

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G322	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2015
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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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(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
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K 000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 01/09/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 02/27/15</p> <p>Facility Number: 000840 Provider Number: 15G322 AIM Number: 100244010</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this PSR 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</p>	K 000		
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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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K 043 Bldg. 01	<p>smoke detectors powered from the building electrical system installed in 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 03/03/15.</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 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</p>	K 043	<p>1.What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Dead bolt has been removed from both exit doors. · New door knobs have been installed on both exit doors 	03/29/2015

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	<p>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 10:35 a.m. to 10:55 a.m. on 02/27/15, the main exit door and the rear exit door to the exterior of the 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. 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.</p> <p>This deficiency was cited on 01/09/15.</p>		<p>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?</p> <ul style="list-style-type: none"> · 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. <p>1.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Home Manager will monitor on weekly environmental checks conditions of all doors. · Program Director will monitor on monthly environmental checks conditions of all doors. · Quarterly Health and Safety reports will be completed by either Home Manger or Program Director. <p>1.How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Area Director will review all Quarterly Health and Safety Reports and follow-up on repairs needed. · QA Specialist will review all Quarterly Health and Safety Reports and follow-up on repairs needed. <p>1.What is the date by which the systemic changes will be</p>	

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

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	The facility failed to implement a systematic plan of correction to prevent recurrence.		completed? March 29, 2015		