PRINTED:	05/06/2022
FORM AP	PROVED
OMB NO. (	0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	OF CORRECTION	IDENTIFICATION NUMBER: 15G486	A. BUILDING B. WING		COMPLETED 04/13/2022
	PROVIDER OR SUPPLIER		7919 S/	ADDRESS, CITY, STATE, ZIP CODE AN RICARDO COURT APOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	(X5) COMPLETION DATE
E 0000		, ,			
Bldg	Preparedness Surve	sit (PSR) to the Emergency y conducted on 02/18/22 was diana Department of Health 42 CFR 483.475.	E 0000		
E 0026 Bldg	Survey Date: 04/13 Facility Number: 0 Provider Number: 1002 At this PSR survey Preparedness survey Alternatives-Adept with Emergency Pre Medicare and Media and Suppliers, 42 C The facility has 8 cc certified for Medica survey, the census v Quality Review com The requirement at NOT MET as evide 403.748(b)(8), 416 (C)(iv), 441.184(b) 483.475(b)(8), 483 485.920(b)(7), 494 Roles Under a Wa Secretary	<ul> <li>/22</li> <li>01000</li> <li>15G486</li> <li>245010</li> <li>to the Emergency</li> <li>, Community</li> <li>was found not in compliance</li> <li>eparedness Requirements for</li> <li>caid Participating Providers</li> <li>FR 483.475.</li> <li>ertified beds. All 8 beds are</li> <li>id. At the time of the</li> <li>was 6.</li> <li>npleted on 04/13/22</li> <li>42 CFR, Subpart 483.475 is</li> <li>nced by:</li> <li>5.54(b)(6), 418.113(b)(6)</li> <li>0(8), 482.15(b)(8),</li> <li>3.73(b)(8), 485.625(b)(8),</li> <li>4.62(b)(7)</li> </ul>			
	(6)(C)(iv), §441.18	34(b)(8), §460.84(b)(9), 33.73(b)(8), §483.475(b)			

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

TITLE

(X6) DATE

Any definencystatement 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G486 B. WING 04/13/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7919 SAN RICARDO COURT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. \*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the E 0026 CORRECTION: 05/13/2022 facility failed to ensure emergency preparedness [Facilities] must develop and policies and procedures include the role of the *implement emergency* ICF/IID facility under a waiver declared by the preparedness policies and Secretary, in accordance with section 1135 of procedures, based on the the Act, in the provision of care and treatment at emergency plan. Specifically, the an alternate care site identified by emergency facility will incorporate the management officials in accordance with 42 CFR following policies into its 483.475(b)(8). This deficient practice could emergency preparedness plan: affect all occupants. The role of the facility under a waiver declared by the Secretary, FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3DUS22 Facility ID: 001000 If continuation sheet Page 2 of 24

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	r í	ILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/13/2022	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE	-	
COMM	INITY ALTERNATI				SAN RICARDO COURT NAPOLIS, IN 46256		
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(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	Findings include:	,			in accordance with section 1 <sup>2</sup>		
					of the Act, in the provision of		
	Based on review of	of "Emergency/Disaster			and treatment at an alternate		
		ual" documentation dated			site identified by emergency		
	-	ergency, Disaster, Evacuation			management officials.		
		s" documentation dated			The QIDP Manager will		
	-	Maintenance Aide during			collaborate with other resider	ntial	
		n 10:40 a.m. to 11:00 a.m. on			providers to determine a		
		rgency preparedness plan did			functional approach to correc	t this	
		e of the facility under a waiver			deficient practice.		
		cretary, in accordance with			PREVENTION:		
		e Act. Based on interview at			Members of the Operations T	eam	
		review, the Maintenance Aide			(comprised of the Executive		
		d not include the role of the			Director, Operations Manage	rs.	
		niver declared by the Secretary,			Program Managers, Area	,	
	-	1 section 1135 of the Act.			Supervisors, Quality Assuran	се	
					Manager, QIDP Manager, QI		
	This finding was r	eviewed with the Maintenance			Quality Assurance Coordinate		
	Aide during the ex				Nurse Manager and Assistan		
					Nurse Manager) will incorpor		
	This deficiency w	as cited on $02/18/22$ . The			reviews of the facility's		
	-	nplement a systemic plan of			emergency preparedness		
	correction to preve				program into scheduled mont	hlv	
					audits to assure all required		
					components are present.		
					Additionally, the agency Safe	tv	
					committee will review and rev		
					the plan as needed but no les		
					than annually.	55	
					RESPONSIBLE PARTIES: Q	פחו	
					Area Supervisor, Residential	IDI ,	
					Manager, Direct Support Stat	Ŧ	
					Operations Team, Regional	ι,	
					Director		
0037	403.748(d)(1). 4	16.54(d)(1), 418.113(d)(1),					
-		32.15(d)(1), 483.475(d)(1),					
Bldg		4.102(d)(1), 485.625(d)(1),					
5		5.727(d)(1), 485.920(d)(1),					
	486.360(d)(1), 49						
		\ /\ /					1

