

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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
--------------------	--	---------------	---	----------------------

K 0000 Bldg. 01	<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: 10/29/15</p> <p>Facility Number: 001020 Provider Number: 15G506 AIM Number: 100244980</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 facility with a basement was sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of eight and had a census of eight at the time of this survey.</p>	K 0000		
------------------------	--	--------	--	--

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: 15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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
K S018 Bldg. 01	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility slow with an E-score of 4.95.</p> <p>Quality Review on 11/10/15 - DA</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation and interview, the facility failed to ensure 1 of 4 client sleeping room doors would close and latch into their door frames in accordance with 7.2.1.8. This deficient practice could affect all clients as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/29/15 at 2:30 p.m. with the House Manager, the client sleeping room door next to the back exit would not close and latch into its frame.</p>	K S018	<p>The Area Director will work with the Maintenance Supervisor to ensure that the door latch is repaired and in working order.</p> <p>The Area Director will retrain the Program Coordinator and Program Director on completing the monthly walk through checklist that addresses all concerns of the house, including the maintenance concerns.</p> <p>Ongoing, the Program Coordinator and/or Program Director will report any maintenance issues to the Maintenance Crew for repair.</p>	11/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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
K S051 Bldg. 01	<p>Based on interview on 10/29/15 concurrent with the observation it was acknowledged by the House Manager the client bedroom door mentioned would not close and latch into its door frame.</p> <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>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. LSC 9.6.1.4 requires fire alarm systems to be maintained in accordance with NFPA 72. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing</p>	K S051	<p>The annual fire alarm inspection was completed on May 15, 2015. Please see attachment 1 for documentation of this completed inspection.</p> <p>The inspection was completed prior to the date of this survey. The Indiana State Dept of Health Surveyor completing the actual survey at the time did not request a copy of this completed inspection. This report states "based on interview concurrent with review with the House Manager, it was acknowledged after consulting with Central office</p>	11/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G506	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220		
(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>Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all clients, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Fire Alarm Inspection reports on 10/29/15 at 2:55 p.m. with the House Manager, the last fire alarm inspection was done on 07/11/14. Based on interview concurrent with review with the House Manager, it was acknowledged after consulting with Central office staff, no other documentation for an annual Fire Alarm Inspection report was available for review within the past year.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 levels was provided with manual fire alarm boxes. LSC 9.6.2.3 requires manual fire alarm boxes shall be provided near the natural path to exit an area. This deficient practice affects all clients as well visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/29/15 at 2:45 p.m., the basement which is used for storage was not provided with a manual</p>		<p>staff, no other documentation for an annual Fire Alarm Inspection report was available for review within the last year".</p> <p>Upon reviewing the information with the Program Coordinator (referred to as the Home Manager in above statement) she was never requested to show the documentation of the completed Fire Alarm Inspection for 2015. The Program Coordinator also reported that she was never requested to contact, nor did she contact anyone at the main office for the documentation in question. The Program Coordinator contacted the Indiana MENTOR maintenance personnel regarding the need for a manual fire alarm box being placed in the basement of the group home. Indiana MENTOR maintenance personnel will ensure that a manual fire alarm box is installed in the basement to ensure the safety of clients and staff members. Indiana MENTOR maintenance personnel trained the Program Coordinator on activating and testing the fire alarm system. The Program Coordinator will retrain all Direct Support Staff on activating the fire alarm system to be sure that all staff present in the home know how to do so. The Program Coordinator will conduct the next three monthly fire drills for this group home to ensure that staff are completing the required fire drills as expected</p>		

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220		
(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>fire alarm box. The basement was provided with smoke detector protection and was sprinklered. Based on interview with the House Manager on 10/29/15 concurrent with the observation it was acknowledged a manual fire alarm box was not provided for the basement.</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems were tested by personnel fully acquainted with its function. LSC Chapter 9.6.1.4 requires a fire alarm system shall be installed, tested, and maintained in accordance with NFPA 72. This deficient practice could affect all clients, visitors and staff in the event of a fire emergency.</p> <p>Findings include:</p> <p>Based on observation on 10/29/15 at 2:59 p.m. during an inspection of the alarm system with House Manager, the Fire Alarm system could not be activated because of lack of knowledge by personal present. Based on interview on 10/29/15 at 3:05 p.m., it was acknowledged by the House Manager, training as to the operation of the fire alarm system had not been done by management, therefore, the integrity of the fire alarm system could not be tested at the time of inspection.</p>		<p>and to ensure that no updates are needed for the client's individual evacuation plans. Ongoing the Program Coordinator will ensure that all completed inspections are located in a specific location in the group home for review as needed. Ongoing the Program Coordinator will ensure that the fire alarm systems are used regularly and adequately by all staff members.</p>		

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 10/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
---	---

(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
--------------------	--	---------------	---	----------------------

K S152 Bldg. 01	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(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 -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical 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.</p> <p>Based on record review and interview, the facility failed to conduct fire drills on all shifts for 3 of 4 quarters for the past 12 months. This deficient practice affects all clients in the facility as well as staff and visitors.</p> <p>Findings include:</p>	K S152	The fire drill schedule for 2015 was written so that drills each month are scheduled in more varied time frames that the previous 2014 schedule. The Home Manager and Program Director will ensure staff run all 2015 fire drills and that they are completed per the 2015 schedule monthly which will ensure the	11/28/2015
--------------------	--	--------	---	------------

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 10/29/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220		
(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>Based on review of Monthly Fire Drill records on 10/29/15 at 3:10 p.m. with the House Manager, the following fire drill shifts had not been done:</p> <ul style="list-style-type: none"> a. First, second and third shift of the first quarter of 2015. b. First, second and third shift of the second quarter of 2015. c. First and third shift of the second quarter of 2015. <p>Based on interview on 10/29/15 concurrent with record review with the House Manager, it was acknowledged the aforementioned shifts of 2015 had not been done.</p>		<p>drills on all shifts are varied in time frame. All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule. Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met. Ongoing, all completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill.</p>		