

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2015	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 CORNWALL DR JEFFERSONVILLE, IN 47130		
(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
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: 12/23/15</p> <p>Facility Number: 000769 Certification Number: 15G247 AIM Number: 100248810</p> <p>At this Life Safety Code survey, Res Care Community Alternatives SE IN 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 one story facility with a basement was not sprinkled. The facility has a fire alarm system with smoke detection on all levels including the corridors, common living areas and basement. 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 Slow with an E-Score of 1.70.</p> <p>Quality Review completed 01/05/16 - DA.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were inspected at least monthly and the inspections were documented for 9 of 9 months since the last annual inspection date, including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff.</p> <p>Findings include:</p>		K 0130	<p>K130</p> <p>All staff at the home will be in-serviced on the completion of monthly fire extinguisher inspections and documentation of those inspections.</p> <p>The Residential Manager will be in the home at least five times weekly to ensure that all fire extinguishers are inspected and documentation of those inspections is documented each month.</p>	01/22/2016

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K S032 Bldg. 01	<p>Based on observation during a tour of the facility with maintenance worker #1 on 12/23/15 from 10:40 a.m. to 11:45 a.m., service and inspection tags for the portable fire extinguishers located in the kitchen and the basement each bore a service inspection tag indicating the most recent annual inspection was 02/11/15, but no monthly checks were documented on the inspection tags for March, April, May, June, July, August, September, October, and November 2015. Based on interview at the time of observation, maintenance worker #1 stated there is no written documentation of monthly fire extinguisher inspections for the facility and acknowledged the facility did not perform monthly fire extinguisher inspections for the months listed above. This was acknowledged by maintenance worker #1 at the exit conference on 12/23/15 at 11:45 a.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In slow and impractical evacuation capability facilities, the primary means of escape for each sleeping room is not exposed to living areas and kitchens.</p> <p>Exception: Buildings equipped with quick-response or residential sprinklers throughout. Standard response sprinklers</p>				

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	<p>are permitted for use in hazardous areas in accordance with 33.2.3.2. 32.2.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 corridors used as a primary means of escape were not exposed to living areas and kitchens for a Slow rated facility. This deficient practice could affect 4 clients who reside in the Front Hall.</p> <p>Findings include:</p> <p>Based on observations on 12/23/15 during a tour of the facility from 10:40 a.m. to 11:45 a.m. with maintenance worker #1, the Front Hall client sleeping room corridor was exposed to the kitchen and living rooms by a wall opening in the corridor with no smoke barrier door separation. Furthermore, the evacuation map posted on the wall indicated the front living room exit door was the primary means of escape for the Front Hall client sleeping room corridor. This was verified by maintenance worker #1 at the time of observation and acknowledged at the exit conference on 12/23/15 at 11:45 a.m.</p>		K S032	<p>K0032 A second staff will be added to the night shift at the home. The Residential Manager will be at the home at least five times weekly to ensure ratios are consistent with scheduled hours.</p>	01/22/2016