STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G134	A. BUILDING -- B. WING	03/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OPPORTUNITIES INC	0170 W 300 N HOWE, IN 46746

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/07/22 Facility Number: 000671 Provider Number: 15G134 AIM Number: 100234320 At this Emergency Preparedness survey, Arc Opportunities Inc was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 03/10/22	E 0000		
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this			

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

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	section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.			

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	(2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect client health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the QIDP, Facilities Manager, and Residential Director, on 03/07/22 at 12:48 p.m., the provided plan did not address all components for subsistence needs for staff and clients. The items not addressed were emergency food/water and medical supplies, alternate sources of energy, temperatures to protect client health and safety, emergency lighting, and emergency sewage and waste disposal. Based on interview at the time of records review, the QIDP and Residential Director agreed the subsistence needs for staff and clients was not complete. The finding was reviewed with the QIDP, Facilities Manager, and Residential Director during the exit conference.	E 0015	A new subsistence needs policy has been written and implemented. It is the responsibility of the QIDP to train staff on this policy. In the future all staff will be trained on this yearly by the residential team.	04/04/2022

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E 0025 Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the			

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	continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures (EPP) include the development of arrangements with other ICF/IID facilities or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the QIDP, Facilities Manager, and Residential Director on 03/07/22 at 12:44 p.m., the EPP did not include policies and procedures for the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients. Based on interview at the time of record review, the QIDP and Residential Director agreed the EPP did not address arrangements with other ICF/IID facilities or other providers to receive clients in the event of limitations or cessation of operations. The finding was reviewed with the QIDP, Facilities Manager, and Residential Director during the exit conference.	E 0025	It is the responsibility of the QIDP to train staff on the Crisis Management and Business Continuity Plan on relocating the residents to other facilities which can be found on page 1 of this plan. In the future it will be a yearly training completed by the residential team.	04/04/2022

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E 0032 Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance	E 0032	It is the responsibility of the QIDP to train staff on the Crisis Management and Business Continuity Plan beginning on page 7. In the future it will be the	04/04/2022

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	with 42 CFR 483.475(c)(3). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the QIDP, Facilities Manager, and Residential Director, on 03/07/22 at 12:36 p.m., the EPP provided did not address primary and alternate means for communication. Based on interview at the time of records review, the Community Living Manager stated the EPP did not address primary and alternate means for communication. The finding was reviewed with the QIDP, Facilities Manager, and Residential Director during the exit conference.		responsibility of the residential team to train staff yearly.	
K 0000 Bldg. 02	A Life Safety Code Recertification was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/07/22 Facility Number: 000671 Provider Number: 15G134 AIM Number: 100234320 At this Life Safety Code survey, ARC Opportunities Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.	K 0000		

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	This one-story facility was fully sprinklered. The facility has a monitored fire alarm system with heat detection in the attic, smoke detection in the corridors, client sleeping rooms, and common living areas. Additionally, the facility has single station smoke alarms which are powered by electricity, not monitored, and not connected to the fire alarm system in the client's sleeping rooms and in the living room. The facility has a capacity of 6 and had a census of 6 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101, Alternative Approaches to Life Safety, Chapter 6, rated the facility slow with an E-Score of 1.8. Quality Review completed on 03/10/22			
K S222 Bldg. 02	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5.			

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	Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii) Based on observation and interview, the facility failed to ensure 2 of 4 exterior exit doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect all occupants in the facility. Findings include: Based on observation with the QIDP, Facilities Manager, and Residential Director, on 03/07/22 at 2:38 p.m., the front and back entrance/exit doors were equipped with two latching devices, a regular door handle with a turn lock and a separate deadbolt lock. Based on interview at the time of observation, the Facilities Manager agreed front and back entrance/exit doors contained a deadbolt lock in addition to the lock on the door handle.	K S222	It is the responsibility of the Facilities Manager to correct these. The parts are currently on order and The Arc is waiting for them to be delivered. In the future it is the responsibility of the Facilities Manager to ensure they are checked and operate correctly on the Preventative Maintenance checklist.	04/04/2022

