STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G353	A. BUILDING -- B. WING	01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	1012 PARKWAY DR ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 State Department of Health in accordance with 42 CFR 483.475. Survey Date: 01/20/21 Facility Number: 000869 Provider Number: 15G353 AIM Number: 100244230 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. At the time of the survey, the census was 8. Quality Review completed on 01/25/21	E 0000		
E 0007 Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3) EP Program Patient Population [(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:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.]			
	Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice could affect all occupants. Findings include: Based on record review on 01/20/21 at 11:30 a.m. with the Program Supervisor (PS) the emergency preparedness plan (EPP) did not address: a) What services the facility would be able to provide. b) Continuity of services. Based on interview concurrent with record review it was acknowledged by the PS the EPP did not address items a and b above. This was discussed	E 0007	·The emergency preparedness plan will be updated to address the services the facility would be able to provide in an emergency. ·The emergency preparedness plan will be updated to address the continuity of services. ·Staff will be trained on the updated emergency preparedness plan. ·The updated plan will be kept in the home. ·The staff will be trained on the plan upon the revision and at least annually. ·The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits.	02/19/2021

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	with the PS during the exit conference.			
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients [(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 every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must			

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	address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 01/20/21 at 12:05 p.m. with the Program Supervisor (PS) the emergency preparedness plan did not address: 1. Alternate sources of power and protection of provisions. Based on interview concurrent with record review	E 0015	·The emergency preparedness plan will be updated to address: ·Food, water, medical and pharmaceutical supplies ·Alternate sources of energy ·Emergency lighting ·Fire detection, extinguishing, and alarm systems ·Proper disposal of sewage and waste ·Staff will be trained on the updated emergency preparedness plan. ·The updated plan will be kept in the home. ·The staff will be trained on the plan upon the revision and at least annually. ·The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits.	02/19/2021

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	with the PS it was stated she did not believe this information was in the emergency preparedness plan. This was discussed with the PS during the exit conference.			
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients [(b) Policies and procedures. The [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 (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the			

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	emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.			

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	*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 01/20/21 at 11:36 a.m. with the Program Supervisor (PS) there was nothing in the Emergency Preparedness policy which addressed a system to track the whereabouts of staff and clients during an emergency evacuation. Based on interview concurrent with record review with the PS it was acknowledged the plan did not contain a system to track staff and clients. This was discussed with the PS during the exit conference.	E 0018	·The emergency preparedness plan will be updated to include a system to track the whereabouts of staff and clients during an emergency evacuation. ·Staff will be trained on the updated emergency preparedness plan. ·The updated plan will be kept in the home. ·The staff will be trained on the plan upon the revision and at least annually. ·The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits.	02/19/2021
E 0022 Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), 483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place (b) Policies and procedures. The [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			

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	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 (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for clients, staff, and volunteers who remain in the facility in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 01/20/21 at 11:42 a.m. with the Program Supervisor (PS), a policy and procedure that included a means to shelter in place for clients, staff, and volunteers who remain in the facility was not available for review. Based on interview at the time of review it was acknowledged by the PS the Emergency Preparedness Plan did not include a means to shelter in place for clients, staff, and volunteers who remain in the facility. This was discussed	E 0022	·The emergency preparedness plan will be updated to include a means to include a shelter in place for clients, staff, and volunteers who remain in the facility. ·Staff will be trained on the updated emergency preparedness plan. ·The updated plan will be kept in the home. ·The staff will be trained on the plan upon the revision and at least annually. ·The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits.	02/19/2021

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	with the PS during the exit conference.			
E 0023 Bldg. --	403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4) Policies/Procedures for Medical Documentation [(b) Policies and procedures. The [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 (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and			

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	actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review on 01/20/21 at 12:15 p.m. with the Program Supervisor (PS) the facility did not address a system to preserve, protect and secure medical documentation in the Emergency Preparedness Policy (EPP). Based on interview concurrent with record review with the PS, it should be in the policy, but she did not know where to locate it. This was discussed with the PS during the exit conference.	E 0023	·The emergency preparedness plan will be updated to include a means to include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records. ·Staff will be trained on the updated emergency preparedness plan. ·The updated plan will be kept in the home. ·The staff will be trained on the plan upon the revision and at least annually. ·The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits.	02/19/2021
E 0024 Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing [(b) Policies and procedures. The [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			

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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include:	E 0024	·The emergency preparedness plan will be updated to address the use of volunteers including the process and role for integration of State or Federally designated health care professionals to address surge needs during and emergency. ·Staff will be trained on the updated emergency preparedness plan. ·The updated plan will be kept in	02/19/2021

