CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/28/2022		
	PROVIDER OR SUPPLIER			6025 BI	ADDRESS, CITY, STATE, ZIP COD JCKSKIN CT APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	3	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
E 0000							
Bldg		paredness Survey was diana Department of Health in CFR 483.475.	E 00	000			
	Survey Date: 04/28	3/22					
	Community Alterna compliance with En Requirements for M	15G465					
	The facility has 8 ce	ertified beds. All 8 beds are aid. At the time of the survey,					
	Quality Review con	npleted on 05/02/22					
	The requirement at NOT MET as evide	42 CFR, Subpart 483.475 is need by:					
E 0026 Bldg	(iv), 441.184(b)(8) (8), 483.73(b)(8), 4 (7), 494.62(b)(7) Roles Under a Wa §403.748(b)(8), §4 (C)(iv), §441.184(l §482.15(b)(8), §48	6.54(b)(6), 418.113(b)(6)(C) 9, 482.15(b)(8), 483.475(b) 485.625(b)(8), 485.920(b) aiver Declared by Secretary 416.54(b)(6), §418.113(b)(6) b)(8), §460.84(b)(9), 33.73(b)(8), §483.475(b)(8), 485.920(b)(7), §494.62(b)(7).					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[(b) Policies and procedures. The [facilities]

TITLE (X6) DATE

Any defiency statement 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 disclodays 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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	OF CORRECTION	IDENTIFICATION NUMBER  15G465	A. BUILDI B. WING	NG	COMPLETED 04/28/2022	
	PROVIDER OR SUPPLIER		60 IN			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETIC DATE	ϽN
	preparedness polion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and uyears [annually forminimum, the policible address the follow (8) [(6), (6)(C)(iv), [facility] under a with Secretary, in accordance at an altitude by emergency material by emergency existence of the Act, in the paragraph of the Act, in the	(7), or (9)] The role of the aiver declared by the rdance with section 1135 rovision of care and ternate care site identified magement officials.  403.748(b):] Policies and the role of the RNHCI under a sy the Secretary, in the ection 1135 of Act, in the at an alternative care site gency management				
	Based on record reversely failed to ensure emerged and procedures included facility under a wait in accordance with a provision of care and care site identified by officials in accordant This deficient practice.  Based on review of	riew and interview, the facility orgency preparedness policies ude the role of the ICF/IID over declared by the Secretary, section 1135 of the Act, in the d treatment at an alternate by emergency management are with 42 CFR 483.475(b)(8). It is could affect all occupants.  "Emergency/Disaster all" documentation dated	E 0026	CORRECTION: [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan. Specifically, facility will incorporate the following policies into its emergency preparedness plan. The role of the facility under a waiver declared by the Secret in accordance with section 113 the Act, in the provision of care and treatment at an alternate of	ary, 35 of e	22

