

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/09/2015
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NAME OF PROVIDER OR SUPPLIER  REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 568 YORKTOWN RD GREENWOOD, IN 46142
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K010000	<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: 01/09/15</p> <p>Facility Number: 000840 Provider Number: 15G322 AIM Number: 100244010</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, REM Occazio 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 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a fire alarm system with manual fire alarm boxes, sprinkler system flow switches and alarms hard wired to the fire alarm system. The facility has interconnected smoke detectors powered from the building electrical system installed in</p>	K010000		
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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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K01S017	<p>corridors and in all common living areas. 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 Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.3.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 01/20/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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.</p>			

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	<p>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.</p> <p>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.</p> <p>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.</p> <p>Exception No. 4: In previously approved 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.</p> <p>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.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 4 sleeping room doors were capable of resisting smoke for at least 1/2 hour.</p>	K01S017	<p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>Door on northeast bedroom will be repaired or replaced to meet requirement.</li> </ul>	02/08/2015			

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	<p>LSC 8.2.3.2.1(a) states door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with NFPA 80, Standard for Fire Doors and Fire Windows. NFPA 80, Standard for Fire Doors and Fire Windows, 1999 Edition, states the clearance under the bottoms of doors shall be in accordance with Table 1-11.4. Table 1-11.4 states the maximum clearance for a fire rated swinging door with fire hardware shall be 3/4 inch between the bottom of the door and the floor where no sill exists. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with Direct Services Provider (DSP) during a tour of the facility from 11:30 a.m. to 12:10 p.m. on 01/09/14, a two inch clearance was noted in the twenty minute fire rated swinging door with fire hardware between the bottom of the door and the floor where no sill exists was noted on the hinge side of the northeast bedroom door. Based on interview at the time of observation, the DSP acknowledged the clearance at the bottom of the northeast bedroom door was greater than 3/4 inch and was not enclosed with a separation of</p>		<ul style="list-style-type: none"> <li>· Door on southeast bedroom will be repaired to replace to meet requirement.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>· All clients have the potential to be affected by this practice and monitoring will be put in place to ensure reporting and correction of issues.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· Home Manager will monitor on weekly environmental checks conditions of all doors.</li> <li>· Program Director will monitor on monthly environmental checks conditions of all doors.</li> <li>· Quarterly Health and Safety reports will be completed by either Home Manger or Program Director.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Area Director will review all Quarterly Health and Safety Reports and follow-up on repairs needed.</li> <li>· QA Specialist will review all Quarterly Health and Safety Reports and follow-up on repairs needed.</li> </ul>	

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	<p>twenty minute fire resistive construction.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 sleeping room doors were capable of resisting smoke for at least 1/2 hour. NFPA 101, LSC 2000 Edition, in 8.2.4 requires doors in smoke barriers to be in accordance with NFPA 80, 1999 Edition, the Standard for Fire Doors and Windows. NFPA 80, Section 2-3.1.7 requires the clearance between the edge of the door and the frame not exceed 1/8 inch for wood doors. This deficient practice could affect two of eight clients in the facility.</p> <p>Findings include:</p> <p>Based on observation with Direct Services Provider (DSP) during a tour of the facility from 11:30 a.m. to 12:10 p.m. on 01/09/14, the top hinge to the corridor door to southeast bedroom door was loose which caused a 1/2 inch wide gap along the latch side of the closed door. Based on interview at the time of the observation, the DSP acknowledged the southeast bedroom door was not smoke resistant due to a 1/2 inch wide gap along the latch side of the closed door.</p>		<p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>February 8, 2015</p>				

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K01S043	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD No door in any means of escape is locked against egress when the building is occupied.</p> <p>Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5.</p> <p>Based on observations and interview, the facility failed to ensure 2 of 2 exit doors were provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. LSC 33.2.2.5.7 requires compliance with LSC 7.2.1.5.4. LSC 7.2.1.5.4 requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release is one familiar to the average person. Generally, a two step release, such as a knob and independent dead-bolt is not acceptable. In most occupancies, it is important a single action to unlatch the door be present. This deficient practice affects all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observations with Direct Services Provider (DSP) during a tour of the facility from 11:30 a.m. to 12:10 p.m. on 01/09/14, the main exit door and the rear exit door to the exterior of the</p>	K01S043	<p><b>K0043 Life Safety Code</b> The facility failed to ensure 2 of 2 exit doors were provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions.</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>A single action latch will be installed on both exit doors.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All clients have the potential to be affected by this practice and monitoring will be put in place to ensure reporting and correction of issues.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>Home Manager will monitor on weekly environmental checks</li> </ul>	02/08/2015

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K01S152	<p>facility each required a two step release to open the door. A door handle and an independent dead bolt with a thumb twist opening device on the inside of the door was the two step release to open the door. In addition, the thumb twist opening device on the rear exit door would not twist to release the deadbolt which caused the door to be unable to be opened. Based on interview at the time of the observations, the DSP acknowledged each of the aforementioned two facility exit doors required a two step release to open the door and the rear exit door was unable to be opened due to an inoperable deadbolt releasing mechanism.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) 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</p>		<p>conditions of all doors.</p> <ul style="list-style-type: none"> <li>· Program Director will monitor on monthly environmental checks conditions of all doors.</li> <li>· Quarterly Health and Safety reports will be completed by either Home Manger or Program Director.</li> </ul> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <ul style="list-style-type: none"> <li>· Area Director will review all Quarterly Health and Safety Reports and follow-up on repairs needed.</li> <li>· QA Specialist will review all Quarterly Health and Safety Reports and follow-up on repairs needed.</li> </ul> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>February 8, 2015</p>				

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	<p>disabilities:</p> <p>(iii) File a report and evaluation on each drill:</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(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.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (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 provide documentation of fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "ISP Data Collection" documentation with the Direct Services Provider (DSP) during record review from 10:30 a.m. to 11:30 a.m. on 01/09/14, documentation of a fire drill conducted on the third shift (12:00 a.m. to 8:00 a.m.) in the fourth quarter of 2014 was not available for review. Based on interview at the time of record review, the DSP acknowledged documentation of a fire drill conducted on the third shift in the fourth quarter of 2014 was not available for review.</p>	K01S152	<p><b>K0152 Life Safety Code Standard</b></p> <p>The facility failed to provide documentation of fire drills conducted on the third shift for 1 of 4 quarters.</p> <p><b>1.What corrective action will be accomplished?</b></p> <ul style="list-style-type: none"> <li>HMs trained on regulations regarding evacuation drills.</li> </ul> <p><b>1.How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>All clients have the potential to be affected by this deficient practice.</li> </ul> <p><b>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>Home Manager provided with a tracking form to ensure drills are</li> </ul>	02/08/2015			

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			<p>done in accordance to federal guidelines.</p> <p><b>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <p>· Area Director and Program Director will review drills monthly to ensure drills are being properly run.</p> <p><b>1.What is the date by which the systemic changes will be completed?</b></p> <p>February 8, 2015</p>		