

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G745 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 05/25/2017 |
|---|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA | | STREET ADDRESS, CITY, STATE, ZIP CODE 16611 SIMA GRAY RD HENRYVILLE, IN 47126 | | |
| (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: 05/25/17</p> <p>Facility Number: 011663 Provider Number: 15G745 AIM Number: 200902020</p> <p>At this Life Safety Code survey, Res Care Southeast 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.</p> <p>This one story facility was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, common living areas, and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 4 and had a census of 4 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 S100 Bldg. 01 | <p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.08.</p> <p>Quality Review completed on 05/31/17 - DA</p> <p>NFPA 101 General Requirements - Other General Requirements – Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 battery operated emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. 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</p> | K S100 | <p>K100</p> <p>Corrective Action: (Specific): The Residential Manager will be re-trained on ensuring that the emergency lighting is tested at least monthly and documented.</p> <p>How others will be identified: (Systemic): The Area Supervisor will visit the home at least weekly to ensure that the emergency lighting is tested and documented at least monthly.</p> <p>Measures to be put in place: The Residential Manager will be re-trained on ensuring that the emergency lighting is tested at least monthly and documented.</p> | 06/24/2017 |

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| K S353 Bldg. 01 | <p>affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 05/25/17 with the home manager during a tour of the facility from 10:06 a.m. to 11:00 a.m., the facility had a battery operated emergency light fixture located on the wall in the West client sleeping room corridor and the East client sleeping room corridor with a sticker on each light from Koorsen Fire & Security indicating an annual ninety minute test was conducted on February 2017. Furthermore, when asked if the facility had documentation of monthly testing conducted over the past year, the home manager stated the facility does not have documentation of monthly testing over the past year for the two battery backup lights. This was verified by the home manager at the time of observation and at the exit conference on 05/25/17 at 11:00 a.m.</p> | | | <p>Monitoring of Corrective Action: The Area Supervisor will visit the home at least weekly to ensure that the emergency lighting is tested and documented at least monthly.</p> <p>Completion Date: 06/24/17</p> | |

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| | <p>and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System.</p> <p>NFPA 13D Systems</p> <p>Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25:</p> <ol style="list-style-type: none"> 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal | | | |

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| | <p>annually (NFPA 25, section 13.3.3.1).</p> <p>14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4).</p> <p>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).</p> <p>A. Date sprinkler system last checked and necessary maintenance provided.</p> <p>B. Show who provided the service.</p> <p>C. Note the source of the water supply for the automatic sprinkler system.</p> <p>(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.)</p> <p>33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system was tested and inspected in accordance with NFPA 25. NFPA 25, 5.2.6 requires water flow alarm devices to be inspected quarterly and 5.3.3.2 which says vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on record review with the home manager on 05/25/17 at 10:20 a.m., there was no quarterly sprinkler system</p> | K S353 | <p>K0353</p> <p>Corrective Action: (Specific): The Residential Manager will be re-trained on inspection and documentation of the gauges and valves to ensure that they are in good condition, that quarterly sprinkler systems are completed and that annual backflow prevention devices are tested. The quarterly sprinkler inspections and annual inspection of backflow device will be obtained from Simplex Grinnell.</p> | 06/24/2017 |

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| | <p>inspections conducted for the first quarter of the year 2017 or the second, third and fourth quarter of the year 2016. Furthermore, the only documentation provided for review by the home manager at the time of record review was a quarterly sprinkler inspection report from Simplex/Grinnell dated 02/24/16. This was acknowledged by the home manager at the exit conference on 05/25/17 at 11:00 a.m.</p> <p>2. Based on record review, observation and interview, the facility failed to document monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. This deficient practice could affect all clients in the facility.</p> | | <p>How others will be identified: (Systemic): The Area Supervisor will visit the home at least weekly to ensure that the inspection and documentation of the sprinkler system gauges and valves is being completed and that they are in good condition. The Program Manager will ensure that testing completed by simplex Grinnell on quarterly sprinkler inspections and annual backflow prevention device testing is available and in the home.</p> <p>Measures to be put in place: The Residential Manager will be re-trained on inspection and documentation of the gauges and valves to ensure that they are in good condition, that quarterly sprinkler systems are completed and that annual backflow prevention devices are tested. The quarterly sprinkler inspections and annual inspection of backflow device will be obtained from Simplex Grinnell.</p> <p>Monitoring of Corrective Action: The Area Supervisor will visit the home at least weekly to ensure that the inspection and documentation of the sprinkler system gauges and valves is being completed and that they are in good condition. The Program Manager will ensure that</p> | |

