STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G437	A. BUILDING -- B. WING	01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC SOUTHWEST INDIANA, THE	1015 S STOUT ST PRINCETON, IN 47670

(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: 01/27/21 Facility Number: 000951 Provider Number: 15G437 AIM Number: 100244590 At this Emergency Preparedness survey, The Arc of Southwest Indiana was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey, the census was 5. Quality Review completed on 01/28/21.	E 0000		
E 0006 Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]			

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

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	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness			

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	plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475(a) (1) and 42 CFR 483.475(a) (2). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Disaster Preparedness Plan on 01/27/21 between 9:45 a.m. and 12:15 p.m. with the Qualified Intellectual Developmental Professional (QIDP) present, facility-based and community-based risk hazards were addressed in the plan, however, there was no facility-based and community-based risk assessment utilizing an all-hazards approach available. Based on interview at the time of record review, the QIDP said there was no all hazards risk assessment available in the Emergency Disaster Preparedness Plan.	E 0006	Residential Director was in-serviced on completing a Risk Assessment and updating the Emergency Preparedness plan at least every 2 years. It will be the Residential Directors responsibility to complete the Risk Assessment and update the Disaster Emergency Plan. Risk Assessment was found, updated, and addressed in the Disaster Emergency Plan. This plan will be put in place at each home. See Exhibit #1 Residential In-service See Exhibit #2 Risk Assessment Tool See Exhibit #3 Updated Emergency Disaster Preparedness Plan	02/08/2021

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	This finding was reviewed with the QIDP at the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 01/27/21 Facility Number: 000951 Provider Number: 15G437 AIM Number: 100244590 At this Life Safety Code survey, The Arc of Southwest Indiana 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. This one story facility was sprinklered. The facility has a fire alarm system with smoke detection in the corridors, sleeping rooms, and common living areas, plus heat detectors located in the attic connected to the fire alarm system. The facility has a capacity of 8 and had a census of 5 at the 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 1.52. Quality Review completed on 01/28/21.	K 0000		

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K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure complete documentation was provided for 1 of 1 fire alarm system in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. This deficient practice could affect all clients and staff. Findings include: Based on record review on 01/27/21 between 9:45 a.m. and 12:15 p.m. with the Qualified Intellectual Developmental Professional (QIDP) present, there was documentation for an annual fire alarm system test/inspection dated 10/21/20, plus a semi-annual fire alarm system test/inspection dated 05/19/20 by the facility's fire alarm system vendor. The documentation was incomplete for both reports. The inspection reports provided did not include an inspection of the two heat detectors in the facility attic. There was no means of inspecting the attic for heat	K S345	Koorsen's was contacted to ensure they were checking the attic smoke detectors. They come on Friday, 2/5/21 to check the attic smoke detectors to inspect and establish documentation. Koorsen's now have the smoke detectors on their inspection sheet. Koorsen's went to each group home location to check the attic smoke detectors. Maintenance will oversee the inspections to ensure all areas of inspection have been completed in the future. See Exhibit # 4 Koorsen's inspection	02/05/2021

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	detectors during this survey, however, based on phone interview during record review, the Maintenance Supervisor said there were two heat detectors located in the attic. Based on interview at the time of record review, the QIDP acknowledged the lack of inspection of the heat detectors in the attic during the 10/21/20 and 05/19/20 fire alarm system inspections. This finding was reviewed with the QIDP at the exit conference.			
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. 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. 3. Facilities must meet the requirements of			

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	paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 1 of 3 shifts during 1 of 4 quarters during the past 12 months. This deficient practice could affect all clients. Findings include: Based on review of the facility's fire drill reports on 01/27/21 between 9:45 a.m. and 12:15 p.m. with the Qualified Intellectual Developmental Professional (QIDP) present, the facility did perform 18 fire drills during the past 12 months, however, there was no fire drill report available for the second shift (evening) of the fourth quarter (October, November, and December) of 2020. Based on interview at the time of record review, the QIDP confirmed the lack of a fire drill during the second shift of the fourth quarter of 2020. This finding was reviewed with the QIDP at the exit conference.	K S712	In-service was completed by the Home Manager and QIPD who are responsible for new hire and current home employees to complete fire and safety drills. The in-service states that on the quarter all personnel on each shift be made familiar and trained on fire, safety, and disaster procedures. Arc Southwest Indiana will conduct a quarterly evacuation/disaster drill for each shift of personnel, make provisions for the evacuation of consumers with physical disabilities, evaluate the safety drill on the appropriate report completing all areas (no blanks), been trained on the use of a fire extinguisher, investigate all problems with the evacuation drill and correct the problem. Each Home Manager will complete the in-service and enforce it in each home. See Exhibit #5 QIDP In-service See Exhibit #6 Home Manager In-service See Exhibit #7 Evening Fire Drill See Exhibit #8 Overnight Fire Drill	02/08/2021
K S741 Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted,			

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	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 cigarette butts were properly disposed of at 1 of 1 area where cigarettes were smoked. This deficient practice could affect all clients. Findings include: Based on observation on 01/27/21 at 12:00 p.m. during a tour of the facility with the Qualified Intellectual Developmental Professional (QIDP) present, the smoking area outside the rear of the house had a milk jug half filled with water being used to discard cigarette butts. There was not a noncombustible ashtray or receptacle available at the smoking area. This was acknowledged by the QIDP at the time of observation. This finding was reviewed with the QIDP at the exit conference.	K S741	Managers were in-serviced about the Cigarette Butt Receptacle. Manager will continue to monitor and report to the Admin Office if it has blown away, been destroyed, or damaged. Cigarette Butt Receptacle was purchased on 2/2/21, arrived on 2/5/21, and placed at the home the evening of 2/5/21. Exhibit # 9 Manager In-service Exhibit # 10 Receipt	02/05/2021