STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G760	A. BUILDING 01 B. WING	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	5138 GREENVIEW CT BATTLE GROUND, IN 47920

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K0000	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: 12/06/12 Facility Number: 012034 Provider Number: 15G760 AIM Number: 200970250 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Spectrum Community Services of Indiana LLC 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 32, New Residential Board and Care Occupancies. This one story facility with a basement was fully sprinklered. The facility has a fire alarm system	K0000		

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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	with smoke detection in on all levels, corridors, sleeping rooms and in all common living areas except the dining room. The facility has a capacity of 4 and had a census of 4 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 Prompt with an E-Score of 1.2. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/12/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0130	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators were maintained to provide electrical service within 10 seconds of normal electrical power failure. NFPA 99, Health Care Facilities, in Chapter 13, "Other" Health Care Facilities in 13-1 states, "this chapter addresses safety requirements for facilities, or portions thereof, that provide diagnostic and treatment services to patients in health care facilities other than hospitals, nursing homes, or limited care facilities as defined in Chapter 2. NFPA 99, 13-3.3.2.1 requires the essential electrical distribution system to conform to the Type 3 system requirements as described in Chapter 3. NFPA 99, 3-6.4.1.1(a) requires generator sets shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. NFPA 110, 6-3.4 requires a written record of the EPSS inspection, tests, exercising and repairs shall be maintained on the premises. The	K0130	Generator exercise check sheet has been updated to reflect the time and date of the scheduled test. If the generator does not complete the scheduled weekly test, Maintenance will be contacted by the house manager to ensure that the generator is operating correctly. House Manager will be responsible for ensuring that the check sheet has been initialed appropriately weekly. Generator will be maintained by maintenance, a copy of the maintenance check will be provided in the group home. Generator will be serviced twice annually by maintenance to ensure it is in proper working condition. House Manager will ensure that a copy of the service maintenance is in the home.Environmental policy has been changed to reflect the needed changes due to this deficiency.	12/21/2012

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	written report shall include the following: a. The date of the maintenance report. b. Identification of the servicing personnel. c. Notification of any unsatisfactory condition and corrective action taken including parts replaced. d. Testing of any repair for the appropriate time as recommended by the manufacturer. This deficient practice affects all occupants. Findings include: Based on record review with the house manager on 12/06/12 at 2:00 p.m., the Generator Log Sheet had two columns titled "initials" and "date". It was noted the generator was installed 8/10/12. The house manager was asked at the time of record review what the record was for. She said it had the initials of a day shift staff who confirmed the generator ran automatically for 10 minutes every Monday. Dates on the record began 08/13/12 and ran to 12/03/12. Only one entry was made for September 2012 (09/17/12) and two entries for October 2012 (10/22/12 and			

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	10/29/12). The house manager said she did not know why six weekly checks were not documented for three weeks each in September and October of 2012. In addition, the house manager said she was unaware of any other documentation for the generator, could not demonstrate it's function, had no key to open and access controls, did not know what equipment the emergency power was connected to, the fuel required and whether it operated within ten seconds. Additionally, the house manager did not know where the generator was located. It was found on 12/06/12 at 2:20 p.m. with the house manager, after looking in the basement, then at a location outside the home and it was fueled by a gas line.			

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KS147	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff no less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1 Based on record review and interview, the facility administration failed to ensure all employees are instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 4 of 4 clients. Such instruction is reviewed by the staff at least every two months. This deficient practice could affect all clients. Findings include:	KS147	The environmental safety policy in this home was misplaced and not available at time of survey. Fire drills will now be presecheduled for one pershift per quarter to ensure that dirlls are completed. House Manager and QDDP will check monthly to ensure that all drills are completed. House Manager and QDDP will review the environmental policy with staff twice annualy to ensure that all staff and clients are aware of safety protocols are in place.This deficiency has been placed in the Environmental Safety policy.	12/14/2012

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	a. Based on review of Fire Drill Reports with the house manager on 12/06/12 at 1:00 p.m., a lapse in staff fire safety training time was more than the two months allowed as evidenced by the lack of any training or Fire Drill records for the 11:00 p.m. to 7:00 a.m. shift between 06/23/12 to date, a lapse of lapse of five months for staff training. The house manager said at the time of record review, there were no other Fire Drills or other training documentation for this period. b. Based on record review with the house manager at 2:00 p.m. on 12/06/12, a policy and procedure governing the maintenance, operation, and staff response for operation or malfunction of the emergency generator installed on 08/10/12 was not provided. The house manager said at the time of record review, she had no inservice for staff with regard to the operation of the emergency generator and no policy and procedure for reference. She said staff were directed to verify an automatic run each week by			

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	signing and dating a Generator Log Sheet. She assumed if the generator failed to run, staff should call maintenance. There was no reference to the operation of an emergency generator in the emergency procedure manual.			