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			сомр 04/13	(X3) DATE SURVEY COMPLETED 04/13/2022	
	PROVIDER OR SUPPLIEI			7919 SA	5			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
	EP Training Progr §403.748(d)(1), § (1), §441.184(d)(7 §482.15(d)(1), §4 (1), §484.102(d)(7 §485.625(d)(1), § (1), §486.360(d)(7 *[For RNCHIs at § §416.54, Hospital §483.475, HHAs a "Organizations" u §486.360, RHC/F (1) Training progr all of the following (i) Initial training in policies and proce existing staff, indif under arrangeme consistent with the (ii) Provide emergent training at least ev (iii) Maintain docu preparedness trait (iv) Demonstrate a emergency proce (v) If the emergent and procedures a the [facility] must updated policies at "[For Hospices at The hospice must (i) Initial training in policies and proce existing hospice e providing services consistent with the	ram 416.54(d)(1), §418.113(d) 1), §460.84(d)(1), 83.73(d)(1), §483.475(d) 1), §485.68(d)(1), 485.727(d)(1), §485.920(d) 1), §491.12(d)(1). §403.748, ASCs at s at §482.15, ICF/IIDs at at §484.102, nder §485.727, OPOs at QHCs at §491.12:] ram. The [facility] must do g: n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. gency preparedness very 2 years. mentation of all emergency ning. staff knowledge of dures. icy preparedness policies re significantly updated, conduct training on the and procedures. §418.113(d):] (1) Training. t do all of the following: n emergency preparedness edures to all new and employees, and individuals s under arrangement, eir expected roles. staff knowledge of						

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-03 [X3) DATE SURVEY COMPLETED 04/13/2022	
	PROVIDER OR SUPPLIEF			7919 SA	DDRESS, CITY, STATE, ZIP CODE NN RICARDO COURT APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETIC DATE
	training at least ex (iv) Periodically re emergency prepa employees (includ with special emph the procedures ne and others. (v) Maintain docur preparedness trai (vi) If the emerger and procedures a the hospice must updated policies a procedures. *[For PRTFs at §4 program. The PR <sup>5</sup> following: (i) Initial training ir policies and proce existing staff, indiv under arrangemen consistent with the (ii) After initial train preparedness trai (iii) Demonstrate s emergency proce (iv) Maintain docu preparedness trai (v) If the emergen and procedures a the PRTF must co updated policies a *[For PACE at §40 organization must (i) Initial training ir policies and proce	wiew and rehearse its redness plan with hospice ling nonemployee staff), asis placed on carrying out accessary to protect patients mentation of all emergency ning. hoy preparedness policies re significantly updated, conduct training on the and 441.184(d):] (1) Training TF must do all of the nemergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. hing, provide emergency ning every 2 years. staff knowledge of dures. mentation of all emergency ning. cy preparedness policies re significantly updated, onduct training on the					

