

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G471	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2012
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3031 E KESSLER 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: 12/05/12</p> <p>Facility Number: 000985 Provider Number: 15G471 AIM Number: 100244650</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 was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, sleeping rooms and in all living areas. The facility has a capacity of 6 and had a census of 6 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 Slow with an E-Score of 4.5.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/06/12.</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>1. Based on observation and interview, the facility failed to ensure a yearly fire extinguisher inspection was performed for 3 of 3 portable fire extinguishers. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, Standard for Portable Fire Extinguishers, 4-4.1 states 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, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Home Manager during a tour of the facility from 11:45 a.m. to 12:20 p.m. on 12/05/12, the portable fire extinguishers located in the office, in the north hallway and in the dining room each had an inspection and maintenance sticker attached indicating the last yearly inspection date was March 2011. Based on interview at the time of the observations, the Home Manager acknowledged the portable fire extinguishers located in the facility each had an inspection and maintenance tag</p>	K0130	<p>The Area Director and Maintenance Supervisor will work with USAutomatic to ensure that all three fire extinguishers have the annual inspection completed.</p> <p>The Home Manager will be retrained on checking the fire extinguishers monthly to ensure that all appropriate checks have been completed, including making sure that all are charged appropriately.</p> <p>The Area Director and Maintenance Supervisor will work with USAutomatic to ensure that all fire extinguishers have the 12 year hydrostatic inspection completed every 6 years.</p> <p>Ongoing, the Home Manager and Program Director will complete a monthly walk thru of the group home, according to the Home Manager/PD checklist.</p> <p>Responsible Party: Home Manager, Program Director, Area Director, and Maintenance Supervisor.</p> <p>Completion Date: January 4, 2013</p>	01/04/2013			

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	<p>indicating the last yearly inspection date was March 2011.</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers located in the facility was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to 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 that an extinguisher is available and will operate. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Home Manager during a tour of the facility from 11:45 a.m. to 12:20 p.m. on 12/05/12, the portable fire extinguisher located in the office had an inspection and maintenance tag lacking monthly inspections for the period of June 2012 through November</p>						

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	<p>2012. Based on interview at the time of observation, the Home Manager stated no other documentation of monthly fire extinguisher monthly inspections was available for review and acknowledged monthly checks of the portable fire extinguisher located in the office had not been documented for the aforementioned six month period.</p> <p>3. Based on observation and interview, the facility failed to ensure 3 of 3 portable fire extinguishers which require a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Section 4-4.3. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, 4-4.3 requires every six years, stored pressure fire extinguishers which require a 12 year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Home Manager during a tour of the facility from 11:45 a.m. to 12:20 p.m. on 12/05/12, the</p>			

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	portable fire extinguisher located in the office, in the north hallway and in the dining room each had an affixed label and collar stating the most recent six year maintenance had been performed in February 2006. Documentation of six year maintenance performed after February 2006 was not available for review. Each portable fire extinguisher's manufacturer label indicated it is a stored pressure fire extinguisher manufactured in 1989. Based on interview at the time of the observations, the Home Manager acknowledged the aforementioned portable fire extinguishers were past due for the six year maintenance procedure.			

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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. Based on observation and interview, the facility failed to ensure 1 of 4 sleeping room doors would close and latch into the door frame. This deficient practice could affect 1 of 6 clients in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Home Manager during a tour of the facility from 11:45 a.m. to 12:20 p.m. on 12/05/12, the northwest bedroom entry door latching mechanism did not protrude into the door frame which caused the door to fail to latch into the door frame. Based on interview at the time of observation, the Home Manager acknowledged the northwest bedroom entry door failed to latch into the door frame.</p>	KS018	<p>The Area Director will work with the Maintenance Supervisor to ensure that the door latch is repaired and in working order. The Home Manager will retrain the Home Manager and Program Director on completing the Home Manager and Program Director monthly checklist, which includes the Ongoing, the Home Manager will report any maintenance issues to the Maintenance Crew for repair. Completion Date: January 4, 2013 Responsible Party: Home Manager, Program Director, and Maintenance Crew</p>	01/04/2013			

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KS147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>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 periodically instruct staff of a plan for special staff response, including fire protection procedures needed to ensure the safety of 6 of 6 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:</p> <p>(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.</p> <p>(b) A fundamental knowledge of fire</p>	KS147	<p>A Protection Plan will be written for this group home.</p> <p>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.</p> <p>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.</p> <p>All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills.</p>	01/04/2013

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	<p>growth, containment, and extinguishment necessary to make reasonable judgments about action priorities and viable egress routes.</p> <p>This deficient practice could affect all staff and clients.</p> <p>Findings include:</p> <p>Based on record review with the Area Director at the Corporate Office from 10:30 a.m. to 11:05 a.m. on 12/05/12, records of staff instruction and review of the facility's written protection plan was not available for review. Based on interview at the time of record review, the Area Director acknowledged records of staff instruction regarding the protection plan was not available for review. Furthermore, based on review of "Fire Drill Report" documentation with the Area Director, documentation was not available for review of a fire drill being conducted on the first shift in the second quarter of 2012.</p>		<p>The retraining will include reviewing a copy of the Fire Drill Schedule.</p> <p>Ongoing, the 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.</p> <p>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: 1-4-2013</p> <p>Responsible Party: Program Director and Home Manager</p>		

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KS152	<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 provide documentation of fire drills conducted on the first shift for 1 of 4 quarters. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include: Based on review of "Fire Drill Report" documentation with the Area Director</p>	KS152	The fire drill schedule for 2013 was written so that drills each month are scheduled in more varied time frames that the previous 2012 schedule. The Home Manager and Program Director will ensure staff run all 2013 fire drills and that they are completed per the 2013 schedule monthly which will ensure the drills on all shifts are varied in time frame.	01/04/2013			

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	during record review at the Corporate Office from 10:30 a.m. to 11:05 a.m. on 12/05/12, documentation of a fire drill being conducted on the first shift in the second quarter of 2012 was not available for review. Based on interview at the time of record review, the Area Director acknowledged documentation was not available for review of a fire drill being conducted on the first shift in the second quarter of 2012.		Responsible Party: Program Director and Home Manger Completion Date: 1-4-2013		