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	Based on record review on 01/20/21 at 12:06 p.m. with the Program Supervisor (PS) the emergency preparedness plan (EPP) did not address the use of volunteers in an emergency. Based on interview at the time of record review with the PS it was confirmed the plan did not address use of volunteers. This was discussed with the PS during the exit conference.		the home. ·The staff will be trained on the plan upon the revision and at least annually. ·The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits.	
E 0026 Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary [(b) Policies and procedures. The [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 (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	1012 PARKWAY DR ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all clients. Findings include: Based on record review on 01/20/20 at 12:17 p.m. with the Program Supervisor (PS) there was nothing in the Emergency Preparedness Plan (EPP) which addresses the facilities role in compliance with the 1135 waiver declared by the Secretary. Based on interview concurrent with record review with the PS it was stated she did not know where to look in the EPP to find the 1135 waiver. This was discussed with the PS during the exit conference.	E 0026	·The emergency preparedness plan will be updated to include the 1135 waiver. ·Staff will be trained on the updated emergency preparedness plan. ·The updated plan will be kept in the home. ·The staff will be trained on the plan upon the revision and at least annually. ·The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits.	02/19/2021
E 0030 Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1) Names and Contact Information [(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 at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the			

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following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [facilities].
(v) Volunteers.

*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Patients' physicians
(iv) Other [hospitals and CAHs].
(v) Volunteers.

*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.
(iii) Next of kin, guardian, or custodian.
(iv) Other RNHCIs.
(v) Volunteers.

*[For ASCs at §416.45(c):] The communication plan must include all of the following:
(1) Names and contact information for the following:
(i) Staff.
(ii) Entities providing services under arrangement.

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	(iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and	E 0030	·The emergency preparedness plan will be updated to include the names and contact information for	02/19/2021

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	contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants. Findings include: Based on record review on 01/19/21 at 12:18 p.m. with the Program Supervisor (PS) the Emergency Preparedness Plan (EPP) did not have contact information on client physicians. Based on interview concurrent with record review with the PS it was confirmed the communication portion of the EPP did not include contact information for client physicians. This was discussed with the PS during the exit conference.		the staff, clients physicians, other ICF/IID facilities and volunteers. ·Staff will be trained on the updated emergency preparedness plan. ·The updated plan will be kept in the home. ·The staff will be trained on the plan upon the revision and at least annually. ·The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits.	
E 0033 Bldg. --	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information [(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 at least every 2 years (annually for LTC).] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.			

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	(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants.	E 0033	·The emergency preparedness communication plan will be updated to include a method for sharing information and medical documentation for patients under the facility’s care, as necessary, with other health providers to maintain the continuity of care; a means, in the event of an evacuation, to release client information as permitted; and a means for providing information about the general condition and location of clients under the facility’s care as permitted. ·Staff will be trained on the	02/19/2021

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	Findings include: Based on record review on 01/20/21 at 12:37 p.m. with the Program Supervisor (PS) the Emergency Preparedness Plan (EPP) did not include: a) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; b) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); c. c) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). Based on interview concurrent with record review the PS began searching for this information in the EPP but was unable to find it. The Program Director present at the time stated this would added to the EPP.		updated emergency preparedness plan. The updated plan will be kept in the home. ·The staff will be trained on the plan upon the revision and at least annually. ·The Program Director will ensure that the plan is available in the home when they do their weekly supervisory visits.	
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: 01/20/21 Facility Number: 000869 Provider Number: 15G353 AIM Number: 100244230 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	K 0000		

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	(NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was sprinkled. The facility has a fire alarm system with smoke detection in the corridors common living areas, and hard wired smoke detectors in client sleeping rooms. The attic was not used for living purposes, storage or fuel-fired equipment and was provided with a heat detection system to activate the fire alarm system. 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 0.52. Quality Review completed on 01/25/21			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers were installed in accordance with NFPA 10. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified	K S100	·The fire extinguisher in the laundry room will be lowered to ensure that the top of the extinguisher is no taller than 5 feet from the ground. ·The fire extinguisher in the kitchen will be remounted and ensure that the top of the extinguisher is no taller than 5 feet	02/19/2021