	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 04/13/2022	
	PROVIDER OR SUPPLIEF			7919 SA	ADRESS, CITY, STATE, ZIP COI AN RICARDO COURT APOLIS, IN 46256	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
	participants, and witheir expected role (ii) Provide emergency provide emergency proceed participants of which whom to contact i (iv) Maintain docuu (v) If the emerger and procedures a the PACE must council updated policies a *[For LTC Facilities Training Program all of the following (i) Initial training in policies and proceed existing staff, indivi- under arrangement consistent with the (ii) Provide emergency training at least ar (iii) Maintain docu- preparedness trail (iv) Demonstrate se emergency proceed *[For CORFs at §- The CORF must co- (i) Provide initial the preparedness poli- new and existing services under arrangency consistent with the (ii) Provide emergency proceed *[For CORFs at §- The CORF must co- (i) Provide initial the preparedness poli- new and existing services under arrangency training at least existences and the consistent with the (ii) Provide emergency proceed *[For CORFs at §- The CORF must co- (i) Provide initial the preparedness poli- new and existing services under arrangency training at least existences and the consistent with the (ii) Provide emergency proceed services under arrangency training at least existences and the preparedness poli- new and existing services under arrangency training at least existences and the preparedness poli- new and existences and the preparedness poli- new and existences are arrangency training at least	ency preparedness very 2 years. staff knowledge of dures, including informing at to do, where to go, and in case of an emergency. mentation of all training. hey preparedness policies re significantly updated, onduct training on the and procedures. s at §483.73(d):] (1) The LTC facility must do : emergency preparedness redures to all new and viduals providing services at, and volunteers, eir expected role. ency preparedness mually. mentation of all emergency ning. staff knowledge of dures. 485.68(d):](1) Training. to all of the following: raining in emergency cies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. ency preparedness					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486			A. E	AULTIPLE CC SUILDING VING	CON	(X3) DATE SURVEY COMPLETED 04/13/2022	
				7919 S	ADDRESS, CITY, STATE, ZIP CO AN RICARDO COURT	DDE	
	INITY ALTERNATIV				APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	COMPLETIC DATE
	emergency proce- must be oriented a responsibilities re- emergency plan v workday. The train instruction in the I systems and sign- equipment. (v) If the emerge and procedures a the CORF must of updated policies a *[For CAHs at §48 program. The CAH following: (i) Initial training in policies and proce reporting and exti protection, and wh of patients, person prevention, and ca and disaster author existing staff, indivi- under arrangement consistent with the (ii) Provide emerge training at least ev (iii) Maintain docu (iv) Demonstrate s emergency proce- (v) If the emerge and procedures a the CAH must cor- updated policies a *[For CMHCs at § The CMHC must	35.625(d):] (1) Training H must do all of the n emergency preparedness edures, including prompt nguishing of fires, nere necessary, evacuation nnel, and guests, fire poperation with firefighting porities, to all new and viduals providing services nt, and volunteers, eir expected roles. ency preparedness very 2 years. mentation of the training. staff knowledge of dures. ncy preparedness policies re significantly updated, nduct training on the					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 05/06/2022 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486			COMPLETED 04/13/2022
COMMUN	NITY ALTERNATIV	'ES-ADEPT		APOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETIO
	procedures to all individuals provid arrangement, and their expected rol documentation of must demonstrate emergency proce CMHC must prov preparedness trail Based on record re- facility failed to en regards to emergen procedures. The IC the following: (i) P emergency prepare to all new and exist services under arra- consistent with their emergency prepare two years; (iii) Mail training; (iv) Demo emergency procedu CFR 483.475(d)(1) could affect all occ Findings include: Based on review of Preparedness Manu 01/14/22 and "Eme Plans & Responses 09/01/21 with the M record review from 04/13/22, the facilii staff training on the plan within the more Based on interview the Maintenance A documentation on o	new and existing staff, ing services under volunteers, consistent with es, and maintain the training. The CMHC e staff knowledge of dures. Thereafter, the de emergency ning at least every 2 years. view and interview, the sure staff received training in cy preparedness policies and CF/IID facility must do all of rovide initial training in dness policies and procedures ing staff, individuals providing ngement, and volunteers, r expected roles; (ii) Provide dness training at least every ntain documentation of the nstrate staff knowledge of tres in accordance with 42 . This deficient practice	E 0037	<b>CORRECTION:</b> The facility must have a train program on place with (i) In training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services un arrangement, and volunteer consistent with their expect roles. (ii) Provide emergence preparedness training at leas annually. (iii) Maintain documentation of the trainin Demonstrate staff knowledge emergency procedures. Specifically, the facility will provide an emergency preparedness training progra that includes the following. training in emergency preparedness policies and procedures to all new and es staff, individuals providing services under arrangement volunteers, consistent with expected roles; and provide emergency preparedness tr at least annually; and maint documentation of the trainin	ining ining iitial official of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3DUS22 Facility ID: 001000

