STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 05/12/2014
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150	

(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
K010000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 05/12/14 Facility Number: 000939 Provider Number: 15G425 AIM Number: 100368660 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Quality Community 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. This two story facility with a basement was not sprinkled. The facility has a fire alarm system with smoke detection on all levels including the basement, in the corridors, in common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 8 and had a census of 7 at the	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 15G425	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY COMMUNITY SERVICES INC	1620 SHELBY PL NEW ALBANY, IN 47150

(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
	time of this survey. 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 0.35. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/15/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K01S148	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1 Based on observation and interview, the facility failed to provide a metal container with a self closing cover for 1 of 1 areas where smoking is permitted. This deficient practice could affect all clients in the facility. Findings include: Based on observation of the back porch exit smoking location on 05/12/14 at 10:40 a.m. with the director of	K01S148	Quality Community has installed a new metal container with aself closing cover for staff to deposit cigarettes appropriately. The home manager will monitor for maintenanceand upkeep of this container weekly. Thehome manager reports weekly to the Director of Operation with any maintenanceor purchase requests.	05/27/2014

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	community services, the back porch outside smoking location was provided with a clay pot ashtray which was full of discarded cigarette material, but lacked a metal container with a self closing cover for discarded smoking material. This was verified by the director of community services at the time of observation and acknowledged at the exit conference on 05/12/14 at 11:00 a.m.			