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KS148	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1 Based on observation, interview, and record review; the facility failed to develop and enforce an effective facility smoking policy to prevent smoking in an unauthorized area and maintain safe smoking equipment for the use and protection of 4 of 4 clients. This deficient practice could affect all occupants. Findings include: Based on observation on 12/06/12 at 12:35 p.m., three staff including a house manager were smoking by a smoking tower on the back deck. They left the area. A thick smoke was observed coming from the opening at the top of the unattended smoking tower on 12/06/12 at 12:40 p.m. The staff were asked to immediately attend to the smoke tower where something within had apparently begun to burn. The house manager was asked on 12/06/12 at 12:44 p.m., what the policy was for maintenance of the	KS148	Previous smoking policy has been updated to reflect that overnight staff will empty the smoking tower and will document on the midnight cleaning checklist. Smoking area has been restated to staff in a 12/21/12 meeeting. Smoking is only allowed in approved areas. Anyone smoking must extinguish their cigarette approrpriately in the smoking tower.House Manager and Assistant House Manager will check randomly to ensure that the smoking tower is emptied.	12/14/2012

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	tower, i.e. emptying and disposing of the contents. She said at the time of interview, she was not the regular house manager and had no idea what was done at the house. Staff # 1, identified as the newly appointed assistant house manager said she was not aware of the tower being emptied at any time since her employment four or more months prior. The smoking policy was reviewed on 12/06/12 at 2:20 p.m. with the house manager. The policy for employee smokers noted smoking would occur "(3.) outside the office door or outside the back door of garage and (4.) Absolutely no smoking would be permitted on the back deck, front porch, or in the garage where customers have access to smoke or smoking paraphernalia at any time." The house manager confirmed at the time of record review, the three staff had been smoking in an area not designated for use by the smoking policy. She agreed staff use of the deck smoking tower contributed to filling up the container, were accessible to clients and, without a policy for emptying the contents, they accumulated and			

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	could catch fire more readily.			

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KS152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities; (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) 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. Facilities meet the requirements of paragraphs (1) and (2) of this section for any live-in and relief staff that they utilize.			
	Based on record review and interview, the facility failed to ensure fire and evacuation drills were conducted for each shift for 1 of 4 quarters. This deficient practice affects all occupants. Findings include: Based on review of fire drills with	KS152	Policy has been updated and fire drills will now be prescheduled for one per shift per quarter. House Manager will remind staff during the given time frame that a fire drill must be completed. House Manager and QDDP will check montly to ensure that drills are completed as instructed in Environmental Safety Policy.	12/14/2012

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	the house manager on 12/06/12 at 2:10 p.m., a fire drill record was not found for the 11:00 p.m. to 7:00 a.m. shift during the third quarter of 2012. The house manager reviewed the fire drill records for a second time, and confirmed the drill was missing.			

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KS155	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 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. 9.6.1.8 Based on record review and interview, the facility failed to provide a written policy including all required 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 24 hour period to protect 4 of 4 clients. LSC 33.7.1 requires every residential board and care facility have in effect and available to all supervisory personnel a plan for the protection of all persons. This deficient practice could affect all occupants. Findings include: Based on review of the Environmental Safety Policy (page 1 of 1) dated January 2010 on 11/15/11 at 12:50 p.m. with the house manager, the policy included a section providing for	KS155	Environmental Policy was in place however the policy was misplaced due to recent administrative vacancy. Enviromental policy has been replaced and an electronic copy is available in the event of misplacement. House Manager and QDDP will ensure that all policies are accesasble.	12/14/2012

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	action for: Electrical loss, however, there was nothing to address a fire alarm system outage. The house manager said she had no other information to provide.			