

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G403	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2015
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NAME OF PROVIDER OR SUPPLIER  DAMAR SERVICES INC--BRADFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 8835 E CR 200 S AVON, IN 46168
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K 0000  Bldg. 01	<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: 05/14/15</p> <p>Facility Number: 000917 Provider Number: 15G403 AIM Number: 100249320</p> <p>At this Life Safety Code survey, Damar Services Inc.-Bradford 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 building with a basement was determined to be nonsprinklered. The facility has a monitored fire alarm system with smoke detection on all levels in corridors, in bedrooms and all living areas. 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</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 0130 Bldg. 01	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Impractical with an E-Score of 6.7.</p> <p>Based on record review, observation and interview; the facility failed to ensure the building was protected throughout by an approved, supervised automatic sprinkler system. LSC 33.2.3.5.3 states all impractical evacuation facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5.2. This deficient practice could affect all clients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Safety Survey - 2000 Life Safety Code Worksheet for Rating Residents F-1" forms during record review with the Home Manager from 9:40 a.m. to 10:50 a.m. on 05/14/15, the resident evacuation capability for the facility was rated as " Impractical ". Based on interview at the time of record review, the Home Manager stated evacuation capability scoring on "F-1" forms were correctly</p>	K 0130	<p>1. During the last year –there were several discharges and admissions within the home that resulted in anew total F-1 score. Admits added all had significant lower F-1 rating(unknown until after admission). A new protocol has been added to assessing individuals referred for placement. Protocol includes during the replacement visits two fire drill assessments will be completed. One will be during awake time and the other during sleep time and an F-1 will be completed to gather a general idea of ones ability. Those with high rating will be assessed to determine if training should be done to improve one's score and/or if this is likely the functioning level of the person. The results will help determine if individual is appropriate for placement within the staffing ratio present. In addition to this – F-1 rating will be completed by the IDT instead of the Residential Manager. Clarification on rating for the "risk factors" have been discussed with all team members to and now a better understanding of the</p>	06/13/2015

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	completed for each resident, one staff member is present on the overnight shift from 11:30 p.m. to 7:30 a.m. and acknowledged the resident evacuation capability for the facility was rated as " Impractical " . Based on observations with the Home Manager during a tour of the facility from 10:50 a.m. to 11:20 a.m. on 05/14/15, the building was not protected throughout by an approved, supervised automatic sprinkler system for an Impractical rated evacuation capability facility. Based on interview at the time of the observations, the Home Manager acknowledged the facility is not protected throughout by an approved, supervised automatic sprinkler system for an impractical rated evacuation capability facility.		<p>scores is known. F-1 scores at timeof survey were incorrect and have been corrected and Client A has been discharged. It is anticipated thatoverall score does not indicateimpractical but does require two staff present on 3rd shift. Additional staff has been hired.</p> <p>2. All Homes F-1rating was reviewed to compare to this home to determine if increased staffingwas needed. None indicated a need to adjust staffing on 3rdshift.</p> <p>3. Clarifications onrating for the "risk factors" have been discussed with all team members and nowa better understanding of how to scores is known. Individuals visitingduring preplacement will participate in two fire drill assessments. Onewill be during awake time and the other during sleep time and an F-1 will be completedto gather a general idea of ones ability. Those with high rating will beassessed to determine if training should be done to improve one's score and/orif this is likely the functioning level of the person. The results willhelp determine if individual is appropriate for placement within the staffingratio present.</p> <p>4. All F-1worksheets will be completed by the IDT upon considering a new admission andquarterly on all residents to asses the overall scores of a home. Staffing will be adjusted if</p>		

