

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
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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: 08/07/14</p> <p>Facility Number: 000892 Provider Number: 15G378 AIM Number: 100244290</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 with a basement was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in corridors, in bedrooms and in all 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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K010130	<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 3.2.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/11/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Based on observation and interview, the facility failed to maintain 1 of 2 smoke barrier doors. LSC 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be maintained or removed. 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 11:10 a.m. to 11:40 a.m. on 08/07/14, the smoke barrier door in the south hallway</p>	K010130	<p>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 smoke barrier door that was not fully closing during the activated fire alarm has been repaired. Ongoing, the Home Manager will complete the monthly HomeManage/PD checklist and request that any repairs be made in the appropriate timeframe. Responsible Party: Home</p>	09/06/2014

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K01S147	<p>which is held open by a magnetic hold device and arranged to automatically close, did not self close when the fire alarm system was activated at 11:30 a.m. The magnetic holding device released the door from the hold open position, but the door did not swing to self close and remained almost in the fully opened position when the fire alarm system was activated. Based on interview at the time of observation, the Home Manager acknowledged the aforementioned smoke barrier door did not self close and remained almost fully open when the fire alarm system was activated.</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</p>		Manager		

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	<p>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 8 of 8 clients in the facility. This deficient practice could affect all staff and clients.</p> <p>Findings include:</p> <p>Based on record review with the Home Manager from 10:10 a.m. to 11:10 a.m. on 08/07/14, 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 Home Manager stated new staff are trained at the time of hiring but acknowledged records of periodic staff instruction regarding special staff response and the protection plan for the facility was not available for review. Furthermore, based on review of "Fire Drill Report" documentation, there was no record of a fire drill conducted on the first shift in the first quarter of 2014, or for the second shift in the fourth quarter of 2013 and the first quarter of 2014 available for review.</p>	K01S147	<p>A Protection Plan will be written for this group home to address the needs of all clients and a plan of where to meet in case of an emergency. All staff will be trained on this protection plan. 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.</p> <p>Responsible Party: Program Director and Home Manager</p>	09/06/2014	

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K01S152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(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 -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities:</p> <p>(iii) File a report and evaluation on each drill;</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(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 provide</p>	K01S152	The fire drill schedule for 2014 was written so that drills each month are scheduled in more	09/06/2014

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	<p>documentation of a fire drill conducted on the first shift for 1 of 4 quarters and on the second shift for 2 of 4 quarters. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Home Manager during record review from 10:10 a.m. to 11:10 a.m. on 08/07/14, documentation of a fire drill conducted on the first shift (6:00 a.m. to 2:00 p.m.) in the first quarter of 2014 was not available for review. In addition, documentation of a fire drill conducted on the second shift (2:00 p.m. to 10:00 p.m.) in the fourth quarter of 2013 and the first quarter of 2014 was not available for review. Based on interview at the time of record review, the Home Manager acknowledged documentation of a fire drill conducted on the aforementioned shifts and quarters in 2013 and 2014 was not available for review.</p>		<p>varied time frames that the previous 2013 schedule. The Home Manager and Program Director will ensure staff run all 2014 fire drills and that they are completed per the 2014 schedule monthly which will ensure the drills on all shifts are varied in time frame. 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 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 into and reviewed by Quality Assurance for accuracy and thoroughness of each drill. Responsible Party: Program Director and Home Manger</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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