STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G432	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	3606 HIGHWOODS DR N INDIANAPOLIS, IN 46222

(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
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/01/15 Facility Number: 000946 Provider Number: 15G432 AIM Number: 100244570 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. 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 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety,	K 0000		

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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	15G432		09/01/2015

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	Chapter 6, rated the facility Prompt with an E-Score of 1.3. Quality Review completed 09/03/2015-LB			
K 0130 Bldg. 01	Based on record review, observation and interview; the facility failed to ensure 2 of 4 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. Findings include: Based on record review with the Program	K 0130	The Area Director and Maintenance Supervisor will work with Koorsen to ensure that all three fire extinguishers have the six year inspection completed. The Program Coordinator will be retrained on checking the fire extinguishers monthly to ensure that all appropriate checks have been completed, including making sure that all are charged appropriately. The Area Director and Maintenance Supervisor will work with Koorsen to ensure that all fire extinguishers have the 12 year hydrostatic inspection completed every 6 years. The Program Director will complete once a month audits of the fire extinguishers ongoing, to ensure adequate charges and ensure that as a backup to the Program Coordinator, the fire extinguishers get checked routinely.	10/01/2015

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	Director from 11:45 a.m. to 12:25 p.m. on 09/01/15, monthly portable fire extinguisher inspection documentation for the most recent twelve month period was not available for review. Based on observations with the Program Director during a tour of the facility from 12:25 p.m. to 12:40 p.m. on 09/01/15, the portable fire extinguisher located near the main entrance and the portable fire extinguisher located in the south hallway each had an affixed inspection and maintenance tag lacking documentation of monthly inspections for July and August 2015. Based on interview at the time of interview and of the observations, the Program Director stated no other documentation of monthly portable fire extinguisher inspections was available for review and acknowledged documentation of monthly inspections for July and August 2015 for the aforementioned portable fire extinguishers were each not available for review.			