

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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
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: 10/30/14</p> <p>Facility Number: 001082 Provider Number: 15G568 AIM Number: 100245520</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 was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has a capacity of 8 and had a census of 7 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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
K01S149	<p>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 11/05/14.</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 Where smoking is permitted, noncombustible safety type ashtrays or receptacles are provided in convenient locations. 32.7.4.2, 33.7.4.2</p> <p>Based on record review, observation and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container at 1 of 1 areas where smoking was permitted. This deficient practice could affect all clients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Smoke Safety Skills Assessment Form" documentation with the Direct Services Provider (DSP) during record review from 11:55 a.m. to 12:20 p.m. on 10/30/14, 6 of 7 clients are</p>	K01S149	<p>Home Manager will assess the need for a different container to dispose of the cigarette butts in. Retraining will be provided to all staff and consumers regarding disposing of cigarette butts in a container and not on the floor of the patio. The retraining will also include ensuring that all trash and potentially combustible items are kept out of the container that that cigarette butts are placed in.</p> <p>For 4 weeks the HM and/or Program Director will complete walkthroughs of the home a minimum of three times weekly to ensure that all cigarette butts are being disposed of in proper</p>	11/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G568	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7740 ALLISONVILLE RD INDIANAPOLIS, IN 46250
---	---

(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
	<p>allowed to smoke. Based on interview at the time of record review, the DSP staff member stated 6 of 7 clients in the facility are allowed to smoke in the designated smoking area on the rear patio outside the home. Based on observation with the DSP during a tour of the facility from 12:20 p.m. to 12:35 p.m. on 10/30/14, three cigarette butts were on the floor of the rear patio and the container provided had sand, two plastic bottles, three empty cigarette packs, leaves and in excess of 50 extinguished cigarette butts in the container where clients are allowed to smoke. The container was provided with a metal lid but the lid was not covering the container. Based on interview at the time of observation, the DSP acknowledged clients had disposed cigarette butts on the floor of the patio and the container provided had combustible trash and leaves also stored in the container.</p>		<p>containers and no combustible items are kept in the container that cigarette butts are placed in.</p> <p>Ongoing, after the 4 weeks, the HM and/or Program Director will complete walkthroughs of the home a minimum of twice weekly to ensure that all cigarette butts are being disposed of in proper containers and no combustible items are kept in the container that cigarette butts are placed in.</p> <p>Responsible Party: Home Manager, Program Director</p>	