

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G433	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2013
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3938 PRANGE AVE LAFAYETTE, IN 47905
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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: 08/26/13</p> <p>Facility Number: 000947 Provider Number: 15G433 AIM Number: 100244580</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, REM-Indiana 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 determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, in sleeping rooms and in living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p>	K010000		
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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 Impractical with an E-Score of 5.5.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/03/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010130	<p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were inspected at least monthly, and the inspections were documented, including the date and initials of the person performing the inspection. LSC 4.6.12.2 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, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice affects all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observations with the house manager between 2:30 p.m. and 3:30 p.m. on 08/26/13, the service and inspection tags for the portable fire extinguishers located in the kitchen and entry each noted they were placed in service in January 2013. Monthly checks were not documented. The house manager acknowledged at the time of observations, the tags were the only documentation for</p>	K010130	<p>The facility ensures that portable fire extinguishers are inspected, at least monthly. The facility maintenance staff will be trained to inspect every portable fire extinguisher in the home, on a monthly basis. Maintenance staff will document on the fire extinguisher tag, that the unit has been inspected and is in working order. The Home Manager will check, monthly that the fire extinguisher has been inspected, and will document this on the monthly evacuation drill report. The Program Director verifies all evacuation drills, monthly, for accuracy and will keep a copy of every drill in the safety book in the home. Responsible Parties : Maintenance staff, Home Manager, Program Director</p>	09/25/2013	

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	the monthly inspection and the extinguisher checks had not been noted.				

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K01S053	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms are powered from the building electrical system and when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms are installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3.</p> <p>Exception No 1: Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system.</p> <p>Exception No. 2: Where buildings are protected throughout by an approved automatic sprinkler system, in accordance with 32.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms.</p> <p>Based on record review and interview, the facility failed to provide a current sensitivity test report to evidence smoke detectors protecting 8 of 8 clients were tested by a qualified service technician to ensure they were within their listed and</p>	K01S053	The facility ensures sensitivity tests on sprinkler systems are conducted, as required. The sensitivity tests were conducted, in accordance with policy, however, the Home Manager did not have access to the most recent test. The Home Manager	09/25/2013			

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	<p>marked sensitivity range. LSC 9.6.2.10.1 requires smoke alarms shall be in accordance with the requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3 requires testing to be in accordance Section 7-3, Inspection and Testing Frequencies. NFPA 72, 7-3.2.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its 		<p>was unable to produce this sensitivity test for review. The Program Director will be retrained to ensure that current and up to date sensitivity testing documentation is available in the home. This documentation will be filed, in the safety book, within the home and updated regularly, per the standard. Responsible Parties: Home Manager, Program Director Date of Completion: 9/25/13</p>				

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	<p>sensitivity is outside its listed sensitivity range.</p> <p>(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. The detector sensitivity cannot be tested or measured using any spray device administering an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2.2 requires a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of records provided with the house manager on 08/26/13 at 3:00 p.m., the most recent documentation of a smoke detector sensitivity test report was dated 09/28/10. The house manager said at the time of record review, she had provided all the reports she was given for review.</p>				

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K01S147	<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>1. Based on record review and interview, the facility failed to ensure the fire protection plan included the necessary staff 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:</p> <p>Based on review of the Emergency Plans-Fire Procedure, Client F-1 worksheets for rating residents and interview with the house manager on 08/26/13 at 3:15 p.m., clients were to be evacuated in the event of fire to a location outside the home. A review of the F-1s,</p>	K01S147	The facility protects all persons in the event of a fire. All staff are trained upon hire, and ongoing as it relates to client evacuation in the event of a fire, including how to evacuate residents with unusual needs. All staff will be retrained on specific procedures to follow, regarding safely evacuating all clients, in the event of a fire. In addition, written protocols for evacuation of clients with unusual needs, will be developed, by the Program Director. All staff will be trained on these written protocols, and will be retrained at each monthly staff meeting to ensure safe evacuation of each client. The Home Manager will be	09/25/2013			

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	<p>rating the resident on risk factors, noted client # 8 needs limited assistance from 2 staff." The house manager confirmed there was one staff on duty overnight. Clients # 3 and # 7 were noted as "needs full assistance or very slow." The house manager acknowledged it was unlikely one staff could provide the assistance needed for a Client needing two staff and full assistance to two other Clients if there were and emergency during the overnight shift.</p> <p>2. Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients, which is amended or revised whenever any resident with unusual needs is admitted to the home. Such instruction is reviewed by the staff at least every two months. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on Fire Drill Reports reviewed with the house manager on 08/26/13 at 3:15 p.m., a lapse in staff fire safety training time was more than the two</p>		<p>responsible for ensuring monthly staff review of each clients evacuation needs. The Program Director will ensure that monthly staff meeting notes are maintained in the training book in the home, for review, as well as will maintain a copy in the office, for reference as needed. Responsible Parties: Program Director, Home Manager Completion Date: 9/25/13</p>				

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	months allowed as evidenced by the lack of any record of a fire drill for the 10:00 p.m. to 8:00 a.m. and 12:00 a.m. to 10:00 a.m. shifts during the third and fourth quarters of 2012, a lapse of six months; the 3:00 p.m. to 11:00 p.m. shift during the fourth quarter of 2012, a lapse of three months; during the three month fourth quarter of 2012 and between 03/27/13 to date for the 6:00 a.m. to 3:00 p.m. shift, a lapse of five months. The house manager said at the time of record review, there was no fire drill documentation available for these periods.			

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K01S152	<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 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 fire and evacuation drills were provided for each shift for 3 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include: Based on the Fire Drill Report review with the house manager on 08/26/13 at</p>	K01S152	The facility ensures that evacuation drills are run, for each client, on a monthly basis. The Home Manager will be retrained to ensure that all evacuation drills are conducted, per the posted schedule. The Home Manager will review the drills for accuracy and submit each drill to the Program Director for review. The Program Director will document, on the monthly Program Director	09/25/2013			

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	3:15 p.m., fire drill records were not provided for periods between 03/27/13 to date for the 6:00 a.m. to 3:00 p.m. shift; 10/01/12 to 12/31/12 for the 3:00 p.m. to 11:00 p.m. shift during the fourth quarter of 2012, or for the 10:00 p.m. to 8:00 a.m. on the third and fourth quarters of 2012. The house manager said at the time of record review, all the fire drill records had been provided.		checklist, that an accurate and appropriate evacuation drill has been conducted. The Home Manager will ensure that copies of all evacuation drills are placed in the safety book in the home. The Program Director will also maintain a file, in the office, for inspection and review. Persons responsible: Home Manager and Program Director Completion Date: 9/25/13		