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TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	_	COMPLETED
		15G486	B. WING		04/13/2022
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
AME OF	PROVIDER OR SUPPLIE	R	7919 S	SAN RICARDO COURT	
OMMU	INITY ALTERNATIV	VES-ADEPT	INDIAN	NAPOLIS, IN 46256	
K4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	two year period wa	as not available for review at		demonstrate staff knowledge	of
	the time of the sur			emergency procedures. Facil	
		5		Specific Emergency	5
	This finding was re	eviewed with the Maintenance		Preparedness Training has b	een
	Aide during the ex			added to new hire On-the-Jol	
		at conterence.		Training curriculum and Area	
	This deficiency w	as cited on $02/18/22$ . The		Supervisors and the QIDP wi	
		nplement a systemic plan of		responsible for providing ann	
	correction to preve			retraining as well as training v	
	correction to preve	ent recurrence.		<b>.</b>	when
				the plan is updated.	
				The QIDP Manager will work	
				the Human Resources Team	
				facility management to mainta	
				reproducible system to provid	le
				training documentation to	
				regulatory agencies. PREVENTION:	
				Members of the Operations T	eam
				(comprised of the Operations	
				Managers, Program Manager	
				Nurse Manager, Executive	5,
				Director, Quality Assurance	
				Manager, Quality Assurance	
				Coordinators and QIDP Mana	- /
				will incorporate reviews of the	;
				facility's emergency	
				preparedness program into	
				scheduled twice monthly aud	
				assure all required componer	nts
				are present. Additionally, the	
				agency Safety Committee wil	
				review and revise the plan as	
				needed but no less than annu	-
				RESPONSIBLE PARTIES: Q	IDP,
				Area Supervisor, Residential	
				Manager, Safety Committee,	
				Human Resources Departme	nt,
				Operations Team, Regional	
				Director	
				1	

3DUS22 Facility ID: 001000

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIP A. BUILDIN B. WING	G <u></u>	ION	COMI	e survey pleted 3/2022
NAME OF	PROVIDER OR SUPPLIEF	•			CITY, STATE, ZIP CODE ARDO COURT	-	
COMMU	INITY ALTERNATIV	ES-ADEPT	INE	DIANAPOLIS	, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION)	ID PREFI TAC	X (EACH CROSS-	ROVIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOULE REFERENCED TO THE APPRC DEFICIENCY)	BE	(X5) COMPLETIO DATE
0039	403.748(d)(2), 41	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2),					
3ldg	483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 (2), §460.84(d)(2) §483.73(d)(2), §4 (2), §485.68(d)(2) §485.727(d)(2), §4 (2), §494.62(d)(2) *[For ASCs at §4 OPO, "Organization CMHCs at §485.9 §491.12, and ESF	102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d) , §482.15(d)(2), 83.475(d)(2), §484.102(d) , §485.625(d)(2), 485.920(d)(2), §491.12(d) 16.54, CORFs at §485.68, pns" under §485.727, 20, RHCs/FQHCs at RD Facilities at §494.62]:					
	exercises to test t annually. The [fac following: (i) Participate in a	facility] must conduct he emergency plan ility] must do all of the full-scale exercise that is					
	not accessible, co functional exercise (B) If the [fac natural or man-mar- requires activation the [facility] is exe next required com facility-based func the onset of the a- (ii) Conduct an ad every 2 years, op	nunity-based exercise is induct a facility-based e every 2 years; or ility] experiences an actual ade emergency that n of the emergency plan, mpt from engaging in its imunity-based or individual, itional exercise following ctual event. ditional exercise at least posite the year the onal exercise under					

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486			IULTIPLE CO UILDING 'ING	COMP	(X3) DATE SURVEY COMPLETED 04/13/2022		
	PROVIDER OR SUPPLIEF			7919 S	ADDRESS, CITY, STATE, ZIP CODI AN RICARDO COURT IAPOLIS, IN 46256	3		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETIC	
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	community-based functional exercise (B) A mock disast (C) A tabletop exe led by a facilitator discussion using a clinically-relevant a set of problem s messages, or pre to challenge an er (iii) Analyze the [fa maintain documer exercises, and en the [facility's] eme *[For Hospices at (2) Testing for ho the patient's home conduct exercises at least annually. following: (i) Participate in a community based (A) When a comm accessible, condu based functional e (B) If the hospice man-made emerg activation of the e is exempt from en full scale communi individual facility-t following the onse (ii) Conduct an ac years, opposite th functional exercise of this section is c	scale exercise that is or individual, facility-based e; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and tatements, directed pared questions designed mergency plan. acility's] response to and ntation of all drills, tabletop hergency events, and revise rgency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must to test the emergency plan The hospice must do the						