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	î ´	JILDING	NSTRUCTION	(X3) DATE COMPL <b>04/28</b> /	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	Plans & Responses' 09/01/21 with the M review from 9:30 a. emergency prepared role of the facility u Secretary, in accord Act. Based on inter review, the Mainten not include the role declared by the Secretary in 1135 of the	viewed with the Maintenance			site identified by emergency management officials.  The QIDP Manager will collab with other residential providers determine a functional approa correct this deficient practice.  PREVENTION:  Members of the Operations Te (comprised of the Executive Director, Operations Managers Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QID Quality Assurance Coordinato Nurse Manager and Assistant Nurse Manager) will incorpora reviews of the facility's emerge preparedness program into scheduled monthly audits to assure all required component are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annua RESPONSIBLE PARTIES: QII Area Supervisor, Residential Manager, Direct Support Staff Operations Team, Regional Director	es to ch to eam s, ee DP, rs, ate ency ts	
E 0037 Bldg	441.184(d)(1), 482 483.73(d)(1), 484. 485.68(d)(1), 485. 486.360(d)(1), 491 EP Training Progr §403.748(d)(1), §4 §441.184(d)(1), §4 §483.73(d)(1), §48	. , . ,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/28/2022	
	PROVIDER OR SUPPLIER		6025 B	ADDRESS, CITY, STATE, ZIP COD BUCKSKIN CT NAPOLIS, IN 46250	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI	D BE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DATE
	(1), §485.920(d)(1 §491.12(d)(1).	), §486.360(d)(1),			
	*[For RNCHIs at § Hospitals at §482. HHAs at §484.102 §485.727, OPOs a at §491.12:] (1) Training prograll of the following (i) Initial training ir policies and proce existing staff, indiv under arrangemer consistent with the (ii) Provide emerg at least every 2 ye (iii) Maintain docu preparedness train (iv) Demonstrate s emergency proce (v) If the emergen and procedures at [facility] must cond updated policies at *[For Hospices at The hospice must (i) Initial training ir	n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. ency preparedness training ears. mentation of all emergency ning. etaff knowledge of dures. cy preparedness policies re significantly updated, the duct training on the and procedures.  §418.113(d):] (1) Training. do all of the following: a emergency preparedness			
	existing hospice e	dures to all new and mployees, and individuals			
		under arrangement,			
	consistent with the	· · · · · · · ·			
	(ii) Demonstrate s	_			
	emergency proced				
	· ·	ency preparedness training			
	at least every 2 ye	ears.			
	(iv) Periodically re	view and rehearse its			
	emergency prepar	redness plan with hospice			
	employees (including nonemployee staff),				

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION	(X3) DATE COMPL 04/28/	ETED		
	OF PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	with special emph the procedures no and others.  (v) Maintain docu preparedness trai (vi) If the emerger and procedures are hospice must consupdated policies are procedures.  *[For PRTFs at §a program. The PR following: (i) Initial training in policies and procedures arrangeme consistent with the (ii) After initial training preparedness training training preparedness training training preparedness training training to the procedures are procedures are procedures are procedures are procedures and	masis placed on carrying out eccessary to protect patients mentation of all emergency ining. Incy preparedness policies are significantly updated, the iduct training on the and  441.184(d):] (1) Training TF must do all of the In emergency preparedness edures to all new and viduals providing services int, and volunteers, eir expected roles. Ining, provide emergency ining every 2 years. In staff knowledge of edures.  Immentation of all emergency ining. Incy preparedness policies are significantly updated, the funct training on the updated edures.  60.84(d):] (1) The PACE to do all of the following: In emergency preparedness edures to all new and viduals providing on-site rangement, contractors, volunteers, consistent with ess. Igency preparedness training							

