STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	723 E 116TH ST CARMEL, IN 46032

(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
K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 06/07/12 Facility Number: 000890 Provider Number: 15G376 AIM Number: 100244260 Surveyor: Mark Caraher, Life Safety Code Specialist, 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. This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, in client sleeping rooms and all living areas. The facility has a capacity of 8 and had a census of 7 at the time of this survey.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	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 2.6. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/08/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0130	Based on observation and interview, the facility failed to ensure a yearly fire extinguisher inspection was performed for 1 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. Findings include: Based on observation with the Home Manager during a tour of the facility from 10:15 a.m. to 10:45 a.m. on 06/07/12, the portable fire extinguisher located in the laundry room had an inspection and maintenance tag indicating the last yearly inspection date was March 2010. Based on interview at the time of observation, the Home Manager acknowledged the portable fire extinguisher located in the laundry room had an inspection and	K0130	The Home Manager will be retrained to include up to date quality checks and inspections on the monthly Home Manager/PD checklist. If any problems should arise, the Home Manager will inform the appropriate maintenance personnel. The Home Manager will ensure that all fire extinguishers are maintained and inspected within the appropriate time frames (annually or more) as needed. Ongoing, the Home Manager will complete the monthly Home Manage/PD checklist and request that any repairs be made in the appropriate timeframe. Responsible Party: Home Manager Completion Date: July 7, 2012	07/07/2012

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	maintenance tag indicating the last yearly inspection date was March 2010.			
KS016	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Interior wall and ceiling finish materials in accordance with 10.2 and 10.2.3 is Class A or Class B. 32.2.3.3.2, 33.2.3.3 Based on observations and interview, the facility failed to ensure the interior finish in 2 of 9 rooms was rated Class A or Class B for a Slow rated facility. This deficient practice could affect all clients in the facility. Findings include: Based on observation with the Home Manager during a tour of the facility from 10:15 a.m. to 10:45 a.m. on 06/07/12, wood paneling covered each of four walls in the southwest bedroom and all four walls in the living room. Based on interview at the time of the observations, the Home Manager stated there was no documentation available to show the flame spread rating for the wood paneling was Class A or Class B.	KS016	The Area Director will get with the Maintenance Supervisor to discuss the wood paneling in the bedroom and the living room to ensure that documentation is found to show if Class A or Class B. Ongoing, the Program Director will complete random audits of the home to ensure that all maintenance issues are completed when addressed. Completion Date: July 7, 2012 Responsible Party: Area Director, Maintenance Supervisor	07/07/2012

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KS147	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 Based on record review and interview, the facility failed to provide and to periodically instruct staff of a plan for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients in the facility. Further, NFPA 101A, Guide on Alternative Approaches to Life Safety, 2001 edition at 6-5.2.1 states the protection plan should include the following features: (a) A description of all available evacuation, escape, and rescue routes and the procedures and techniques needed to evacuate all the residents using the various routes. (b) A fundamental knowledge of fire	KS147	A Protection Plan has been written for this group home, as of June 20, 2012 Ongoing, The Protection Plan will be reviewed quarterly, or more as needed, to ensure that staff are aware and trained on how to handle an emergency situation of this matter. Ongoing, The Protection Plan will be made available to all staff in the home, by being placed in the safety book for their use as needed.**All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule. Ongoing, the**	07/07/2012

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	growth, containment, and extinguishment necessary to make reasonable judgments about action priorities and viable egress routes. This deficient practice could affect all staff and clients. Findings include: Based on record review with the Regional Director from 9:35 a.m. to 10:10 a.m. on 06/07/12, a copy of the facility's protection plan and records of staff instruction regarding the protection plan was not available for review. Based on an interview at the time of record review, the Regional Director acknowledged the facility's protection plan and records of staff instruction regarding the protection plan was not available for review. Furthermore, based on review of "Fire Drill Report" documentation with the Regional Director during record review from 9:35 a.m. to 10:10 a.m. on 06/07/12, there is no documentation available for review of fire drills being conducted on the first shift in the second and third quarter of 2011 or in the first quarter of 2012, or on the second shift in the second and fourth quarter of 2011 and in the first quarter of 2012 to provide staff training.		**Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met. Ongoing, all completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill.** **Completion Date: 7-7-2012** **Responsible Party: Home Manager**	

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KS152	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. (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. (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 provide documentation of fire drills conducted for 2 of 3 shifts for 3 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Regional Director	KS152	The fire drill schedule for 2012 was written so that drills each month are scheduled in more varied time frames that 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.	07/07/2012

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	during record review from 9:35 a.m. to 10:10 a.m. on 06/07/12, there is no documentation available for review of a fire drill being conducted: a) on the first shift in the second and third quarter of 2011 or in the first quarter of 2012. b) on the second shift in the second and fourth quarter of 2011 or in the first quarter of 2012. Based on interview at the time of record review, the Regional Director acknowledged there is no documentation available for review of fire drills being conducted on the aforementioned shifts and quarters.		Responsible Party: Program Director and Home Manger Completion Date: 7-7-2012	