

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G712	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2013
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8337 N COLLEGE AVE INDIANAPOLIS, IN 46240
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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: 11/18/13</p> <p>Facility Number: 001089 Provider Number: 15G712 AIM Number: 100239940</p> <p>Surveyors: Mark Caraher, Life Safety Code Specialist & Brett Overmyer, 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 was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, in sleeping rooms and in all living areas. The facility has a capacity of 7 and had a census of 7 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 2.9.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/20/13.</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>1. Based on observation and interview, the facility failed to maintain 1 of 2 smoke barrier doors. 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 observations with the Direct Services Provider (DSP) during a tour of the facility from 11:25 a.m. to 12:00 p.m. on 11/18/13, the smoke barrier door in the hallway near the front entrance which is held open by a magnetic hold device and arranged to automatically close did not latch into the door frame when tested five times. The latching mechanism did not protrude into the door frame enough to latch the door. In addition, when the fire alarm system was activated at 11:50 a.m. the magnetic holding device released the door but the door failed to latch into the door frame because the latching mechanism did not protrude into the door frame. Based on interview at the time of the observations, the DSP acknowledged the aforementioned smoke barrier door did not latch into the door frame.</p>	K010130	<p>1. The maintenance staff fixed the smoke barrier door in the back hallway so that it will self-close when the fire alarm system is activated. The fire alarm system was tested and the smoke barrier door now self-closes when the fire alarm system is activated. All direct care staff will be retrained to notify the Home Manager and maintenance staff if there are any issues with the fire alarm system and/or the smoke barrier doors when the fire alarm system is activated to ensure that reports are made so that repairs can be completed in a timely manner. 2. The maintenance staff replaced the fire extinguisher bracket in the kitchen so the fire extinguisher can be hung on the wall. All direct care staff will be retrained to notify the Home Manager and maintenance staff if there are any issues with the mounting systems for any fire extinguishers that prevent them from being mounted on the wall so that reports are made so that repairs can be completed in a timely manner. Ongoing the Home Manager will complete walkthroughs of the house a minimum of once per week to observe and review if there are any maintenance issues that need to be addressed and report them to the maintenance staff as soon as possible so that repairs can be made in a timely</p>	12/18/2013			

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	<p>2. Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers were installed on hangers, brackets, mounted in cabinets or set on shelves.</p> <p>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. NFPA 10, the Standard for Portable Fire Extinguishers, 1998 edition, Chapter 1-6.7 requires fire extinguishers shall be installed on the hangers or in the brackets supplied, mounted in cabinets or set on shelves. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observation with the Direct Services Provider (DSP) during a tour of the facility from 11:25 a.m. to 12:00 p.m. on 11/18/13, the fire extinguisher in the kitchen was sitting on the floor. Based on interview at the time of observation, the DSP acknowledged the aforementioned kitchen fire extinguisher was not installed on a hanger, brackets supplied, mounted in a cabinet or set on a shelf.</p>		manner. Responsible party: Home Manager, Maintenance staff, Direct Care Staff		

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K01S046	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of over 10 electrical outlet boxes in the facility was provided with a cover plate. LSC 9.1.2 refers to NFPA 70, National Electrical Code. NFPA 70, 1999 Edition, Article 370-25, Covers and Canopies, states, "In completed installations each box shall have a cover, faceplate or fixture canopy." This deficient practice could affect one client, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Direct Services Provider (DSP) during a tour of the facility from 11:25 a.m. to 12:00 p.m. on 11/18/13, the electrical outlet box by the chest of drawers in the northwest bedroom had a broken cover plate and the electrical outlet box on the wall in the locked water heater room which houses the facility's fire panel had no cover plate. Each of the aforementioned outlet boxes exposed the electric wiring for the outlet. Based on interview at the time of observation, the DSP acknowledged the aforementioned electrical outlet boxes had a broken or missing cover plate which exposed the electric wiring for each outlet box.</p>	K01S046	The maintenance staff replaced the missing outlet covers in the northwest bedroom and on the electrical box on the wall in the locked water heater room. All direct care staff will be retrained to notify the Home Manager and maintenance staff if there are any outlet covers that are missing or broken and are exposing wiring so that repairs can be completed in a timely manner. Ongoing the Home Manager will complete walkthroughs of the house a minimum of once per week to observe and review if there are any maintenance issues that need to be addressed and report them to the maintenance staff as soon as possible so that repairs can be made in a timely manner. Responsible party: Maintenance staff, maintenance supervisor.	12/18/2013			

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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 first shift for 4 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. All drills are turned into the Quality Assurance	12/18/2013			

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	during record review at the Corporate Office from 9:30 a.m. to 10:40 a.m. on 11/18/13, there is no documentation available for review of a fire drill being conducted on the first shift for the fourth quarter of 2012 and for the first, second, third and fourth quarters of 2013. Based on interview at the time of record review, the Regional Director acknowledged documentation of fire drills conducted on the first shift for the aforementioned quarters was not available for review.		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		