 1:00 p.m. with the home manager, there was a two month lapse in documentation indicating employees were periodically instructed and kept informed with respect to their duties and responsibilities under the fire plan between fire drills conducted on 03/18/14 and 06/26/14, and between 04/09/14 and 09/17/14. Based on an interview with the home manager on 10/08/14 at 1:20 p.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 under the Fire Drill Procedure Policy every two months other than the Fire Drill Reports and it was acknowledged the facility had missed a number of fire drills over the past year.</p>		<p>the emergency plan will be available in the home, and staff will review their duties and responsibilities related to this at least every other month at a staff meeting. The Life Safety book in the home will be updated to include a training documentation section. To prevent the deficient practice from recurring, the TM will check all LifeSafety documentation as part of the TM Weekly Report, which is reviewed with the ND/Q and submitted to the CEO. The Maintenance Supervisor and Quality Assurance Director fill do spot inspections as part of their regular checks of all residences.</p>				

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K01S152	<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 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 3 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>	K01S152	To correct the deficient practice, a drill schedule has been posted. Staff will be provided additional training related to the timeframes in which drills must be completed. To ensure the deficient practice does not continue, the Team Manager will complete a weekly report that summarizes events for each customer in the home,	11/07/2014			

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	Based on a review of Fire Drill Reports on 10/08/14 at 1:00 p.m. with the home manager, there was no record of a fire drill conducted on first shift and third shift for the first quarter of the year 2014, third shift for the second quarter of the year 2014, and first shift and second shift for the third quarter of the year 2014. This was verified by the home manager at the time of record review and acknowledged at the exit conference on 10/08/14 at 2:00 p.m.		including completed drills, as well as any needed follow up. The Team Manager, ND/Q will meet weekly at the home to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns. The ND/Q will complete a quarterly Quality Assurance Review to ensure all drills in the home are current. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. The QAD report is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors.		