STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G331	A. BUILDING 01 B. WING	03/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARENTS AND FRIENDS INC	1709 FARRAND AVE LA PORTE, IN 46350

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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: 03/17/14 Facility Number: 000849 Provider Number: 15G331 AIM Number: 100243820 Surveyor: W. Chris Greeney, Life Safety Code Specialist. At this Life Safety Code survey, Parents and Friends, 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 one story facility with a basement was not sprinklered. The facility has a monitored fire alarm system with smoke detection on all levels including in the corridors, in the living areas and in the client sleeping rooms. The facility has a capacity of 6 and had a census of 6 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.

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	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 Slow with an E-Score of 2.2. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/18/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010130	1. Based on observation and interview, the facility failed to ensure evidence of monthly fire extinguisher inspections were documented, including the date	K010130	1) 1) On 3/25/14 Approved Protection Systems conducteda thorough fire system inspection in all four group homes. During thisinspection all fire	04/16/2014

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	and initials of the person performing the inspections for 2 of 3 portable fire extinguishers. LSC 101, 4.5.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. NFPA 10, Standard for Portable Fire Extinguishers, 4-3.1 requires extinguishers shall be inspected monthly. NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. NFPA 10, 4-3.4.2 requires at least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. This deficient practice could affect all residents staff and visitors of the home. Findings include: Based on observation of fire extinguisher inspection/maintenance tags on 03/17/14 at 12:05 P.M. during a tour of facility with the Residential Program Manager (RPM) and Maintenance staff, two of two portable fire extinguishers located in the home had a monthly inspection tag. The last inspection date on each tag was 01/17/14. Interview with the RPM and maintenance staff during the observation indicated there was no evidence the		extinguishers were tested and passed. To ensure future systemiccompliance of this citation the Residential Director will create a new formthat will include all mandatory checks/inspections to be completed by themaintenance department. The list will include reminders to place date andinitials directly on the device tag. The completed form will be submitted to theResidential Director each month and she will maintain her own file. In theevent she does not receive a report for one month, she will provide a reminderto the Maintenance Director and/or notify the Executive Director and theCorporate Compliance Officer. 2) 2) The Maintenance Director will inspect all otherexits at this home to ensure changes in level are in compliance with LifeSafety Code. All other group home exits are at ground level and do not havesteps or ramps at any exit. The maintenance department will repair the damagedstep or replace it altogether to ensure it meets LSC. During monthlyinspections of this home the maintenance staff will also monitor that all exitswith change in level are in compliance with LSC. Those found to need repair orreplacement will be communicated to the Residential Director and the ExecutiveDirector within 48 hours. 3) 3) On 3/25/14	

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	facility had conducted the monthly inspection of those two extinguishers since January 2014. 2. Based on observation and interview, the facility failed to ensure a change in level of an egress exit from a bedroom to outside was achieved by a ramp or stairs. LSC 101, 7.1.7.2 states "Changes in level in means of egress not in excess of 21 inches shall be achieved by either a ramp or a stair complying with the requirements of 7.2.2 ...The tread depth of such stair shall not be less than 13 inches and the presence and location of each step shall be readily apparent." This deficient practice could affect clients using the northwest bedroom exit. Findings include: During observation on 3/17/14 at 12:20 P.M. with the Residential Program Manager (RPM) the northwest bedroom was found to have an egress door to the outside. The exit opened to a small wooden deck approximately 18 inches off of the ground with no stair or ramp to grade level. The RPM confirmed the exit was used as a secondary fire exit from the bedroom. The RPM also indicated the deck formerly had steps to ground level but "they broke this past		Approved Protection Systems conducteda thorough fire system inspection in all four group homes. During thisinspection all emergency lighting was tested and passed. To ensure future systemiccompliance of this citation the Residential Director will create a new formthat will include all mandatory checks/inspections to be completed by themaintenance department. The list will include reminders to place date andinitials directly on the device tag. The completed form will be submitted to theResidential Director each month and she will maintain her own file. In theevent she does not receive a report for one month, she will provide a reminderto the Maintenance Director and/or notify the Executive Director and theCorporate Compliance Officer. Responsible Parties: Executive Director, Maintenance Director, Residential Director, Corporate Compliance Officer.	

