

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/29/2013
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
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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: 05/29/13</p> <p>Facility Number: 001020 Provider Number: 15G506 AIM Number: 100244980</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist,</p> <p>At this Life Safety Code survey, REM - Indiana, Inc. 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 building with a basement was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in corridors, sleeping rooms and all living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p>	K010000		

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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	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 4.3.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/05/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010130	<p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke barrier doors held open by devices arranged to automatically close and latch into the door frame once the fire alarm system is activated. LSC 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Home Manager during a tour of the facility from 10:30 a.m. to 11:05 a.m. on 05/29/13, the smoke barrier door in the north hallway which is held open by magnetic hold device and arranged to automatically close did not fully close and latch into the door frame when the fire alarm system was activated at 11:00 a.m. An upholstered chair was placed up against the smoke barrier door in the fully open position and prevented the door from swinging to close and latch into the door frame. Based on interview at the time of observation, the Home Manager acknowledged an upholstered chair was placed up against the smoke barrier door preventing it from swinging to close and</p>	K010130	<p>All staff and the Home Manager will receive retraining on not blocking smoke barrier doors so that they are not able to automatically close and latch when the fire alarm system was activated.</p> <p>Ongoing, the Home manager will complete walkthroughs of the group home a minimum of weekly to ensure that there is nothing blocking the smoke barrier doors so that they are not able to automatically close and latch when the fire alarm system is activated.</p> <p>Responsible party: Home Manager, Program Director</p>	06/28/2013			

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	latch into the door frame when the fire alarm system was activated.				

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K01S051	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 manual fire alarm systems was maintained in accordance with Section 9.6. Section 9.6.1.4 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, Section 7-1.1.2 states system defects shall be corrected. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of USAutomatic Sprinkler Corporation "Alarm & Detection Equipment Test Report" documentation dated 08/23/12 during record review at the Corporate Office with the Regional Director from 9:20 a.m. to 10:15 a.m. on 05/29/13, smoke</p>	K01S051	<p>US Automatic visited the group home on 5/29/13 to verify smoke detectors listed on the 8/12/12 inspection report operate within listed sensitivity range. Ongoing, the Indiana Mentor maintenance supervisor will work with US Automatic to ensure that all reports are completed thoroughly and accurately and all necessary equipment to be tested is included in all reports. Responsible Party: Maintenance supervisor</p>	06/28/2013

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	detectors in the northeast bedroom, the back hallway, the office area and the living were each listed as "Fail" for the most recent functional testing of the manual fire alarm system. Based on interview at the time of record review, the Regional Director stated no other documentation was available for review for the subsequent repair or replacement of the aforementioned smoke detectors and acknowledged the smoke detectors failed the most recent functional testing of the manual fire alarm system. Based on observation with the Home Manager during a tour of the facility from 10:30 a.m. to 11:05 a.m. on 05/29/13, the aforementioned smoke detectors are hard wired to the fire alarm system.			

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K01S147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>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 persons 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 not 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</p> <p>Based on record review and interview, the facility failed to periodically, at least every two months, instruct staff of a plan for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients in the facility. This deficient practice could affect all staff and clients.</p> <p>Findings include:</p> <p>Based on record review with the Regional Director at the Corporate Office from 9:20 a.m. to 10:15 a.m. on 05/29/13, records of staff instruction and review of the facility's written protection plan was</p>	K01S147	<p>The staff working in the home will be retrained on Evacuation Drills, including ensuring that drills on different shifts are completed at least quarterly. An Evacuation Drill Schedule is located in the home which includes the type of drill to be completed, the date the drill is to be completed, and the time frame that the drill is to be completed in.</p> <p>All drills are turned into the Quality Assurance Manager for review. The Quality Assurance Manager will return the drill if corrections are needed. The original drill will remain in the home. The Quality Assurance Manager and Area Director will</p>	06/28/2013			

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	not available for review. Based on interview at the time of record review, the Regional Director acknowledged records of staff instruction regarding the protection plan was not available for review. Furthermore, based on review of "Fire Drill Report" documentation with the Regional Director documentation was not available for review of a fire drill being conducted on the second shift in the third quarter of 2012.		track the drills in a database and forward the database to the Area Director no less than monthly. Responsible Party: Home Manager, Program Director, Quality Assurance Specialist		

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K01S152	<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 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.</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 second shift for 1 of 4 quarters. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include: Based on review of "Fire Drill Report" documentation with the Regional Director</p>	K01S152	The staff working in the home will be retrained on Evacuation Drills, including ensuring that drills on different shifts are completed at least quarterly. An Evacuation Drill Schedule is located in the home which includes the type of drill to be completed, the date the drill is to be completed, and the time frame that the drill is to be completed in.	06/28/2013			

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	during record review at the Corporate Office from 9:20 a.m. to 10:15 a.m. on 05/29/13, documentation of a fire drill being conducted on the second shift in the third quarter of 2012 was not available for review. Based on interview at the time of record review, the Regional Director acknowledged documentation was not available for review of a fire drill being conducted on the second shift in the third quarter of 2012.		All drills are turned into the Quality Assurance Manager for review. The Quality Assurance Manager will return the drill if corrections are needed. The original drill will remain in the home. The Quality Assurance Manager and Area Director will track the drills in a database and forward the database to the Area Director no less than monthly. Responsible Party: Home Manager, Program Director, Quality Assurance Specialist		