

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	<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: 03/22/12</p> <p>Facility Number: 000892 Provider Number: 15G378 AIM Number: 100244290</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist,</p> <p>At this Life Safety Code survey, REM-Indiana, Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story building with a basement was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including in corridors, bedrooms and all living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p>	K0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
---	---

(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
	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 4.7.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/27/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254			
(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			
K0130	<p>Based on observations and interview, the facility failed to ensure 2 of 3 fire extinguishers which require a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Section 4-4.3. NFPA 101, Section 4.5.7, requires any device, equipment or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 10, 4-4.3 requires every six years, stored pressure fire extinguishers which require a 12 hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on observations with the House Manager during a tour of the facility from 12:10 p.m. to 12:40 p.m. on 03/22/12, the following was noted;</p> <p>a) the portable fire extinguisher located in the living room by the main entrance was manufactured in 2002 and did not have any attached documentation showing six year maintenance had been performed. The portable fire extinguisher's manufacturer label indicated it is a stored</p>	K0130	<p>The Home Manager will be retrained to include up to date quality checks and inspections on the monthly Home Manager/PD checklist. If any problems should arise, the Home Manager will inform the appropriate maintenance personnel.</p> <p>The Home Manager will ensure that all fire extinguishers are maintained and inspected within the appropriate time frames (annually or more) as needed.</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</p> <p>Completion Date: April 14, 2012</p>	04/21/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>pressure fire extinguisher.</p> <p>b) the portable fire extinguisher located in the basement at the bottom of the stairwell was manufactured in 1995 and had an attached inspection collar and sticker which indicated the last six year maintenance procedure occurred in September 2002.</p> <p>Based on interview at the time of the observations, the House Manager acknowledged the fire extinguisher six year maintenance procedure was past due for the aforementioned fire extinguishers.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254			
(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			
KS046	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 3 electrical outlets in facility bathrooms were provided with functional ground fault circuit interrupter (GFCI) protection against electric shock. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, the 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 at receptacles intended to serve the counter top surfaces. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observations with the House Manager during a tour of the facility from 12:10 p.m. to 12:40 p.m. on 03/22/12, the following was noted;</p> <p>a. the electrical outlet one foot from the sink in the bathroom adjoining the south hallway was provided with GFCI</p>	KS046	<p>Indiana MENTOR Maintenance replaced the GFCI outlets on March 26, 2012.</p> <p>Ongoing, Indiana MENTOR Maintenance will ensure that all GFCI outlets remain in proper working order. Indiana MENTOR Maintenance will complete monthly walk-thrus in the home to ensure that no issues arise.</p> <p>Completion Date: April 21, 2012</p> <p>Responsible Party: Indiana MENTOR Maintenance</p>	04/21/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
---	---

(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
	<p>electrical outlet but the GFCI outlet test switch was inoperable which did not allow interruption of the electrical current to the outlet. The GFCI outlet was tested with a GFCI tester and the outlet did not trip when the trip button on the tester was pushed five times.</p> <p>b) the electrical outlet one foot from the sink in the basement bathroom is not provided with GFCI electrical outlet. The outlet was tested with a GFCI tester and the outlet did not trip when the trip button on the tester was pushed five times which indicated neither the outlet nor the circuit breaker for this outlet provides GFCI protection.</p> <p>Based on interview at the time of the observations, the House Manager acknowledged the aforementioned bathroom electrical outlets were not provided with GFCI protection against electrical shock.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254			
(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			
KS147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review, observation and interview; the facility failed to provide and to periodically instruct staff of a plan for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients in the facility. Further, NFPA 101A, Guide on Alternative Approaches to Life Safety, 2001 edition at 6-5.2.1 states the protection plan should include the following features:</p> <p>(a) A description of all available evacuation, escape, and rescue routes and the procedures and techniques needed to evacuate all the residents using the various routes.</p> <p>(b) A fundamental knowledge of fire</p>	KS147	<p>A Protection Plan has been written for this group home, as of April 1, 2012.</p> <p>Ongoing, The Protection Plan will be reviewed quarterly, or more as needed, to ensure that staff are aware and trained on how to handle an emergency situation of this matter.</p> <p>Ongoing, The Protection Plan will be made available to all staff in the home, by being placed in the safety book for their use as needed.</p> <p>Completion Date: April 21, 2012</p> <p>Responsible Party: Program Director and Home Manager</p>	04/21/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
---	---

(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
	<p>growth, containment, and extinguishment necessary to make reasonable judgments about action priorities and viable egress routes.</p> <p>This deficient practice could affect all staff and clients.</p> <p>Findings include:</p> <p>a. Based on record review with the House Manager from 11:55 a.m. to 12:10 p.m. on 03/22/12, a copy of the facility's protection plan and records of staff instruction regarding the protection plan was not available for review. Based on an interview at the time of record review, the House Manager acknowledged the facility's protection plan and records of staff instruction regarding the protection plan was not available for review.</p> <p>2. Based on observation with the House Manager during a tour of the facility from 12:10 p.m. to 12:40 p.m. on 03/22/12, the basement bedroom door is equipped with a lock on the room entry door which requires the use of a key to unlock. Based on interview at the time of observation, the House Manager stated no key was available to unlock the bedroom entry door and acknowledged the facility does not have a key available on site to unlock the bedroom entry door in case of emergency.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254			
(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			
KS154	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 8 of 8 clients by providing a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. This deficient practice affects all clients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the House Manager from 11:55 a.m. to 12:10 p.m. on 03/22/12, the facility did not have a written policy and procedure for an impaired automatic sprinkler system available for review. Based on an interview at the time of record review, the House Manager acknowledged a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24</p>	KS154	<p>Within 24-48 hours after each fire drill, the Home Manager and/or Program Director will check the fire alarm system. Ongoing, the Home Manager will complete the monthly Home Manage/PD checklist to ensure that all of the alarms are working properly, and will follow up with US Automatic if not. The Direct Support Professionals will be retrained on implementing the Indiana Mentor Fire Safety Watch Policy and Procedures. Responsible Party: Program Director and Home Manger Completion Date: 4-21-2012</p>	04/21/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254
---	---

(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
	hour period was not available for review.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254		
(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	
KS155	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to protect 8 of 8 clients by providing a written policy containing procedures to be followed in the event the fire alarm system is out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice affects all clients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the House Manager from 11:55 a.m. to 12:10 p.m. on 03/22/12, the facility did not have a written policy and procedure for an impaired fire alarm system available for review. Based on an interview at the time of record review, the House Manager acknowledged a written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period was not available for review.</p>	KS155	<p>A Protection Plan has been written for this group home, as of April 1, 2012. Ongoing, The Protection Plan will be reviewed quarterly, or more as needed, to ensure that staff are aware and trained on how to handle an emergency situation of this matter. Ongoing, The Protection Plan will be made available to all staff in the home, by being placed in the safety book for their use as needed. All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule. Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met. Ongoing, all completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill. Completion Date:</p>	04/21/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  03/22/2012
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4002 N MOLLER RD INDIANAPOLIS, IN 46254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
			4-21-2012 Responsible Party: Home Manager		