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15G465	A. BU B. W		<del></del>	04/28/	
		136403	B. W	_		04/20/	2022
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
COMMU	NIITY ALTEDNIATIV	VEC ADEDT			JCKSKIN CT		
COMMO	NITY ALTERNATIV	ES-ADEP I		INDIAN	APOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY (		DATE
		staff knowledge of dures, including informing					
		at to do, where to go, and					
		n 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.						
	*F   TO F   'W'   (0400 70(  ) ) 1(4)						
	*[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						
	1 '	viduals providing services					
	under arrangemei	nt, and volunteers,					
	consistent with the	eir expected role.					
	1 ' '	ency preparedness training					
	at least annually.						
	1 ' '	mentation of all emergency					
	preparedness trai	ning. staff knowledge of					
	emergency proce	_					
	omorgancy proces	dd:00.					
	*[For CORFs at §	485.68(d):](1) Training. The					
	CORF must do all	I of the following:					
	(i) Provide initial tı	raining in emergency					
		icies and procedures to all					
	1	staff, individuals providing					
		rangement, and volunteers,					
		eir expected roles.					
	(ii) Provide emerg at least every 2 ye	ency preparedness training					
		mentation of the training.					
	1 ' '	staff knowledge of					
	1 ' '	dures. All new personnel					
		and assigned specific					
		garding the CORF's					
	1	vithin 2 weeks of their first					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
I II I D I DI III	or conduction	15G465	B. W.			04/28	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
	NITY ALTERNATIV				JCKSKIN CT APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ning program must include ocation and use of alarm					
		als 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						
		edures, including prompt					
	reporting and exti	nguishing of lires, here necessary, evacuation					
	-	nnel, and guests, fire					
		poperation with firefighting					
		orities, to all new and					
		viduals providing services					
	_	nt, and volunteers,					
	consistent with the	eir expected roles.					
	(ii) Provide emerg	ency preparedness training					
	at least every 2 ye						
	, ,	mentation of the training.					
	` '	staff knowledge of					
	emergency proce						
		ncy preparedness policies re significantly updated, the					
		ct training on the updated					
	policies and proce	- · · · · · · · · · · · · · · · · · · ·					
	*IEor CMUCs at s	485.920(d):] (1) Training.					
		provide initial training in					
		•					
	emergency preparedness policies and procedures to all new and existing staff,						
	individuals providi	_					
		volunteers, consistent with					
	their expected role						
	•	the training. The CMHC					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G465		(X2) MULTIPL A. BUILDIN B. WING	(X3) DATE SURVI COMPLETED 04/28/2022	COMPLETED		
	PROVIDER OR SUPPLIER		602	EET ADDRESS, CITY, STATE, ZIP COD 25 BUCKSKIN CT DIANAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPR	LD BE COPRIATE	(X5) IPLETION DATE
IAU	must demonstrate emergency proced. CMHC must provide preparedness train Based on record regarded to emergency preparedness. The IC following: (i) Provide procedures. The IC following: (i) Provide preparedness policical and existing staff, in under arrangement, with their expected preparedness training (iii) Maintain documber Demonstrate staff is procedures in accord (1). This deficient occupants.  Findings include:  Based on review of Preparedness Manual (1) Provided Preparedness Manual (1) Preparedness M	e staff knowledge of dures. Thereafter, the de emergency ning at least every 2 years. View and interview, the facility of received training in regards are duess policies and comments of the de initial training in emergency es and procedures to all new individuals providing services and volunteers, consistent roles; (ii) Provide emergency eng at least every two years; mentation of the training; (iv) anowledge of emergency dance with 42 CFR 483.475(d) practice could affect all commentation dated framence. Aide during record ementation of staff training on the procedures within the most and commentation on emergency es and procedures within the most and procedures within the engree and procedures and procedures and proc	E 0037	CORRECTION:  The facility must have a treprogram on place with (i) training in emergency preparedness policies and procedures to all new and staff, individuals providing services under arrangeme volunteers, consistent with expected roles. (ii) Provide emergency preparedness at least annually. (iii) Main documentation of the train Demonstrate staff knowle emergency procedures.  Specifically, the facility win an emergency preparedness and procedures to all new existing staff, individuals procedures to all new existing staff, individuals procedures to all new existing staff, individuals procedures and procedures to all new existing staff, individuals procedures to all new existing staff, individuals procedures and procedures to all new existing staff, individuals procedures, consistent with expected roles; and providence and providence and procedures. From the staff knowled emergency procedures and the QIDP will be respected providing annual retraining curriculum and Area Superior providing annual retraining annual r	raining Initial  d I existing I on-site I on-site I ent, and In their I e I training Ining. (iv) I dge of II provide I policies I and I oroviding I ent, and In their I de I training I tra	27/2022

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO. AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 15G465 B. WING		CONSTRUCTION (X3) DATE SURVEY  COMPLETED  04/28/2022					
	PROVIDER OR SUPPLIER NITY ALTERNATIV		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
E 0039	403.748(d)(2), 416 441.184(d)(2), 482	3.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2),	TAG	well as training when the plan updated. The QIDP Manager will work with the Human Resources Team a facility management to maintal reproducible system to provide training documentation to regulatory agencies.  PREVENTION: Members of the Operations Teleocomprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manawill incorporate reviews of the facility's emergency prepared program into scheduled twice monthly audits to assure all required components are present Additionally, the agency Safet Committee will review and review the plan as needed but no less than annually.  RESPONSIBLE PARTIES: QI Area Supervisor, Residential Manager, Safety Committee, Human Resources Departmer Operations Team, Regional Director	with and in a e eam s, ger) ness eent. y ise s DP,			
Bldg	483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 49 <sup>-1</sup> EP Testing Require	102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2)						