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	winter." 3. Based on record review and interview, the facility failed to ensure monthly tests were conducted for interior emergency lights. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment requires a functional test be conducted at 30 day intervals for not less than 30 seconds and an annual test be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants if the facility were required to evacuate in an emergency during a loss of normal power. Findings include: During review of facility records on 3/17/14 at 11:30 A.M. at the group home office with the maintenance director, there was no documentation the emergency lighting installed in the home			

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	had monthly 30 second inspections during the months of January and February 2014. Interview with the maintenance director on 3/17/14 indicated the records were not at the office or the group home and were not available for review during the onsite visit.			
K01S016	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Interior wall and ceiling finish materials in accordance with 10.2 and 10.2.3 is Class A or Class B. 32.2.3.3.2, 33.2.3.3 Based on observation and interview; the facility failed to ensure the wood which was used as an interior finish of a kitchen ceiling and part of the walls of the kitchen of the home had a Class A or Class B interior finish in this Slow rated facility to protect 6 of 6 clients. This deficient practice could affect all occupants of the group home. Findings include: During observations on 03/17/14 at 12:05 P.M. with the Residential Program Manager (RPM) and the maintenance staff, the kitchen had a	K01S016	Further efforts to identify the decorative wood ceiling ashaving a fire retardant finish were unsuccessful. The Maintenance Director willseek bids from three (3) companies to either sand and refinish the ceiling andsoffit with a fire retardant finish or replace it with 5/8" 2 hour fireretardant rated drywall. This is the only group home that has this type ofmaterial. All other group homes are constructed and finished with fire grademateriels. The Maintenance Director will ensure any future changes made to the construction or finish of this home will meet Life Safety Code standards. Responsible Parties: Executive	04/16/2014

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	finished decorative wood slat ceiling. It also had an overhang from the ceiling extending down 12 inches which contained recessed lighting and extended around the ceiling above the counters and stove. This overhang was also finished with decorative stained wood slats. Interview with the RPM and the maintenance staff at the time of the observation indicated there was no documentation available that this wood was finished or treated to provide a class A or B interior finish.		Director, Maintenance Director, Residential Director, Corporate Compliance Officer.	

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K01S017	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD 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. 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. 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. 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 the sleeping area is sufficient to awaken staff that might be sleeping. Exception No. 4: In previously approved			

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	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. 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. Based on observation and interview, the facility failed to ensure a bedroom wall separating 1 of 3 bedrooms from the corridor was capable of resisting smoke for at least one half hour. LSC 33.2.3.6.1 states the separation walls of sleeping rooms shall be capable of resisting fire for not less than ½ hour which is considered to be achieved if the portioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. This deficient practice could affect two of six clients in the home. The findings include: During observation with the Residential Program Manager (RPM) and the maintenance staff on 03/17/14 at 12:05 P.M. a hole was found in the closet wall of the northwest bedroom. The closet did not have any doors and the wall was	K01S017	The Maintenance Director will repair the hole in the wall.He will also inspect all other homes for holes or damage to the walls and makeany necessary repairs. To ensure future systemic compliance of this citation theIDT will monitor all homes for holes in the walls and note on theirEnvironmental Observation forms when repairs are needed. The ResidentialDirector will maintain a file of the Environmental Observations and communicateall needed repairs to the Maintenance Director. Responsible Parties: Interdisciplinary Team, Residential Director,Maintenance Director	04/16/2014

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	visible from the middle of the bedroom, with no barrier between the hole in the wall and the bedroom. Interview with the RPM indicated the facility was not aware that the wall had been penetrated.			
K01S029	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Any hazardous area that is on the same floor as, and is in or abuts, a primary means of escape or a sleeping room is protected by one of the following means: (a) Protection is an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than ¾ hour. (b) Protection is automatic sprinkler protection, in accordance with 32.2.3.5, and a smoke partition, in accordance with 8.2.4, located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation is self-closing or automatic closing in accordance with 7.2.1.8. 33.2.3.2.2.			
	Based on observation and interview, the facility failed to ensure 1 of 1 hazardous areas was protected by a self closing or automatic closing fire door in accordance with 7.2.1.8. This deficient practice could affect all residents staff and visitors in the home. Findings include:	K01S029	All stored items will be removed from the garage. This is the only home with an attached garage. To ensure future compliance for this citation the IDT will monitor that no additional items have been stored in the garage when they are conducting their monthly Environmental Observations at this home. In the event they discover items stored in the garage they will make a note on the form and verbally inform the	04/16/2014

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	During observation with the Residential Program Manager (RPM) and the maintenance staff on 03/17/14 at 12:05 P.M., the attached garage was found to contain stacks of various sizes of lumber, a wooden pallet, three tires, extra bedframes with mattresses, rolls of carpeting, four five gallon containers of paint (totaling 20 gallons) and four five gallon containers of floor stripper. The RPM during the observation stated, "This is the only home we have that has a full garage." The RPM further indicated the materials stored in the garage were stored by maintenance in that garage for use in all the group homes owned by the agency. The door from the living area to the garage connected to a hallway by the front exit of the home. That door between the garage and the hallway was rated at 1.5 hours but was not a self-closing or automatic closing door.		Residential Director. The Residential Director will then instruct the Maintenance Director to remove the items. Responsible Parties: Interdisciplinary Team, Residential Director, Maintenance Director	