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K S014 Bldg. 01	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Interior wall and ceiling finish is Class A or Class B in accordance with section 10.2, 33.2.3.2. There are no requirements for interior floor finish.</p> <p>Exception: Class C interior wall and ceiling finish is permitted in prompt evacuation capability facilities.</p> <p>Based on record review, observation and interview; the facility failed to ensure the interior finish in 1 of 1 family rooms was rated Class A or Class B. This deficient practice could affect all clients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Home Manager from 9:40 a.m. to 10:50 a.m. on 05/14/15, documentation of the flame spread rating for interior finishes in the facility was not available for review.</p> <p>Based on observation with the Home Manager during a tour of the facility from 10:50 a.m. to 11:20 a.m. on 05/14/15, wood paneling from the floor to three feet high was noted on the wall of the family room by the garage. Based on interview at the time of record review and of observation, the Home Manager was unaware if the wood paneling was</p>			K S014	<p>scores indicate a significant lower overall score than in previous years.</p> <p>1. The wood panel has been treated and a file will be kept within the house for documentation.</p> <p>2. All homes have been assessed to verify that wood panel does not exist within the homes. Any homes that has panel will have documentation of fire retardant treatment present in the home. There are no other homes with wood panel.</p> <p>3. Any wood decoration or panel added to the homes will be treated with approved fire retardant solution. Documentation of the treatment is kept within a file in the home.</p> <p>4. We have included "checking fire retardant" file on the quarterly House Environment checklist. The checklist is completed by the Lead staff and/or Residential Manager. Missing documentation will be replaced within 48 hours. Dir. Of Maintenance will have a copy of all fire retardant files.</p>		06/13/2015

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K S020 Bldg. 01	<p>treated with a fire retardant material and acknowledged there was no documentation available to show the flame spread rating for the wood paneling was Class A or Class B.</p> <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</p>			

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	<p>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 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</p>			

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K S021  Bldg. 01	<p>Exception No. 3 to 32.2.2.4 and 33.2.2.4. Based on observation and interview, the facility failed to ensure 1 of 2 vertical openings was protected so as not to expose a primary means of escape to the passage of smoke and was capable of resisting fire for at least 1/2 hour. This deficient practice affects all staff, clients, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Home Manager during a tour of the facility from 10:50 a.m. to 11:20 a.m. on 05/14/15, the vertical opening or stairway from the main floor to the second floor was not separated by a smoke partition to prevent the passage of smoke. Based on interview at the time of observation, the Home Manager acknowledged the aforementioned stairway lacked separation by a smoke partition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Vertical openings are protected so as not to expose a primary means of escape. Vertical opening 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</p>	K S020	<p>1.The door has been adjusted sothat the positive latch is closing and working correctly.</p> <p>2. All Group homes have been checked to ensurefire doors with positive latches are working correctly. Work order will be submitted when doors arenot latching properly.</p> <p>3.Checking to see that firedoors are latching correctly has been added to the daily envirnomentalcheck. All staff have received trainingon this addition are aware of the need to check daily. Work orders are written upon finding a doordoes not latch. Failure to correctwithin 48 hours will result in additional work order sent and submitted to Dir.ofMainteanance for completion ofcorrection by end of the day.</p> <p>4.Daily environmental house checks are completedby staff and reviewed by Residential Manager before submitting to Dir. OfMaintenance. Additional Maintenance staff members will be hired and/orwork will be contracted out to ensure timely completion of work orders.</p>	06/13/2015	

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	<p>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. 32.2.3.1.1, 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, 33.2.2.4.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 vertical openings was protected to prevent the passage of smoke and was capable of resisting fire for at least 1/2 hour. LSC 8.2.4.3.5 states doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice affects all staff, clients, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Home Manager during a tour of the facility from 10:50 a.m. to 11:20 a.m. on 05/14/15, the basement stairway door in the family room was equipped with a self closing device but the door failed to self close and latch into the frame because the door hit the frame on the door handle side which failed to prevent the passage of smoke. Based on interview at the time of observation, the Home Manager acknowledged the aforementioned</p>	K S021	<p>1.The door has been adjusted sothat the positive latch is closing and working correctly.</p> <p>2. All Group homes have been checked to ensure fire doors with positive latches are working correctly. Work order will be submitted when doors aren't latching properly.</p> <p>3.Checking to see that fire doors are latching correctly has been added to the daily environmental check. All staff have received training on this addition and are aware of the need to check daily. Work orders are written upon finding a door does not latch. Failure to correct within 48 hours will result in additional work order sent and submitted to Dir.of Maintenance for completion of correction by end of the day.</p> <p>4.Daily environmental house checks are completed by staff and reviewed by Residential Manager before submitting to Dir. Of Maintenance. Additional Maintenance staff members will be hired and/or work will be contracted out to ensure timely completion of work orders.</p>	06/13/2015	