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| | <p>Findings include:</p> <p>Based on record review with the home manager on 05/25/17 at 10:20 a.m., the Simplex/Grinnell sprinkler inspection report dated 02/24/16 indicated the locked garage sprinkler riser room one sprinkler water pressure gauge and three sprinkler water valves were visually inspected during the sprinkler inspection. Based on an interview with the home manager on 05/25/17 at 10:40 a.m., it was indicated the facility does not perform monthly inspections on the one sprinkler system water pressure gauge and the three sprinkler water valves. The lack of monthly sprinkler system water pressure gauge and sprinkler water valve inspections was acknowledged by the home manager at the exit conference on 05/25/17 at 11:00 a.m.</p> <p>3. Based on record review, observation and interview, the facility failed ensure 1 of 1 backflow prevention device in the sprinkler system piping was tested annually in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.6.2.1 states all backflow preventers installed in fire protection system piping shall be tested</p> | | | <p>testing completed by simplex Grinnell on quarterly sprinkler inspections and annual backflow prevention device testing is available and in the home.</p> <p>Completion Date: 06/24/17</p> | |

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| K S363 Bldg. 01 | <p>annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review with the home manager on 05/25/17 at 10:20 a.m., there was no record of an annual backflow preventer available for review over the past year on the backflow preventer device for the sprinkler system water supply. Based on observation of the backflow preventer on the sprinkler system piping on 05/25/17 at 10:45 a.m. with the home manager, the backflow preventer had a tag from Simplex/Grinnell indicating the last annual test was conducted in the year 02/24/16. The lack of an annual backflow preventer test was verified by the home manager at the time of record review and observation and acknowledged at the exit conference on 05/25/17 at 11:00 a.m.</p> <p>NFPA 101 Corridor - Doors Corridor – Doors 2012 EXISTING (Prompt) Doors shall meet all of the following</p> | | | |

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| | <p>requirements:</p> <ol style="list-style-type: none"> 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. 33.2.3.6.4 <p>Based on observation and interview, the facility failed to ensure 2 of 4 sleeping room doors were capable of resisting smoke and provided with mechanisms suitable for keeping the doors closed. This deficient practice affects 2 of 4 clients who reside in client sleeping rooms #1, and client sleeping room #2 on the East Hall.</p> <p>Findings include:</p> <p>Based on observations with the home manager on 05/25/17 from 10:07 a.m. to 11:00 a.m., the corridor doors to client sleeping room #1, and client sleeping room #2 on the East Hall each failed to latch into the door frames and had a one inch gap around the top and latching sides of the doors in the closed position. This was verified by the home manager at the time of observations and at the exit conference on 05/25/17 at 11:00 a.m.</p> | K S363 | <p>K0363</p> <p>Corrective Action: (Specific: The door frames and doors for client sleeping rooms 1 and 2 as will be repaired to ensure that each door latches into the frame on all sides with no gaps.</p> <p>How others will be identified: (Systemic: The area supervisor will be in the home weekly to ensure the home is in good repair and report any identified need of repair to the program manager immediately.</p> <p>Measures to be put in place: The door frames and doors for client sleeping rooms 1 and 2 as will be repaired to ensure that each door latches into the frame on all sides with no gaps.</p> | 06/24/2017 |

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| | | | | <p>Monitoring of Corrective Action: The area supervisor will be in the home weekly to ensure the home is in good repair and report any identified need of repair to the program manager immediately.</p> <p>Completion Date: 06/24/17</p> |