

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/09/2012
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
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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: 08/09/12</p> <p>Facility Number: 000754 Provider Number: 15G230 AIM Number: 100243370</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 determined to be fully sprinklered. The facility has a fire alarm system with smoke</p>	K0000		

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>detection on all levels in corridors, common living areas and client rooms. The facility has the capacity for 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 Prompt with an E-Score of 1.0.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/29/12.</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 provide 1 of 3 portable fire extinguishers with a current verification of service collar. NFPA 10, the Standard for Portable Fire Extinguishers, at 4-4.4.2 requires each extinguisher that has undergone maintenance which includes internal examination or has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. Each extinguisher that has undergone the six year maintenance procedure shall have a "Verification of Service Collar" around the neck of the extinguisher indicating the date of 6 year maintenance. This deficient practice could affect all occupants using the basement which serves as a tornado shelter.</p> <p>Findings include:</p> <p>Based on observation with the program director on 08/09/12 at 2:35 p.m., the verification of service collar for the portable fire</p>	K0130	<p>The facility maintains portable fire extinguishers per state standards. The Fire Extinguisher, located in the basement, has been replaced. Ongoing, facility maintenance staff will check each portable fire extinguisher to ensure that each unit is maintained, checked and operated according to standard. The Home Manager will review each portable fire extinguisher, monthly, to ensure that all portable fire extinguishers are properly maintained. The Home Manager will document this on the monthly evacuation drills. Completion Date: 9/8/12 Responsible Party: Home Manager, Maintenance staff.</p>	09/08/2012

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	<p>extinguisher in the basement indicated the last six year maintenance check had been done in 2003. The program director acknowledged at the time of observation, she could not provide evidence the six year check was done since 2003.</p>			

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KS147	<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>Based on record review and interview, the facility failed to ensure the Fire Plan included activation of the fire alarm for the protection of 8 of 8 clients. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of the Facility Fire Plan for response to fire with the program director on 08/09/12 at 2:00 p.m., no mention of activating the fire alarm was found. At the time of record</p>	KS147	The facility has in place, a written plan for protecting all persons in the event of a fire. The facility ensures the Fire Plan includes activation of the fire alarm, for the protection of 8 of 8 clients in the home. (see attached, page XVI-2, #15 Safety Policy stating, "all group homes have a fire alarm system that is tested monthly and inspected annually). In addition, the monthly fire drill report clearly notes that the alarm was sounded, and that the alarm was audible in all areas. The Home Manager will review evacuation drills monthly to ensure that each drill indicates an audible alarm for each drill. In addition, the Home Manager will ensure that there is	09/08/2012			

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	review, the program director acknowledged this element was missing from the Fire plan.		a current copy of the Safety policy in the safety book, located in the home.Date of completion: 9/8/12Responsible Party: Home Manager		

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KS154	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide one written policy containing clear procedures to be followed in the event the sprinkler system has to be placed out of service for four hours or more in a 24 hour period to protect 8 of 8 clients. LSC 33.7.1 requires every residential board and care facility to have in effect and available to all supervisory personnel a plan for the protection of all persons. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Procedures for a Fire Watch and the Fire Prevention Procedures with the program director on 08/09/12 at 1:55 p.m., the written policy and procedure for an impaired</p>	KS154	<p>The facility has a written policies which are consistent with procedures to be followed in the event the sprinkler system has to be placed out of service for four hours or more in a 24 hour period. The Program Director had placed an outdated policy in the Safety Book, located in the home. The policies for fire safety, and the fire watch procedure are consistent and have been replaced in the safety book in each home. The Area Director will retrain the Program Director on the most updated Fire Watch Procedure and Fire Safety Policies. The Program Director will retrain the staff on the current Fire Watch Procedure and Fire Safety Policies that are to be utilized. Responsible Parties: Area Director, Program Director and Home Manager Completion Date: 9/8/12</p>	09/08/2012			

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	sprinkler system system stated the fire watch walk through of the home would be conducted "every 15 minutes." The Fire watch reference in the Fire Prevention procedures stated the "watch will include a walk through of the house every 30 minutes." The program director agreed at the time of record review, the two procedures referred to the same policy and gave conflicting directions to staff in the implementation of a fire watch.			

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KS155	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide one written policy containing clear procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period to protect 8 of 8 clients. LSC 33.7.1 requires every residential board and care facility to have in effect and available to all supervisory personnel a plan for the protection of all persons. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Procedures for a Fire Watch and the Fire Prevention Procedures with the program director on 08/09/12 at 1:55 p.m., the written policy and</p>	KS155	<p>The facility has a written policies which are consistent with procedures to be followed in the event the sprinkler system has to be placed out of service for four hours or more in a 24 hour period. The Program Director had placed an outdated policy in the Safety Book, located in the home. The policies for fire safety, and the fire watch procedure are consistent and have been replaced in the safety book in each home. The Area Director will retrain the Program Director on the most updated Fire Watch Procedure and Fire Safety Policies. The Program Director will retrain the staff on the current Fire Watch Procedure and Fire Safety Policies that are to be utilized. Responsible Parties: Area Director, Program Director and Home Manager Completion Date: 9/8/12</p>	09/08/2012	

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	<p>procedure for an impaired fire alarm system system stated the fire watch walk through of the home would be conducted "every 15 minutes." The Fire watch reference in the Fire Prevention procedures stated the "watch will include a walk through of the house every 30 minutes." The program director agreed at the time of record review, the two procedures referred to the same policy and gave conflicting directions to staff in the implementation of a fire watch.</p>			