

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 03/31/2015
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342
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K 000 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: 03/31/15</p> <p>Facility Number: 001107 Provider Number: 15G593 AIM Number: 100245570</p> <p>Surveyor: Bridget Brown, 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 hard wired 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>	K 000		
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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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K 130 Bldg. 01	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.5.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were given maintenance at periods not more than one year apart. LSC 4.6.1.2.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. NFPA 10, 4.2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p>	K 130	<p>K 130 The facility maintains fire extinguishers in all areas of the home as needed to ensure safety in event of fire.</p> <p>The Home Manager will contact a vendor to service/check the fire extinguishers in the home.</p> <p>The home manager will monitor all fire extinguishers weekly plus document checks monthly to ensure the fire extinguishers are in working condition with routine maintenance. In addition the home manager will ensure a vendor inspects the fire extinguishers at least yearly. If repair is needed, the home manager will call the appropriate vendor to correct.</p> <p>Responsible Party: Program Director Completion Date: 4/30/15</p>	04/30/2015

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K 120 Bldg. 01	<p>Based on observation with the House Manager on 03/31/15 between at 12:05 p.m. and 2:00 p.m., the service and inspection tag on the portable fire extinguisher located in the sleeping room corridor and near the laundry revealed the extinguishers had been placed in service in June of 2013. Monthly checks were documented on this same tag for 2013 and January 2014. The last contractor report for the annual maintenance and inspection of the fire extinguishers was dated 06/26/13. The House Manager confirmed the report was the only documentation of the annual fire extinguisher inspections available.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In addition to the primary route, each sleeping room in facilities that use Exception No. 1 to 32.2.3.5.1 has a second means of escape that consists of one of the following:</p> <p>(a) It is a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape.</p> <p>(b) It is a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to an approved means of escape.</p>			

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	<p>(c) It is an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 sq. ft. The width is not less than 24 inches. The bottom of the opening is not more than 44 inches above the floor. Such means of escape is acceptable where one of the following criteria are met:</p> <p>(1) The window is within 20 ft of grade.</p> <p>(2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.</p> <p>(3) The window or door opens onto an exterior balcony. 33.2.2.3</p> <p>Exception No. 1: If the sleeping room has a door leading directly to the outside of the building with access to grade or to a stairway that meets the requirements of exterior stairs in 33.2.3.1.2, that means of escape is considered as meeting all the escape requirements for the sleeping room.</p> <p>Exception No. 2: A second means of escape from each sleeping room is not required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.</p> <p>Exception No. 3: Existing approved means of escape is permitted to continue to be used.</p> <p>Based on observation, record review, and interview the facility failed to ensure 1 of 4 means of escape remote from the primary exit was unobstructed. This</p>	K 120	K S120: The facility checks the home routine for open and easy egress to enable the clients to evacuate promptly without obstacles.	04/30/2015	

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K 152 Bldg. 01	<p>deficient practice could affect all occupants.</p> <p>Findings Include:</p> <p>Based on observation with the House Manager on 03/31/15 at 12:30 p.m., the northwest sleeping room had a door which opened directly to the outside. A bed was positioned directly in front of, and across the doorway with a two by four secured the floor to prevent the bed from being moved. The House Manager said at the time of observation, the arrangement was made because a difficult client did not want their bed positioned in any other orientation. A review of the Emergency Evacuation Plan posted for occupants identified the blocked door as an emergency exit. The House Manager acknowledged at the time, the bed obstructed one of the identified means of emergency exits.</p> <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</p>		<p>The Home Manager will ensure the bed is moved and positioned in the bedroom to allow free unblocked access to the secondary emergency exit door in the bedroom. The group home staff will be trained that all egresses must be kept open and not blocked.</p> <p>In the future, the Home Manager will check the egress access throughout the home on a weekly basis to ensure free access. The Program Director will complete monthly checks.</p> <p>Responsible Staff: Program Director Completion Date: 4/30/15</p>		

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	<p>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 ensure a written fire protection plan included the necessary means for evacuating 1 of 8 clients during the night shift in the event of fire. This deficient practice affects 1 of 8 clients.</p> <p>Findings include: Based on review of the Fire Drill Procedure with the House Manager on 03/31/15 at 1:50 p.m., clients were to be evacuated in the event of fire to a location outside the home. A review of</p>	K 152	<p>K S152: The facility clients are assessed on an at least annual basis per regulations to gauge the level of assistance needed to evacuate safely. The facility staffs according to the needs of the clients based on assessment results, regulatory guidelines and client team recommendations The fire evacuation assessments for the clients of the home were completed at the time of the survey. The home is currently providing two overnight staff to assist clients in event of a fire to safely evacuate. The rating of client 1 will be reassessed to determine the level of assistance</p>	04/30/2015

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	the F-1s, Worksheet for Rating Residents on risk factors, noted Client #1 needed "limited assistance from two staff" (to evacuate). The House Manager acknowledged the aforementioned rating for the resident and confirmed only one staff was on duty during the 11 p.m. to seven a.m. shift at the time of record review. He could provide no documentation of training by which any resident needing assist by two could be safely evacuated by one staff.		necessary to evacuate. The home staffing pattern will reflect the reevaluation of all the client assessments to ensure optimal safety. In the future, the Program Director will use the client Individual Support Plans and assessments when determining the skill level for the ability to ambulate and evacuate of all clients in the home. In addition, if the condition of the client should change, the Program Director will reassess the client as needed. The Program Director will ensure appropriate staffing levels are maintained in the home for the clients by bi-weekly review of the schedule to ensure client safety. Responsible Person: Program Director Completion Date: 4/30/15		