STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G550	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES- ADEPT	8307 CASTLETON BLVD INDIANAPOLIS, IN 46256

(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
W0000	Paper compliance was completed 8/7/12 for the Fundamental Certification and State Licensure survey completed 5/9/12. Facility Number: 001064 Provider Number: 15G550 AIMS Number: 100245440 Surveyor: Steve Corya, Surveyor Supervisor Tags Corrected; W149, W153, W154, W262, W323, W436 Not Corrected: W198	W0000		

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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W0198	483.440(b)(1) ADMISSIONS, TRANSFERS, DISCHARGE Clients who are admitted by the facility must be in need of and receiving active treatment services.	W0198	**CORRECTION:** *Clients who are admitted by the facility must be in need of and receiving active treatment services.* Specifically regarding client #1, with assistance from the facility, the client and his family are exploring providers, roommates and housing for Supported Living. **PREVENTION:** The facility will continue to work with the client, family members and the Bureau of Developmental Disability Services until such time that a provider has been determined and the transition process completed. **Responsible Parties:** BDDS Service Coordinator, QDDPD, Home Manger, Support Associates, Quality Assurance Team, Operations Team	12/01/2012