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460.84(d)(2), 482.15(d)(2), 483.73(d)(2),

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	 ILDING	NSTRUCTION	(X3) DATE COMPI <b>04/28</b>	LETED
	ROVIDER OR SUPPLIER		6025 BL	DDRESS, CITY, STATE, ZIP COD JCKSKIN CT APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	\$483.475(d)(2), \$4845.625(d)(2), \$485.625(d)(2), \$491.12(d)(2)  *[For ASCs at \$41 OPO, "Organization CMHCs at \$485.9 \$491.12, and ESF  (2) Testing. The [for exercises to test to annually. The [fact following:  (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the [fact natural or man-materization of the exempt from encommunity-based functional exercise actual event.  (ii) Conduct an addevery 2 years, oppor functional exercise (i) of this section is include, but is not (A) A second full-section (II).	R LSC IDENTIFYING INFORMATION 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) , §494.62(d)(2).  6.54, CORFs at §485.68, ons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]: facility] must conduct the emergency plan ility] must do all of the  full-scale exercise that is		CROSS-REFERENCED TO THE APPROPI	ERIATE	
	led by a facilitator discussion using a	er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	ì	UILDING	NSTRUCTION		SURVEY LETED 1/2022		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250						
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	ON BE PRIATE	(X5) COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		pared questions designed							
	to challenge an e								
		acility's] response to and							
		ntation of all drills, tabletop							
	exercises, and emergency events, and revise the [facility's] emergency plan, as needed.								
	*[For Hospices at								
	(2) Testing for hospices that provide care in								
the patient's home. The hospice must conduct exercises to test the emergency									
	plan at least annually. The hospice must do								
	the following:								
	(i) Participate in a full-scale exercise that is community based every 2 years; or								
	, ,	nunity based exercise is not							
		uct an individual facility							
		exercise every 2 years; or							
		experiences a natural or							
	_	gency that requires activation							
		plan, the hospital is aging in its next required full							
		based exercise or individual							
	· ·	ctional exercise following the							
	onset of the emer	_							
		dditional exercise every 2							
	` '	ne year the full-scale or							
		e under paragraph (d)(2)(i)							
		conducted, that may							
		limited to the following:							
		-scale exercise that is							
		l or a facility based							
	functional exercis	•							
	(B) A mock disas								
	, ,	ercise or workshop that is							
		and includes a group							
	discussion using	<b>.</b>							
		emergency scenario, and a							
		atements, directed							
		pared questions designed							

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	OF CORRECTION	IDENTIFICATION NUMBER  15G465	l í	UILDING	NSTRUCTION	COMPL 04/28/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	care directly. The exercises to test the per year. The hose (i) Participate in a that is community. (A) When a community-based functional exercise emergency exempt from engal full-scale community functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercise (B) A mock disassi (C) A tabletop exercise facilitator that including a narrated, emergency scenal statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency's emergency is emergency to the hospice's emergency emergency.	spices that provide inpatient hospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise abased; or annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required aity based or facility-based to following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based a; or ter drill; or ercise or workshop led by a sudes a group discussion clinically-relevant rio, and a set of problem end messages, or prepared and to challenge an ospice's response to and intation of all drills, tabletop pregency events and revise argency plan, as needed.					
	*[For PRFTs at §4 §482.15(d), CAHs	41.184(d), Hospitals at at §485.625(d):]					

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Event ID:

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED  B. WING 04/28/2022				
		15G465	B. W.	ING		04/28/2022	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					JCKSKIN CT		
СОММО	NITY ALTERNATIV	'ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIE ID			PROVIDER'S PLAN OF CORRECTION  (1) CHACH CORRECTIVE ACTION SHOULD BE		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	. ,	PRTF, Hospital, CAH] must					
		s to test the emergency					
		ar. The [PRTF, Hospital,					
	CAH] must do the	_					
		an annual full-scale exercise					
	that is community	nunity-based exercise is not					
	` '	ict an annual individual,					
		ctional exercise; or					
	-	Hospital, CAH] experiences					
		or man-made emergency					
		<b>G</b> •					
	that requires activation of the emergency plan, the [facility] is exempt from engaging in						
		ull-scale community based					
	-	ity-based functional exercise					
		et of the emergency event.					
	-	an [additional] annual					
	, ,	nat may include, but is not					
	limited to the follo	-					
		-scale exercise that is					
	community-based						
	facility-based fund	ctional exercise; or					
	(B) A mo	ock disaster drill; or					
	(C) A tableto	exercise or workshop that					
	is led by a facilitat	tor and includes a group					
	discussion, using	a narrated,					
		emergency scenario, and a					
	set of problem sta	tements, directed					
		pared questions designed					
	to challenge an er						
	, , ,	he [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
	<u> </u>	cility's] emergency plan, as					
	needed.						
	*[For PACE at §4	60.84(d):1					
	-	PACE organization must					
	. ,	s to test the emergency					
	plan at least annu						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MUI A. BUII B. WIN		COMPL	C3) DATE SURVEY COMPLETED 04/28/2022		
	PROVIDER OR SUPPLIEI			6025 BL	DDRESS, CITY, STATE, ZIP COD ICKSKIN CT APOLIS, IN 46250		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	P	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT			(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	organization mus	t do the following:					
		an annual full-scale exercise					
	that is community						
	1 ' '	nunity-based exercise is not					
		uct an annual individual,					
	1	ctional exercise; or					
	1 ' '	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
	is exempt from engaging in its next required full-scale community based or individual,						
	facility-based functional exercise following the						
	onset of the emergency event.						
	(ii) Conduct an additional exercise every						
	· '	the year the full-scale or					
	1	e under paragraph (d)(2)(i)					
		conducted that may include,					
	but is not limited t						
	(A) A second full-	-scale exercise that is					
	community-based	l or individual, a facility					
	based functional	exercise; or					
	(B) A mock disas						
		ercise or workshop that is					
	1	and includes a group					
	discussion, using						
	I -	emergency scenario, and a					
		ntements, directed					
	to challenge an e	pared questions designed					
		PACE's response to and					
	. , ,	ntation of all drills, tabletop					
		nergency events and revise					
	· ·	gency plan, as needed.					
		, F,					
	*[For LTC Facilitie	es at §483.73(d):]					
		ity] must conduct exercises					
		ency plan at least twice per					
		announced staff drills using					
	the emergency pr	ocedures. The [LTC facility,					
	ICF/IID] must do t						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		15G465	B. W	ING		04/28/2022		
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	3			UCKSKIN CT			
COMMUI	NITY ALTERNATIV	'ES-ADEPT			APOLIS, IN 46250			
	Г		1		, I			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEI CHENCT!		DATE	
		an annual full-scale exercise						
	that is community	nunity-based exercise is not						
	1 ' '	ict an annual individual,						
	facility-based fund							
	· -	ility] facility experiences an						
	l ' '	nan-made emergency that						
		n of the emergency plan, the						
	-	mpt from engaging its next						
		lle community-based or						
		based functional exercise						
	following the onset of the emergency event.							
	(ii) Conduct an additional annual exercise							
	that may include,	but is not limited to the						
	following:							
		scale exercise that is						
	1	or an individual, facility						
	based functional e							
	(B) A mock disas							
		ercise or workshop that is						
	led by a facilitator							
	discussion, using							
	set of problem sta	emergency scenario, and a						
	I	pared questions designed						
	to challenge an er	·						
	_	LTC facility] facility's						
	` ′	naintain documentation of						
	1	exercises, and emergency						
		e the [LTC facility] facility's						
	emergency plan, a							
							1	
	*[For ICF/IIDs at §	§483.475(d)]:					1	
	(2) Testing. The IC	CF/IID must conduct						
	exercises to test t	he emergency plan at least						
	twice per year. Th	e ICF/IID must do the					1	
	following:							
		n annual full-scale exercise						
	that is community							
	(A) When a comm	nunity-based exercise is not						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING			COMPLETED	
		15G465	B. W	ING		04/28/	/2022	
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEI	R			JCKSKIN CT			
COMMI	NITY ALTERNATIV	/ES-ADEPT		INDIANAPOLIS, IN 46250				
OOMMO				II VIDI/ II V	711 OLIO, 114 40200			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	1	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		uct an annual individual,						
	facility-based functional exercise; or.							
	1 ' '	experiences an actual						
		ade emergency that requires						
		mergency plan, the ICF/IID						
		ngaging in its next required						
		nity-based or individual,						
	1	ctional exercise following the						
	onset of the emer							
	` '	Iditional annual exercise						
	that may include, but is not limited to the							
	following:							
	(A) A second full-scale exercise that is community-based or an individual,							
	1	ctional exercise; or						
	(B) A mock disast							
		ercise or workshop that is						
	_	and includes a group						
	discussion, using							
	I	emergency scenario, and a						
		ntements, directed						
		pared questions designed						
	to challenge an el	CF/IID's response to and						
		ntation of all drills, tabletop						
		nergency events, and revise						
		rgency plan, as needed.						
		rgency plan, as needed.						
	*[For HHAs at §48	84 1021						
		e HHA must conduct						
	` ' ' '	he emergency plan at						
		e HHA must do the						
	following:							
	_	full-scale exercise that is						
	community-based							
		community-based exercise						
	` '	conduct an annual						
	· ·	based functional exercise						
	every 2 years; or.							
		A experiences an actual						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED  B. WING 04/28/2022				
	PROVIDER OR SUPPLIER		6025 B	ADDRESS, CITY, STATE, ZIP COD BUCKSKIN CT NAPOLIS, IN 46250	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ade emergency that requires				
		mergency plan, the HHA is				
		ging in its next required ity-based or individual,				
		tional exercise following the				
	onset of the emer	_				
		ditional exercise every 2				
	` '	e year the full-scale or				
	1 .	e under paragraph (d)(2)(i)				
	of this section is c	onducted, that may				
	include, but is not	limited to the following:				
	(A) A second	full-scale exercise that is				
	community-based					
	facility-based fund					
	1 ' '	saster drill; or				
		exercise or workshop that				
	I -	or and includes a group				
	discussion, using					
	I	emergency scenario, and a				
	set of problem sta					
	to challenge an er	pared questions designed				
	_	HA's response to and				
	1 ' '	ntation of all drills, tabletop				
		nergency events, and revise				
		ency plan, as needed.				
	*[For OPOs at §48	-				
		e OPO must conduct				
		he emergency plan. The				
	OPO must do the	<u> </u>				
		er-based, tabletop exercise ast annually. A tabletop				
		a facilitator and includes a				
	I	using a narrated, clinically				
	• '	cy scenario, and a set of				
	_	ts, directed messages, or				
	•	is designed to challenge an				
	1 ' '	f the OPO experiences an				
		nan-made emergency that				