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	The finding was reviewed with the QIDP, Facilities Manager, and Residential Director during the exit conference.			
K S341 Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation 2012 EXISTING (Prompt) A manual fire alarm system shall be provided in accordance with Section 9.6, unless smoke alarms are interconnected and comply with 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the required smoke alarms. 33.2.3.4.1, 33.2.3.4.1.1, 33.2.3.4.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels were protected. LSC 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observation with the QIDP, Facilities Manager, and Residential Director, on 03/07/22 at 2:25 p.m., the fire control panel located by the	K S341	It is the responsibility of the QIDP to train staff that the fire alarm system must be locked and the key must be kept on the key ring with the med keys. In the future it will be the responsibility of the house manager to ensure this is being completed.	04/04/2022

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	front door was in a cabinet but the door to the cabinet was unlocked and had the key in the lock. This condition does not protect the fire alarm system against unauthorized use. Based on interview at the time of observations, the Residential Director agreed the cabinet door to the fire control panel was not properly secured because the key was in the lock of the unlocked door. The Residential Director did lock the panel and remove the key. The finding was reviewed with the QIDP, Facilities Manager, and Residential Director during the exit conference.			
K S346 Bldg. 02	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include:	K S346	It is the responsibility of the QIDP to train the staff on the updated Fire Watch Policy. In the future it will be the responsibility of the QIDP to ensure staff are trained yearly.	04/04/2022

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	Based on review with the QIDP, Facilities Manager, and Residential Director, on 03/07/22 at 1:28 p.m.: a). The fire watch plan stated a fire watch will be initiated when the fire alarm system is out of service for 10 hours or more in a twenty-four-hour instead of initiating after 4 hours. b). The fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Residential Director acknowledged the fire watch documentation provided stated a fire watch will be initiated after 10 hours and did not state to contact IDOH via the Gateway link or at the e-mail address listed above. The finding was reviewed with the QIDP, Facilities Manager, and Residential Director during the exit conference.			
K S354 Bldg. 02	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service.			

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	33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on review with the QIDP, Facilities Manager, and Residential Director, on 03/07/22 at 1:28 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Residential Director acknowledged the fire watch documentation provided stated to contact the IDOH but not via	K S354	It is the responsibility of the QIDP to train the staff on the updated Fire Watch/Sprinkler Policy. In the future it will be the responsibility of the QIDP to ensure staff are trained yearly.	04/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G134	A. BUILDING 02 B. WING	03/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	the Gateway link or at the e-mail address listed above. The finding was reviewed with the QIDP, Facilities Manager, and Residential Director during the exit conference.			
K S363 Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure 1 of 3 clients sleeping rooms were provided with a door which would self-close and latch securely in the door frame. This deficient practice could affect 2 clients. Findings include: Based on observation with the QIDP, Facilities Manager, and Residential Director, on 03/07/22 at 2:48 p.m., sleeping room door #1 did not latch into the frame due to a misaligned latch. Based on interview at the time of observation, the	K S363	This has been completed by the Facilities Manager. In the future it will be the Facilities Manager's responsibility to monitor this monthly using the Preventative Maintenance checklist.	04/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Facilities Manager confirmed room door #1 did not latch into the frame. The finding was reviewed with the QIDP, Facilities Manager, and Residential Director during the exit conference.			
K S741 Bldg. 02	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect up to all clients and staff. Findings include: Based on observation with the QIDP, Facilities Manager, and Residential Director, on 03/07/22 at 1:28 p.m., the back patio smoking area there were over 10 cigarette butts on the ground. Based on interview at the time of observation, the Residential Director agreed there were cigarette butts on the ground in the smoking area. The finding was reviewed with the QIDP, Facilities Manager, and Residential Director during the exit conference.	K S741	It is the responsibility of the QIDP to train staff on the smoking policy and where to dispose of cigarette butts. In the future it is the responsibility of the Facility's Manager to check monthly on using the preventative maintenance checklist.	04/04/2022