STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G322	A. BUILDING -- B. WING	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	568 YORKTOWN RD GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 12/02/21 Facility Number: 000840 Provider Number: 15G322 AIM Number: 100244010 At this Emergency Preparedness survey, REM Occazio LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 12/02/21 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0004 Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),			

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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	§494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			

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	. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.475(a). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness-Response Plan" documentation dated January 2019 with the Program Supervisor during record review from 10:20 a.m. to 11:40 a.m. on 12/02/21, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually. Based on interview at the time of record review, the Program Supervisor stated the facility has an updated emergency preparedness plan at their main office but it was not available for review at the time of the survey. The Program Director agreed an emergency preparedness plan that was reviewed and updated within the most recent twelve month period was not available for review at the time of the survey. This finding was reviewed with the Program Supervisor during the exit conference.	E 0004	**E004 Develop EP Plan, Review and Update Annually CFR(s)** The facility must comply with all applicable Federal, State and local emergency preparedness requirement. The facility must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. **1. What corrective action will be accomplished?** · The emergency preparedness plan will be updated and revised. · The updated plan will be made available within the home. · Staff will be trained on the updated emergency preparedness plan. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Area Director will update and revise the emergency preparedness plan at least yearly. · Staff will be trained on the emergency preparedness plan.	01/02/2022

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			3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Area Director will update and revise the emergency preparedness plan at least yearly. · Staff will be trained on the emergency preparedness plan. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Program Director will monitor when they complete their quarterly health and safety. **5. What is the date by which the systemic changes will be completed?** January 2nd, 2022	
E 0006 Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2),			

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	486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of			

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	the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan which was based on a facility-based and community-based risk assessment, utilizing and all-hazards approach that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(a). This deficient practice could affect all occupants.	E 0006	**E006 Plan Based on all Hazards Risk Assessment** Emergency plan. The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. (1) Be based on and include a documented, facility-based and	01/02/2022

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	Findings include: Based on review of "Emergency Preparedness-Response Plan" documentation dated January 2019 with the Program Supervisor during record review from 10:20 a.m. to 11:40 a.m. on 12/02/21, a facility-based and community-based risk assessment, utilizing and all-hazards approach that was reviewed and updated at least every two years was not available for review. Based on interview at the time of record review, the Program Supervisor stated the facility has an updated plan at their main office but agreed a facility-based and community-based risk assessment, utilizing and all-hazards approach that was reviewed and updated at least every two years was not available for review at the time of the survey. This finding was reviewed with the Program Supervisor during the exit conference.		community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment. **1. What corrective action will be accomplished?** · The emergency preparedness plan will be updated and revised. · The updated plan will be made available within the home. · Staff will be trained on the updated emergency preparedness plan. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Area Director will update and revise the emergency preparedness plan at least yearly. · Staff will be trained on the emergency preparedness plan. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does**	

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			not recur: · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Area Director will update and revise the emergency preparedness plan at least yearly. · Staff will be trained on the emergency preparedness plan. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Program Director will monitor when they complete their quarterly health and safety. **5. What is the date by which the systemic changes will be completed?** January 2nd, 2022	
E 0013 Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b),			

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	§494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment,			

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	power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update its emergency preparedness policies and procedures at least every two years. The policies and procedures must be reviewed and updated at least every two years in accordance with 42 CFR 483.475(b). In addition, the facility failed to review and update its emergency preparedness policies and procedures to include policies and procedures for emerging infectious diseases. This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness-Response Plan" documentation dated January 2019 with the Program Supervisor	E 0013	**E013 Development of EP Policies and Procedures CRF (s)** Policies and procedures. Facilities must develop and implemented emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (z) of this section, risk assessment paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.	01/02/2022

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	during record review from 10:20 a.m. to 11:40 a.m. on 12/02/21, emergency preparedness policies and procedures based on a documented facility-based and community-based risk assessment, utilizing an all-hazards approach reviewed within the most recent two year period was not available for review. Based on interview at the time of record review, the Program Supervisor stated the facility has an updated emergency preparedness plan at their main office but it was not available for review at the time of the survey. This finding was reviewed with the Program Supervisor during the exit conference.		**1. What corrective action will be accomplished?** · The emergency preparedness plan will be updated and revised. · The updated plan will be made available within the home. · Staff will be trained on the updated emergency preparedness plan. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Area Director will update and revise the emergency preparedness plan at least yearly. · Staff will be trained on the emergency preparedness plan. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book.	

