PRINTED:	02/09/2022
FORM API	PROVED

OMB NO. 0938-039

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G486		(X2) MULTIPL A. BUILDIN B. WING	e construction g <u>00</u>	COME	(X3) DATE SURVEY COMPLETED 01/18/2022	
	PROVIDER OR SUPPLIEI		791	EET ADDRESS, CITY, STATE, ZIP CO 9 SAN RICARDO COURT IIANAPOLIS, IN 46256	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE AP	ULD BE	(X5) COMPLETION DATE
W 0000						
Bldg. 00	recertification and a visit included a Corcontrol survey.	15G486	W 0000			
W 0336	accordance with 46	this report completed by #15068				
Bldg. 00	clients certified as care plan, a revie which must be on frequent basis de Based on record re- sampled clients (#1 services failed to er #2's health status w a quarterly basis. Findings include: 1. Client #1's recor 12:03 PM. Client # documentation clie reviewed for the fin March), the second	must include, for those s not needing a medical w of their health status a quarterly or more pending on client need. view and interview for 2 of 3 and #2), the facility's nursing nsure review of clients #1 and ras conducted by the nurse on d was reviewed on 1/13/22 at 1's record did not indicate nt #1's health status had been rst quarter (January, February, quarter (April, May, June), the August, September) or the	W 0336	<b>CORRECTION:</b> Nursing services must in those clients certified as needing a medical care review of their health sta must be on a quarterly of frequent basis dependin need. Specifically, the A Nurse Manager will be r expectations for quarter physicals. A review of m records indicated this de practice affected all clien home, with the exception	a not plan, a atus which or more og on client assistant etrained on ly nursing nedical eficient nts in the	02/17/2022

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

TITLE

(X6) DATE

Any define cystatement 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.

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUI		(X2) MULTIPLE C A. BUILDING B. WING	BUILDING <u>00</u>		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 01/18/2022	
AND PLAN OF CORRECTION NAME OF PROVIDER OR SU COMMUNITY ALTERN (X4) ID SUM PREFIX (EACH DE TAG REGULATO fourth quarter 2021. 2. Client #2's 11:26 AM. Cl documentatio reviewed for February, Ma June), the thin or the fourth of December) of QIDPM (Qua Professional I		15G486   PR   VES-ADEPT   2 STATEMENT OF DEFICIENCIE   NCY MUST BE PRECEDED BY FULL   PR LSC IDENTIFYING INFORMATION   tober, November, December) of   rd was reviewed on 1/13/22 at   #2's record did not indicate   ent #2's health status had been   or the first quarter (January,   the second quarter (April, May,   arter (July, August, September)   er (October, November,   1.   d Intellectual Disabilities   iger) #1 was interviewed on			COMPLETED 01/18/2022 COD COD COD COD COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE COMPLETI DATE		
		4. QIDPM #1 indicated clients #1 e their health status reviewed juarterly basis.		will follow-up with the Nurse Manager as needed to add issues raised through audi incident reports or other co brought to management at Members of the Operation (comprised of the Executiv Director, Operations Mana Program Managers, Qualit Assurance Manager, QIDF Manager, QIDP, Quality Assurance Coordinators, A Supervisors, Nurse Manager) nursing staff will incorpora medical chart reviews into formal audit process, whic occur no less than monthly assure that medical follow- including but not limited to quarterly nursing physical examinations take place a required. <b>RESPONSIBLE PARTIES</b> Area Supervisor, Site Sup- Direct Support Staff, Healt	dress its, poncerns itention. s Team /e agers, ty po Area ger and and te their h will y to -along s : QIDP, ervisor,		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G486 B. WING 01/18/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7919 SAN RICARDO COURT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Services Team, Operations Team W 0352 483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC Bldg. 00 SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview for 1 of 2 CORRECTION: W 0352 02/17/2022 sampled clients (#1), the facility failed to ensure Comprehensive dental diagnostic client #1 was assessed by a Dentist annually. services include periodic examination and diagnosis Findings include: performed at least annually. Specifically, the facility will obtain Client #1's record was reviewed on 1/13/22 at 12:03 a dental examination for client #1. PM. Client #1's ROV (Record of Visit) dated An audit of facility medical charts 2/25/20 indicated client #1 was evaluated by a indicated this deficient practice did dentist on 2/25/20. Client #1's ROV dated 2/25/20 not affect additional clients who was the most current dental examination in client reside at the facility. #1's record. **PREVENTION:** The Facility nurse will QIDPM (Qualified Intellectual Disabilities complete monthly audits of all Professional Manager) #1 was interviewed on charts and turn in the audits to the 1/13/22 at 1:25 PM. QIDPM #1 indicated the Nurse Manager for review. facility did not have documentation regarding a The Nurse Manager will current dental examination for client #1. review issues revealed in audits with the Executive Director and 9-3-6(a) Department heads weekly for follow-up. The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP 3DUS11 Event ID: Facility ID: 001000 Page 3 of 4 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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TATEMEN	T OF DEFICIENCIES	XAID SERVICES X1) PROVIDER/SUPPLIER/CLIA		ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>00</b>		(X3) DATE SURVEY COMPLETED	
		15G486	B. WING		01/18/2022	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP COD 7919 SAN RICARDO COURT				
		INDIAN				
X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		DATE	
				Manager, QIDP, Quality		
				Assurance Coordinators, Are		
				Supervisors, Nurse Manager		
				Assistant Nurse Manager) an nursing staff will incorporate	lu	
				medical chart reviews into the	bir	
				formal audit process, which w		
				occur no less than monthly to		
				assure that medical follow-alo		
			including but not limited to de	0		
				examinations take place as		
				required.		
				RESPONSIBLE PARTIES: Q	IDP,	
				Area Supervisor, Residential		
				Manager, Health Services Te	am,	
				Direct Support Staff, Operation	ons	
				Team, Regional Director		

3DUS11 Facility ID: 001000

1000 If continua

If continuation sheet Page 4 of 4