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K S043 Bldg. 01	<p>stairwell door failed to self close and latch into the door frame.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD No door in any means of escape is locked against egress when the building is occupied.</p> <p>Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5.</p> <p>Based on observations and interview, the facility failed to ensure 2 of 5 exit doors were provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. LSC 33.2.2.5.7 requires compliance with LSC 7.2.1.5.4. LSC 7.2.1.5.4 requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release is one familiar to the average person. Generally, a two step release, such as a knob and independent dead-bolt is not acceptable. In most occupancies, it is important a single action to unlatch the door be present. This deficient practice affects all clients, staff, and visitors.</p> <p>Findings include:  Based on observations with the Home</p>	K S043	<p>1. The two exterior doors will be replaced or adjusted to include an one step process to unlock and open the door.</p> <p>2. All Group Homes have been assessed to ensure that exterior doors include only one step in the process. All homes were in compliance.</p> <p>3. Any exterior door that requires to be replaced will be purchased by the Maintenance Manager to ensure they are in compliance with one step process.</p> <p>4. All maintenance staff have been trained on this requirement.</p>	06/13/2015

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K S147  Bldg. 01	<p>Manager during a tour of the facility from 10:50 a.m. to 11:20 a.m. on 05/14/15, the front door and the kitchen exit door to the exterior of the facility each required a two step release process to open the door. A door handle and an independent dead bolt with a thumb twist opening device on the inside of the door was the two step release process to open the door. Based on interview at the time of the observations, the Home Manager acknowledged each of the aforementioned two facility exit doors required a two step release process to open the door.</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</p>						

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	<p>readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review and interview, the facility failed to ensure the written fire safety plan included adequate staffing and procedures needed to ensure the safety of any resident with unusual needs. This deficient practice could affect four clients in the facility.</p> <p>Findings include:</p> <p>Based on review of "Emergency Action Plan" documentation with the Home Manager during record review from 9:40 a.m. to 10:50 a.m. on 05/14/15, the number of staff required for resident assistance for each of three facility shifts was not stated. In addition, review of "Fire Safety Survey - 2000 Life Safety Code Worksheet for Rating Residents F-1" forms stated "Needs Limited Assistance from 2 staff" for residents identified as CM, FF, FS &amp; CC. Based on interview at the time of record review, the Home Manager stated evacuation capability scoring on "F-1" forms were correctly completed for each of the aforementioned four residents, one staff member is present on the overnight shift from 11:30 p.m. to 7:30 a.m. and acknowledged only one staff member is present in the facility on the overnight shift.</p>	K S147	<p>1. Emergency Action Plan have been replaced inthe Group Home. They are located withinthe fire drill book. All staff willreceive training on the Emergency Action Plan and will continue to receivetraining every other month. In addition,new staff hired within the homes will receive training on fire drills andemergency action plan during their observation week. Documentation of training will be kept inwithin the Fire Drill book.</p> <p>2.Residential Managers willensure that Emergency Action Plans are secure within the homes.</p> <p>3.Emergency Action Plan will bechecked quarterly within the Environmental House check. Checks are completed by Lead staff orResidential Manager and submitted to Dir. Of Group Home. Missing documents will be replaced with 48hours. All copies of emergency action arestore in notebook within the Dir. Of Maintenance office.</p> <p>4.Residential Managers havebeen retrained on the need for the Emergency Action plans to be included in thehomes .</p>	06/13/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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