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			· The Area Director will update and revise the emergency preparedness plan at least yearly. · Staff will be trained on the emergency preparedness plan. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Program Director will monitor when they complete their quarterly health and safety. **5. What is the date by which the systemic changes will be completed?** January 2nd, 2022	
E 0029 Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated			

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	at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update its emergency preparedness communication plan that complies with Federal, State, and local laws at least every two years in accordance with 42 CFR 483.475(c). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness-Response Plan" documentation dated January 2019 with the Program Supervisor during record review from 10:20 a.m. to 11:40 a.m. on 12/02/21, the emergency preparedness communication plan for the facility had not been reviewed and updated within the most recent two year period. Based on interview at the time of record review, the Program Supervisor stated the facility has an updated emergency preparedness communication plan at their main office but it was not available for review at the time of the survey. This finding was reviewed with the Program Supervisor during the exit conference.	E 0029	**E029 Development of Communication Plan** Emergency plan. The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. **1. What corrective action will be accomplished?** · The emergency preparedness plan will be updated and revised. · The updated plan will be made available within the home. · Staff will be trained on the updated emergency preparedness plan. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Area Director will update and revise the emergency preparedness plan at least yearly. · Staff will be trained on the emergency preparedness plan.	01/02/2022

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			3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Area Director will update and revise the emergency preparedness plan at least yearly. · Staff will be trained on the emergency preparedness plan. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Supervisor will ensure that the emergency preparedness plan is located in the life safety book. · The Program Director will monitor when they complete their quarterly health and safety. **5. What is the date by which the systemic changes will be completed?** January 2nd, 2022	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program			

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	15G322	A. BUILDING -- B. WING	12/02/2021

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	§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness			

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	training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors,			

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	participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of			

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	emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff,			

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	individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure staff received training in regards to emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness-Response Plan"documentation dated January 2019 with the Program Supervisor during record review from 10:20 a.m. to 11:40 a.m. on 12/02/21, the facility lacked documentation of staff training on the emergency preparedness plan within the most recent two year period. Based on interview at the time of record review, the Program Supervisor stated they do have documented staff training on emergency preparedness within the most recent two year period but it was not available for review at the time of the survey.	E 0037	**E0037 EP Training Program** Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii.) Provide emergency preparedness training at least annually. (iii.) maintain documentation of the training. (iv.) Demonstrate staff knowledge of emergency procedures. **1. What corrective action will be accomplished?** · The staff will be trained on the emergency preparedness plan. · A competency test will be completed by all staff regarding the emergency preparedness plan. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice.	01/02/2022

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	This finding was reviewed with the Program Supervisor during the exit conference.		· The staff will be trained on the emergency preparedness plan. · A competency test will be completed by all staff regarding the emergency preparedness plan. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · The staff will be trained on the emergency preparedness plan. · A competency test will be completed by all staff regarding the emergency preparedness plan. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · The Program Supervisor will complete the training with the staff. · The Program Supervisor will maintain a copy of the training and tests in the life safety book. · The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits. **5. What is the date by which the systemic changes will be completed?**	

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K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 12/02/21 Facility Number: 000840 Provider Number: 15G322 AIM Number: 100244010 At this Life Safety Code survey, REM Occazio LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a fire alarm system with manual fire alarm boxes, sprinkler system flow switches and alarms hard wired to the fire alarm system. The facility has interconnected smoke detectors powered from the building electrical system installed in corridors and in all common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey. 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 0.4. Quality Review completed on 12/02/21	K 0000	· January 2nd, 2022	

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K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 4 bedrooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Program Supervisor during a tour of the facility from 11:40 a.m. to 12:10 p.m. on 12/02/21, the latching mechanism for the corridor door to BN's bedroom in the south hallway was taped over to prevent the mechanism from protruding from the door and into the latching plate on the door frame and prevented the door from latching into the door frame when tested to close multiple times. The latching mechanism failed to protrude into the latching plate on the door	K S363	**K0363 Corridor- Doors** Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings or other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15.	01/02/2022

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	frame. When the tape was removed, the latching mechanism protruded from the door and when the door was shut the door failed to open when tested to open. The bedroom was not occupied at the time of the observations. The door handle was also equipped with a lock which was locked and unlocked with a key by the Program Supervisor but the door still failed to open. Based on interview at the time of the observations, the Program Supervisor agreed the door would not latch into the door frame when the latching mechanism was taped over. The Program Supervisor called maintenance staff who stated they were now enroute to the facility to open the door. This finding was reviewed with the Program Supervisor during the exit conference.		**1. What corrective action will be accomplished?** · The bedroom door for BN's room will be repaired to ensure that it latches into the door frame properly. **2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected by the same deficient practice. · All of the bedroom doors will be checked to ensure that they latch properly into the door frame. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · All of the bedroom doors will be checked to ensure that they latch properly into the door frame. **4. How will the corrective action be monitored to ensure the deficient practice will not recur?** · Quarterly Health and Safety assessments will be completed quarterly by the Program Supervisor or Program Director to ensure that there are no environmental concerns in the	

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			home and that safety needs are being addressed. · The Program Supervisor will utilize a monthly maintenance report to track maintenance needs for the home. · The maintenance tracking forms will be completed and submitted monthly. These will be turned into the Program Director and Area Director to monitor for concerns that need to be addressed. **5. What is the date by which the systemic changes will be completed?** January 2nd, 2022	