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AND PLAN OF CORRECTION  XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15G465		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED  B. WING 04/28/2022					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (FACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			
	requires activation OPO is exempt for required testing exempt for required testing exempt for the emergency (ii) Analyze the Olymaintain documer exercises, and entitle [RNHCl's and needed.  *[RNCHIs at §403 (d)(2) Testing. The exercises to test to the total formulation of the company of the exercises to test total formulation of the company of the exercises to test total formulation of the company of the exercises of the exemption of the exercises, and entitle the exercise that is company of the following the exercise that is company of the following the exercise full-section of the following the onset for the exercise that is company of the exercise of the following the onset following the onset following the onset following the onset for the exercise of the exercise full-section of the exercise full-section of the exercise o	n of the emergency plan, the om engaging in its next exercise following the onset event.  PO's response to and nation of all tabletop nergency events, and revise OPO's] emergency plan, as  3.748]:  e RNHCI must conduct he emergency plan. The ne following:  er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a A-relevant emergency et of problem statements, as, or prepared questions enge an emergency plan.  NHCI's response to and nation of all tabletop nergency events, and revise regency plan, as needed. A view and interview, the facility least two exercises to test the an annual basis using the ares. The ICF/IID facility must ing: (i) participate in a full-scale munity-based or when a exercise is not accessible, an a based. If the ICF/IID facility all natural or man-made uries activation of the et ICF/IIC facility is exempt from nunity-based or individual, acale exercise for 1 year of the actual event; (ii)	E 0039	CORRECTION: The [facility] must conduct exercises to test the emergen plan at least annually. Specific the agency's Quality Assurant Department has submitted a formal request to the Indianap Metropolitan Police Department/Department of Homeland Security Communic Emergency Response Team (CERT) to conduct an initial "talk" disaster exercise, with bi-annual exercises thereafter	cally, ce polis  ty able		
	conduct an addition	nal exercise that may include,		Additionally, the ResCare Qua	ality		