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	in applicable NFPA standards. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation with the Program Supervisor (PS) at 1:15 p.m. on 01/20/21, the portable fire extinguisher located in the Laundry was mounted on the wall with the top of the extinguisher 69 inches above the floor. Based on interview at the time of observation, the PS stated the portable fire extinguisher has been mounted that way for many years and the PS agreed the fire extinguisher was mounted more than five feet above the floor. 2. Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers in the Kitchen was protected. NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.4 requires that portable fire extinguishers types shall be (1) secured on a hanger (2) in the bracket supplied by the manufacturer (3) in a listed bracket approved for such purpose (4) in cabinets or wall recesses. This deficient practice could affect all occupants. Findings include: Based on observation with the Program Supervisor on 01/20/21 at 12:41 p.m., a fire extinguisher was sitting on the countertop unsupported in the Kitchen. Based on interview at the time of observation, the PS acknowledged the portable fire extinguisher was unsupported.		from the ground. ·The Program Supervisor and Koorsens will monitor to ensure new extinguishers are not hung higher than 5 feet from the ground. ·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 home and that safety needs are being addressed.	

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K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation and interview, the facility failed to ensure 1 of 1 staff office doors was provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the	K S222	·The regular door knob with the turn lock on the Program Supervisor office has been removed and replaced with a regular door knob with no lock. ·The Program Supervisor will ensure that double locks are not present on the doors of egress.	02/19/2021

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	releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect all staff in the facility. Findings include: Based on observation on 01/20/21 at 12:10 p.m. with the Program Supervisor (PS) the staff office door had a knob lock and a deadbolt which would require more than one motion to open the door. This was acknowledged by the PS at the time of observation. This was discussed with the PS during the exit conference.		·The Program Supervisor and Program Director will complete monthly observations to ensure double locks are not present on the doors of egress. ·The Program Supervisor and/or Program Director will complete quarterly health and safety forms that monitor the safety needs of the home.	
K S351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with Section 9.6, as modified below. The adequacy of the water supply shall be documented. In Prompt Evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or			

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	materials providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.1, 33.2.3.5.3.3,			

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	33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7 Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation with the Program Supervisor (PS) on 01/20/21 at 12:53 p.m., in the Riser utility room there were two low voltage wires strapped to a 2 1/2 inch diameter metal sprinkler pipe located at the ceiling. Based on interview at the time of observation, the PS acknowledged the attached pipe and was unaware this was not allowed.. This was discussed with the PS during the exit conference.	K S351	·The two low voltage wires strapped to a 2 ½ inch diameter metal sprinkler pipe located at the ceiling have been moved so they are no longer attached to the sprinkler pipe. ·The Program Supervisor will ensure that wires are not connected to the sprinkler pipes. ·Koorsens will also ensure that wires are not connected to the sprinkler pipes. ·The Program Supervisor and/or Program Director will complete monthly observations to ensure that wires are not connected to the sprinkler pipes. ·Koorsens will monitor when they complete their inspections. ·The Program Supervisor and/or Program Director will complete quarterly health and safety forms that monitor the safety needs of the home.	02/19/2021
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.			

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	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 1 of 5 client sleeping rooms were provided with a door which would latch securely in the door frame. This deficient practice could affect 2 client. Findings include: Based on observation on 01/20/21 at 12:02 p.m. with the Program Supervisor (PS), bedroom door #1 did not latch securely into its respective frame. Based on interview the PS was asked to view client bedroom door #1 to observe it did not latch into its frame and she confirmed the observation. This was discussed with the PS during the exit conference.	K S363	·The bedroom door for room #1 will be repaired to ensure that it latches into the door frame properly. ·All of the bedroom doors will be checked to ensure that they latch properly into the door frame. ·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 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.	02/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G353	A. BUILDING 01 B. WING	01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	1012 PARKWAY DR ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 4 ground fault circuit interrupter (GFCI) tested worked properly to provide protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect all staff. Findings include: Based on observations on 01/20/21 during the tour between 12:40 p.m. and 2:15 p.m. with the Program Supervisor (PS) there was one GFCI receptacle to the left of the Kitchen sink which when tested showed "open ground" and did not trip. Also, the GFCI in the Main bathroom was inoperable. Based on interview at the time of observations and tests with the PS it was acknowledged the GFCI's needed to be replaced.	K S511	·The outlet to the left of the kitchen sink has been replaced with a working GFCI. The outlet in the main bathroom was replaced with a working GFCI. ·The Program Supervisor and Program Director will monitor as they complete their observations in the home. ·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 home and that safety needs are being addressed.	02/19/2021

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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G353	A. BUILDING 01 B. WING	01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REM OCCAZIO LLC	1012 PARKWAY DR ANDERSON, IN 46012

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	This was discussed with the PS during the exit conference.			