

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342
---	---

(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
K0000	<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: 02/17/12</p> <p>Facility Number: 001107 Provider Number: 15G593 AIM Number: 100245570</p> <p>Surveyor: W. Chris Greeney, 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 facility was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, sleeping rooms and 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</p>	K0000		

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:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/17/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342		
(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>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.9.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/22/12.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342			
(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			
KS056	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD PROMPT</p> <p>Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7, 33.2.3.5.2 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p> <p>Exception No. 1: In prompt evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, is permitted. Automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 2: Not applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342
---	---

(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>Residential Occupancies up to and Including Four Stories in Height, are permitted.</p> <p>Exception No. 5: Not applicable</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>SLOW Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p> <p>Exception No. 1: Not Applicable</p> <p>Exception No. 2: Not Applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted.</p> <p>Exception No. 5: Not Applicable</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342
---	---

(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>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p><b>IMPRACTICAL</b> Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction. 33.2.3.5.2.</p> <p>Exception No. 1: Not Applicable.</p> <p>Exception No. 2: In slow and impractical evacuation capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and Two Family Dwellings and Manufactured Homes, with a 30 minute water supply, is permitted. All habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 3: Not Applicable.</p> <p>Exception No. 4: Not Applicable.</p> <p>Exception No. 5: In impractical evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted. All habitable areas and closets are sprinklered. Automatic</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342
---	---

(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>sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>Based on observation and interview, the facility failed to ensure sprinklers in 3 of 9 rooms and 1 of 1 hallways were free of paint and not loaded with dirt. LSC 32.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-2.1.1 requires sprinklers shall be free of corrosion, foreign materials and paint. Any sprinkler shall be replaced which is painted, corroded, damaged or loaded. This deficient practice could affect any clients in the living room, family room, kitchen or hallway between the family room and kitchen.</p> <p>Findings include:</p> <p>Based on observations between 12:15 pm and 12:45 pm on 02/17/12 with the facility Program Director, sprinklers in the living room, kitchen, laundry room and the hallway leading to all the bedrooms had a residue which matched</p>	KS056	<p>The Program Director will contact the vendor to have all the sprinklers cleaned and or replaced that contain residue, dirt and paint. In addition , the vendor will send the facility reports on how the sprinklers are being maintained quaterly. The Home Manager will do checks through the home on a weekly basis to ensure that sprinklers do not need to be cleaned or replaced. if problems are noted , the Program Director will be notified so the vendor can be contacted. In addition the Program Director will do a check on the home on a monthy basis to ensure there are no problems with the sprinklers. Responsible party: Area Director by 3/12/2012</p>	03/08/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342
---	---

(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
	the color of the ceiling paint on the base of the deflectors and/or collections of dust on the deflectors. This was acknowledged by the Program Director at the time of the observations.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342			
(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			
KS147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD 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 administration failed to provide a written plan for protecting 7 of 7 clients in the event of fire by providing an emergency policy and procedure manual, which is readily available in the event of an emergency. This deficient practice could affect all seven clients currently residing in the home.</p> <p>Findings include:</p> <p>During interview with the Program Director at the administrative office at 9:45 am on 02/17/12 regarding the facility's fire safety plan, the Program Director stated the fire safety plan was</p>	KS147	Currently the facility has procedures in place to direct staff how to react to a fire and evacuate the clients safely. Staff are trained in emergency procedure upon hire and annually. The Program Director will retrain staff on the written fire plan of the home which contains items such as who should be contacted if there is a fire, where the clients should be evacuated during the drill, and what level of assistance do each client need. The Area Director will retrain The Program Director on maintaining a copy of the fire plan in the home for all parties to have access to the document when needed. Responsible Party: Area Director	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/17/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342		
(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	
	maintained in the home. During observation in the group home at 12:30 pm on 02/17/12, a written fire safety plan could not be located. The Program Director indicated it was her understanding that the diagram on the wall which noted the evacuation routes was the plan. When asked if there was a written plan that specified interventions and directions for staff to follow in the event of a fire emergency, which included, where clients are evacuated to, who is contacted, etc, she indicated she was not aware if one could be located.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342			
(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			
KS148	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1</p> <p>Based on observation and interview, the facility failed to ensure the facility administration had adopted a smoking policy for the home to protect 7 of 7 clients in the home. This deficient practice could affect all seven of the clients.</p> <p>Findings include:</p> <p>Interview with the facility's Program Director on 02/17/12 at 12:30 pm indicated she could not locate and was not aware of a facility smoking policy. During observation in the group home from 12:15 pm to 12:45 pm, no smoking policy or regulations were observed.</p>	KS148	The facility currently has a smoking policy that should be adhered to. The Program Director will retrain all staff on the smoking policy. The Area Director will retrain the Program Director and Home Manager on maintaining a copy in the home for the use of all parties. Responsible Party: Area Director	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342			
(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			
KS154	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing all procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period to protect 7 of 7 clients. LSC 33.7.1 requires plans for the protection of residents shall include special staff response, including the fire protection procedures needed to ensure the safety of any resident. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>During interview with the Program Director at the administrative office at 9:45 am on 02/17/12 regarding the facility's fire safety plan, the Program Director stated the fire safety plan was maintained in the home. During observation in the group home at 12:30 pm on 02/17/12, a written fire safety plan could not be located. The Program</p>	KS154	The facility currently has an emergency procedure in place if the fire or sprinkler system fails to be active. The Program Director will retrain all staff on Indiana Mentor Procedures for a Fire Watch. The Area Director will retrain the Program Director and Home Manager on maintaining a copy of the procedure for a fire watch guidelines in the home. Responsible Party: Area Director	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342
---	---

(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
	Director indicated it was her understanding that the diagram on the wall which noted the evacuation routes was the plan. When asked if there was a written plan that specified interventions and directions for staff to follow in the event of a fire emergency, which included a fire watch or evacuation system in case the alarm or sprinkler systems were not operational for four hours or more, she indicated she was not aware if one could be located.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342			
(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			
KS155	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period to protect 7 of 7 clients. LSC 33.7.1 requires every residential board and care facility to have in effect and available to all supervisory personnel a plan for the protection of all persons. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>During interview with the Program Director at the administrative office at 9:45 am on 02/17/12 regarding the facility's fire safety plan, the Program Director stated the fire safety plan was maintained in the home. During observation in the group home at 12:30 pm on 02/17/12, a written fire safety plan could not be located. The Program Director indicated it was her understanding that the diagram on the wall which noted the evacuation routes was the plan. When asked if there was a written plan that specified interventions and directions for staff to follow in the event of a fire emergency, which included a</p>	KS155	The facility currently has an emergency procedure in place if the fire or sprinkler system fails to be active. The Program Director will retrain staff on Indiana Mentor Procedures for a Fire Watch. The Area Director will retrain the Program Director and Home Manager on maintaining a copy of the procedure for a fire watch guidelines in the home. Responsible Party: Area Director	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	fire watch or evacuation system in case the alarm system was not operational for four hours or more, she indicated she was not aware if one could be located.			