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  15G465		lì í	UILDING	ONSTRUCTION	(X3) DATE COMPL <b>04/28</b> /	ETED	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE	
	but is not limited to	the following: (A) a second			Assurance Department has			
		hat is community-based or			requested assistance from the	9		
		based. (B) a tabletop exercise			IMPD District Commander to			
		p discussion led by a			coordinate with CERT to facili	tate		
		narrated, clinically-relevant			this process. ResCare Facility			
	_	o, and a set of problem			supervisors, the QIDP and			
		l messages, or prepared			administrative level managem	ent		
		to challenge an emergency			(Operations Managers, Progra			
		he ICF/IID facility's response to			Managers, Quality Assurance			
	and maintain docum	nentation of all drills, tabletop			Manager, QIDP Manager, Qu			
	exercises, and emergency events, and revise the				Assurance Coordinators, Nurs	-		
	ICF/IID facility's emergency plan, as needed in				Manager and Assistant Nurse			
	accordance with 42 CFR 483.475(d)(2). This				Manager) will participate in the			
	deficient practice could affect all occupants.				exercises to assure facility			
					emergency preparedness			
	Findings include:				protocols are consistent with			
					community emergency			
	Based on review of	"Emergency/Disaster			management practices.			
	Preparedness Manu	al" documentation dated		The facility will develop				
	01/14/22 and "Eme	rgency, Disaster, Evacuation		documentation of the activation of				
	Plans & Responses	" documentation dated		the Emergency Preparedness				
	09/01/21 with the N	Maintenance Aide during record		Plan during the 2020-2021				
		.m. to 10:55 a.m. on 04/28/22,			COVID-19 epidemic, by 5/27/2	22		
		community based disaster drill			using the current state of			
		ent twelve month period was			emergency as a platform. At t	he		
		view. Based on interview at the			time of this exercise, a "table			
	time of record revie	ew, the Maintenance Aide			exercise will be scheduled wit	h		
	_	currently experiencing an			local emergency managemen	t		
		gency due to Covid-19 and			officials within 6 months of the	;		
		d procedures currently in effect			full-scale event.			
	-	re stated in the emergency			The QIDP Manager will collab			
		mentation but agreed the			with other residential provider			
	-	ducted a second community			determine a functional approa	ch to		
		or conducted a tabletop			correct this deficient practice.			
		most recent twelve month			PREVENTION:			
	period and agreed a	_			Members of the Operations To	eam		
		not available for review at the			(comprised of the Executive			
	time of the survey.				Director, Operations Manager	S,		
	TE1 : C' 1:	1 11 11 11 3 5 5 1 1			Program Managers, Area			
	This finding was re	viewed with the Maintenance			Supervisors, Quality Assurance	ce		

