

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G663	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/05/2013
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5662 N CRESTVIEW AVE INDIANAPOLIS, IN 46220
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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: 12/05/13</p> <p>Facility Number: 001216 Provider Number: 15G663 AIM Number: 100233690</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, bedrooms and all living areas. The facility has a capacity of 6 and had a census of 5 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</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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	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.2.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/09/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010130	<p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers located in the facility were 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 observations with the Home Manager during a tour of the facility from 11:40 a.m. to 12:10 p.m. on 12/05/13, the portable fire extinguisher located in the dining room and in the kitchen each had an affixed inspection and maintenance tag lacking a monthly inspection for October and November 2013. Based on interview</p>	K010130	<p>The Home Manager and Program Director will be retrained on checking the fire extinguishers on a monthly basis. All fire extinguishers in this group home were checked on 12/9/2013. See attachment 1 for verification. 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.</p> <p>Ongoing, the Home Manager will complete the monthly Home Manage/PD checklist and request that any repairs be made in the appropriate timeframe.</p> <p>Responsible Party: Home Manager, Program Director, and Area Director</p>	01/04/2014			

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	at the time of the observations, the Home Manager stated no other documentation of monthly fire extinguisher inspections was available for review and acknowledged monthly inspections for October and November 2013 for the aforementioned portable fire extinguishers had not been documented.			

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K01S017	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those of 1¾ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2.</p> <p>Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved</p>						

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	<p>facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms are separated from escape routes by walls and doors that are smoke resistant.</p> <p>No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 sleeping room doors was capable of resisting smoke for at least 1/2 hour. NFPA 101, LSC 2000 Edition, in 8.2.4 requires doors in smoke barriers to be in accordance with NFPA 80, 1999 Edition, the Standard for Fire Doors and Windows. NFPA 80, Section 2-3.1.7 requires the clearance between the edge of the door and the frame not exceed 1/8 inch for wood doors. This deficient practice could affect one of six clients in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Home Manager during a tour of the facility from 11:40 a.m. to 12:10 p.m. on 12/05/13, the corridor door to east bedroom by the entrance to the south hallway was not smoke resistant due to a hole in the bottom of the door by the door jamb</p>	K01S017	<p>The Maintenance supervisor provided approval for 4 bedroom doors to be replaced due to holes and dents. The doors were replaced on 12/10/2013. 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.</p> <p>Ongoing, the Home Manager will complete the monthly Home Manage/PD checklist and request that any repairs be made in the appropriate timeframe.</p> <p>Responsible Party: Home Manager, Program Director, and Area Director</p>	01/04/2014			

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	along the latching side of the door which measured six inches long by one inch wide. Based on interview at the time of observation, the Home Manager acknowledged the aforementioned corridor door was not capable of resisting smoke for at least 1/2 hour.			

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K01S051	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 manual fire alarm systems was maintained in accordance with Section 9.6. Section 9.6.1.4 states a fire alarm system shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, Table 7-3.2 states all initiating devices shall be function tested annually. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of USAutomatic Sprinkler Corporation "Alarm &amp; Detection Equipment Test Report" documentation dated 09/11/12 during record review at the Corporate Office with the Regional Director from 10:00</p>	K01S051	The Home Manager and Program Director will be retrained on inappropriate restrictions. The lock from the bedroom door was removed so the pull station for the alarm is fully accessible. Ongoing, the Home Manager will ensure that the pull station will be fully accessible to everyone in case of an emergency. Responsible Party: Home Manager, Program Director, and Area Director	01/04/2014			

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	a.m. to 10:45 a.m. on 12/05/13, the smoke detector and the manual fire alarm box listed in the southeast bedroom were not functionally tested because "The southeast bedroom door was locked and the smoke detector and the manual pull station in this room were not tested during this inspection." Based on interview at the time of record review, the Regional Director stated no other documentation was available for review indicating the results of functional testing performed within the most recent twelve month period for the aforementioned initiating devices in the southeast bedroom. Based on observation with the Home Manager during a tour of the facility from 11:40 a.m. to 12:10 p.m. on 12/05/13, the aforementioned initiating devices are hard wired to the fire alarm system.				

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K01S053	<p>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 ensure 1 of 9 smoke detectors were within their listed and marked sensitivity range. LSC Section 9.6.2.10.1 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3</p>	K01S053	The Area Director has requested that USAutomatic complete all required and incomplete testing be completed, including, but not limited to, the Smoke Detector Sensitivity Testing The Area Director will be retrained on ensuring that all Indiana State	01/04/2014

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	<p>requires testing to be in accordance with Section 7-3, Inspection and Testing Frequency. 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 methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method.</li> <li>(2) Manufacturer's calibrated sensitivity test instrument.</li> <li>(3) Listed control equipment arranged for the purpose.</li> <li>(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.</li> <li>(5) Other calibrated sensitivity method acceptable to the authority having</li> </ol>		<p>Department of Health's mandatory testing be completed by USAutomatic and be followed up on in a timely manner if recommendations are made. Ongoing, the Area Director and/or Maintenance Supervisor will stay in constant contact with USAutomatic to ensure that all work and updates are completed and followed up with. Responsible Party: USAutomatic, Area Director, Maintenance Supervisor</p>	

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	<p>jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.</p> <p>The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of USAutomatic Fire &amp; Security "Alarm &amp; Detection Equipment Test Report" documentation dated 10/01/12 with the Regional Director during record review at the Corporate Office from 10:00 a.m. to 10:45 a.m. on 12/05/13, the "Dining Rm Bdrm" smoke detector listed "Fail" as the result for sensitivity testing. Based on interview at the time of record review, the Regional Director stated she was unaware of any subsequent documentation of the repair or replacement of the aforementioned smoke detector and acknowledged documentation of the aforementioned smoke detector sensitivity testing within its listed range for the most recent two year period was not available for review.</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. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the first and third shift for 2 of 4 quarters. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include:  Based on review of "Fire Drill Report"</p>	K01S152	The fire drill schedule for 2013/2014 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 2013/2014 fire drills and that they are completed per the 2013/2014 schedule monthly which will ensure the drills on all shifts are varied in time frame.	01/04/2014	

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	documentation with the Regional Director during record review at the Corporate Office from 10:00 a.m. to 10:45 a.m. on 12/05/13, documentation of a fire drill conducted on the first shift for the third quarter of 2013 and on the third shift for the second quarter of 2013 was not available for review. Based on interview at the time of record review, the Regional Director acknowledged documentation of fire drills conducted on the aforementioned shifts and quarters in 2013 was not available for review.		Responsible Party: Program Director and Home Manger	