

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G599	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 860 W 65TH LN MERRILLVILLE, IN 46410
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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: 03/17/14</p> <p>Facility Number: 001113 Provider Number: 15G599 AIM Number: 100245610</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 with a basement was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in resident rooms and in common 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 Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.8.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/20/14.</p>	K010000		

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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K01S053	<p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: 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 evidence 17 of 17</p>	K01S053	The facility is committed to maintaining the health and safety of all the clients we serve. The facility currently contracts with an	04/11/2014

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	<p>smoke detectors were tested by a qualified service technician to ensure they were within their listed and 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 sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. 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 		<p>outside vendor in order to maintain and test our smoke detectors per state requirements. The test was performed on 2/20/2014. The program director will be retrained by the Area director to obtain a copy of the smoke detector report yearly. The program director will also be retrained by the Area director to maintain the most current copy of the smoke detector testing in the home. The Area director will monitor the status of when the facility is due to be tested and will make sure that the most current copy of the test per state guidelines is located in the home for review. Responsible Party: Area Director</p>	

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K01S147	<p>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 client, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of fire systems inspection and test records provided by the Program Director on 03/17/14 at 2:15 p.m., the most recent documentation of a smoke detector sensitivity test was dated 09/30/10. The program director said at the time of record review, she had provided all inspection reports she was given for review.</p> <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>	K01S147	The facility is committed to treating all the clients we serve				

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	<p>Based on record review and interview, the facility administration failed to provide evidence 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 review of Fire Drill Reports with the program director on 03/17/14 at 1:50 p.m., fire drill training documentation was missing for the first shift (7:00 a.m. to 3:00 p.m.) between 03/01/13 to 10/06/13, a period of nine months. The program director immediately reviewed the training documentation and acknowledged there was no evidence of training for the first shift staff during this time frame.</p>		<p>with dignity and respect. The facility is also comitted to maintaining the health and safety of all the clients. The program director will be retrained by the Area director to retrain all staff on the policies and procedures and how to implement their job duties and responsibilities in regards to an emergency situation . The program director will be retrained by the Area director to make sure that the fire drills are done during various shifts and times and that adequate documentation is kept in the home. For the next 3 months the Area director will monitor the documentation in the home to make sure all the correct information is recordedand that the documents are present in the home for review. The program director will also be retrained by Area director that if for any reason the needs of the clients change or if we receive a new client staff will assist the client with responding to an emergency situation according to their most current needs during that timeframe. Staff will be retrained by the program director on their job duties and responsibilities and how to implement the policies and procedures during an emergency situation. Staff will also be retrained by the program director that if for any reason the needs of the clients change or if we receive a new client staff will assist the client following the clients most current needs during that</p>				

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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.</p> <p>Based on record review and interview, the facility failed to ensure fire and evacuation drills were provided for each shift for 2 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p>	K01S152	<p>timeframe. Responsible Party: Area Director</p> <p>The facility is committed to maintiaing the health and safety of all the clients we serve. Staff will be retrained to review and follow the fire drill schedule and implement the schedules as it is written. The Home Manager and the Program Director will be retrained by the Area Director to review and monitor the</p>	

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	Based on review of Fire Drill Reports with the program director on 03/17/14 at 1:50 p.m., fire drill training documentation was missing for the first shift (7:00 a.m. to 3:00 p.m.) between 03/01/13 to 10/06/13, the second and third quarter of 2013. The program director immediately reviewed the training documentation and acknowledged there was no evidence of fire drills for the first shift staff during this time frame.		evacuation schedule and make sure staff are following the times as written per month. For the next 3 months the Area Director will moniotr the documentation in the home to make sure the schedules are being implemented and that the documentation is correct and present in the home.Responsible Party: Area Director		