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	ID PLAN OF CORRECTION IDENTIFICATION NUMBER  15G465		A. BUILDING B. WING		COMPLETED 04/28/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PREFIX (EACH CORRECTION A CORRECTION OF ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
	Aide during the exit	conference.		Manager, QIDP Manager, Quality Assurance Coordir Nurse Manager and Assis Nurse Manager) will incorpreviews of the facility's empreparedness program into scheduled twice monthly a assure all required compoincluding but not limited to bi-annual community-based disaster exercises, are preadditionally, the agency Scommittee will review and the plan as needed but not than annually.  RESPONSIBLE PARTIES Area Supervisor, Resident Manager, Direct Support Scoperations Team, Regional Director	nators, tant porate ergency oudits to nents, d esent. afety revise less : QIDP, ial staff,			
K 0000								
Bldg. 01	conducted by the In accordance with 42  Survey Date: 04/28  Facility Number: 04  Provider Number: 1002  At this Life Safety C  Alternatives - Adep with Requirements 142 CFR Subpart 483 and the 2012 edition	00979 15G465	K 0000					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING				
	PROVIDER OR SUPPLIER		6025 BI	ADDRESS, CITY, STATE, ZIP CO UCKSKIN CT APOLIS, IN 46250	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
TAG		er 33, Existing Residential	TAU			DATE
	sprinklered. The fa with smoke detection areas. The attic was storage or fuel-fired with a heat detection alarm system. The had a census of 7 at Calculation of the E (E-Score) using NF Approaches to Life	ling was determined to be fully cility has a fire alarm system on in corridors and all living is not used for living purposes, a equipment and was provided in system to activate the fire facility has a capacity of 8 and the time of this survey.  Evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the				
	facility Prompt with an E-Score of 0.1.  Quality Review completed on 05/02/22					
K S712 Bldg. 01	least quarterly for under varied cond a. Ensure that a trained to perform b. Ensure that a familiar with the usemergency and diprocedures.  2. The facility mus	Il personnel on all shifts are assigned tasks; Il personnel on all shifts are se of the facility's saster plans and				
	one drill each year b. Make special evacuation of clier disabilities; c. File a report a d. Investigate all	r on each shift; provisions for the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		15G465	B. W	VING 04/28/2022			/2022
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	evacuated to a sar under the Health (of the Life Safety (3. Facilities must r paragraphs (i) (1) any live-in and relided to provide do conducted on the firm on the second shift deficient practice and visitors.  Findings include:  Based on review of Fire" documentation and the Program Marting from 9:30 a.m. to 10 documentation of a shift in the fourth quality Documentation of a second shift in the to September) 2021 was also not available for the time of records stated the facility of agreed fire drill documentationed shift available for review	meet the requirements of and (2) of this section for itef staff that they utilize.  ) riew and interview, the facility cumentation of a fire drill rest shift for 1 of 4 quarters and for 2 of 4 quarters. This iffects all clients, staff and  "Emergency Evacuation Drill: In with the Maintenance Aide anager during record review 0:55 a.m. on 04/28/22, fire drill conducted on the first fire drill conducted on the first fire drill conducted on the hird quarter (July, August, and the fourth quarter 2021 was for review. Based on interview of review, the Program Manager perates two shifts per day and numentation for the fits and quarters was not reviewed with the Maintenance	KS	712	CORRECTION: The facility must hold evacuate drills at least quarterly for each shift of personnel and under viconditions. Specifically, the facility on the each shift during the current quarter. PREVENTION: Professional staff will be retrained regarding the need to conduct evacuation drills at varied time each shift for all staff each quater and training will also focus on procompletion of evacuation drill forms and assessment of individual drill compliance. The Operations (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will review and trackfacility evacuation drill reports follow up with professional staneeded to assure drills occur ascheduled and follow up with tagency Safety Committee	h aried cility tion the ned es on arter. per es s, se c all and ff as as	05/27/2022

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING			(X3) DATE SURVEY COMPLETED 04/28/2022	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			ΓE	(X5) COMPLETION DATE
				Re En Ard Ma	ccordingly. esponsible Parties: nvironmental Services Team rea Supervisor, Residential anager, Direct Support Staff, IDP, Operations Team		

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