

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  04/23/2012
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7085 ALLISONVILLE RD INDIANAPOLIS, IN 46220
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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: 04/23/12</p> <p>Facility Number: 001020 Provider Number: 15G506 AIM Number: 100244980</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 with a basement was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including in corridors, sleeping rooms and all living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p>	K0000		
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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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	<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>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/24/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0130	<p>Based on observation and interview, the facility failed to ensure a yearly fire extinguisher inspection was performed for 2 of 3 portable fire extinguishers. NFPA 101, Section 4.5.7, requires any device, equipment, system, condition, arrangement, level of protection or any other feature required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 10, Standard for Portable Fire Extinguishers, 4-4.1 requires extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on observations with the Home Manager during a tour of the facility from 11:40 a.m. to 12:05 p.m. on 04/23/12, two portable fire extinguishers located in the hallway each had an inspection and maintenance tag indicating the last yearly inspection date was January 2011. Based on interview at the time of observation, the Home Manager acknowledged the two portable fire extinguishers located in the hallway each had an inspection and</p>	K0130	<p>A request has been made to US Automatic Sprinkler Company to schedule a time to complete the annual inspections on the portable fire extinguishers located in the hallway.</p> <p>Ongoing, the maintenance staff and maintenance supervisor will work with US Automatic Sprinkler Company to ensure that all fire extinguishers are inspected annually prior to the expiration date.</p> <p>Responsible party: Maintenance staff, maintenance supervisor.</p>	05/23/2012			

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	maintenance tag indicating the last yearly inspection date was January 2011.			

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KS018	<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.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 sleeping room doors would close and latch into the door frame. This deficient practice could affect 2 of 8 clients in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Home Manager during a tour of the facility from 11:40 a.m. to 12:05 p.m. on 04/23/12, the top hinge on the southwest bedroom entry door was missing the screws to attach the hinge to the door frame which caused the door to fail to close and latch into the door frame. Based on interview at the time of observation, the Home Manager acknowledged the southwest bedroom entry door failed to close and latch into the door frame because the top hinge on the door was not screwed into the door frame.</p>	KS018	<p>Indiana Mentor maintenance staff has fixed the top hinge on the southwest bedroom entry door so that the door closes and latches into the door frame. Home manager will receive retraining on ensuring that any maintenance needs are reported to the maintenance staff as soon as they are discovered so that all issues can be addressed within a timely manner. Ongoing the Home Manager and/or PD will complete weekly walkthroughs of the home to ensure that any maintenance needs are documented and reported so they can be addressed in a timely manner. Responsible Party: Home Manager, Program Director, maintenance staff</p>	05/23/2012

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KS152	<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>1. Based on record review and interview, the facility failed to provide documentation of fire drills conducted for 1 of 3 shifts for 1 of 4 quarters. This deficient practice affects all clients and staff.</p> <p>Findings include:  Based on review of "Fire Drill Report"</p>	KS152	<p>1. 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 Manager for</p>	05/23/2012	

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	<p>documentation with the Home Manager at 11:35 a.m. on 04/23/12, there is no documentation available for review of a fire drill being conducted on the first shift in the third quarter of 2011. Based on interview at the time of record review, the Home Manager acknowledged there is no documentation available for review of a fire drill being conducted on the first shift in the third quarter of 2011.</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills under varied conditions for 4 of 5 third shift fire drills. This deficient practice affects all clients and staff.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Home Manager at 11:35 a.m. on 04/23/12, third shift fire drills conducted on 06/06/11, 07/02/11, 09/07/11 and 12/08/11 were conducted at, respectively, 3:30 a.m., 2:30 a.m., 3:30 a.m. and 3:00 a.m. Based on interview at the time of record review, the Home Manager acknowledged third shift fire drills were not conducted under varied conditions.</p>		<p>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. 2. The fire drill schedule for 2012 was written so that drills each month are scheduled in more varied time frames than the previous 2011 schedule. The Home Manager and Program Director will ensure staff run all 2012 fire drills and that they are completed per the 2012 schedule monthly which will ensure the drills on all shifts are varied in time frame. Responsible Party: Home Manager, Program Director, Quality Assurance Specialist</p>		

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