	RS FOR MEDICARE & MEDICAID SERVICES         TEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         PLAN OF CORRECTION       IDENTIFICATION NUMBER:         15G486		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 04/13/2022	
	PROVIDER OR SUPPLIEF			STREET AL 7919 SA INDIANA				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX TAG	Ϋ́,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETIC DATE	
	community-based functional exercise (B) A mock disass (C) A tabletop ex- led by a facilitator discussion using a clinically-relevant a set of problem s messages, or pre- to challenge an er (3) Testing for hose care directly. The exercises to test t per year. The hose (i) Participate in a exercise that is co (A) When a common not accessible, co facility-based funct (B) If the hospice man-made emerge activation of the e hospice is exemp required full-scale facility-based funct the onset of the e (ii) Conduct an act that may include, following: (A) A second full- community-based functional exerciss (B) A mock disass (C) A tabletop ex facilitator that incl using a narrated, emergency scena	ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and tatements, directed pared questions designed mergency plan. spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale ommunity-based; or nunity-based exercise is unduct an annual individual ctional exercise; or experiences a natural or ency that requires mergency plan, the t from engaging in its next community based or ctional exercise following mergency event. dditional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G486 B. WING 04/13/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7919 SAN RICARDO COURT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. \*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] 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] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3DUS22 Facility ID: 001000 If continuation sheet Page 13 of 24

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DEPARTMENT OF HEALTH AND HUN CENTERS FOR MEDICARE & MEDIC		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION
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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G486	A. BUILDING B. WING			pleted 3/2022
	PROVIDER OR SUPPLII		7919 S	ADDRESS, CITY, STATE, ZIP SAN RICARDO COURT NAPOLIS, IN 46256	CODE	
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TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	and maintain doo tabletop exercise	emergency plan. the [facility's] response to cumentation of all drills, es, and emergency events acility's] emergency plan, as				
	conduct exercise at least annually must do the follo	PACE organization must s to test the emergency plan . The PACE organization				
	exercise that is c (A) When a com not accessible, c facility-based fur	community-based; or munity-based exercise is onduct an annual individual, ictional exercise; or				
	natural or man-m requires activation the PACE is exe	experiences an actual nade emergency that on of the emergency plan, mpt from engaging in its next e community based or				
	individual, facility following the ons (ii) Conduct	r-based functional exercise et of the emergency event. an additional exercise every				
	functional exerci- of this section is but is not limited	-				
	led by a facilitato discussion, using	xercise or workshop that is or and includes a group g a narrated, t emergency scenario, and				
	a set of problem	statements, directed epared questions designed				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			04/*	(X3) DATE SURVEY COMPLETED 04/13/2022	
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	maintain document exercises, and ent the PACE's emerge *[For LTC Facilitie (2) The [LTC facilitie (2) The [LTC facilitie to test the emerge facility, ICF/IID] m (i) Participate in a exercise that is con- (A) When a common not accessible, con- facility-based funct (B) If the [LTC facility-based funct an actual natural that requires active plan, the LTC facility-based functional exercise emergency event. (ii) Conduct an actual natural that may include, following: (A) A second full- community-based based functional exercise emergency event. (ii) Conduct an actual that may include, following: (A) A second full- community-based based functional exercise (B) A mock disass (C) A tabletop ex- led by a facilitator discussion, using clinically-relevant a set of problem s	ty] must conduct exercises ency plan at least twice per announced staff drills ncy procedures. The [LTC ust do the following: in annual full-scale immunity-based; or iunity-based exercise is nduct an annual individual, itional exercise. ility] facility experiences or man-made emergency ation of the emergency lity is exempt from required a full-scale or individual, facility-based e following the onset of the dditional annual exercise but is not limited to the scale exercise that is or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and tatements, directed pared questions designed						
	(iii) Analyze the [l	_TC facility] facility's naintain documentation of						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 15G486 B. WING 04/13/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7919 SAN RICARDO COURT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. \*[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID 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 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, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3DUS22 Facility ID: 001000 If continuation sheet Page 16 of 24

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING CEDEET ADDRESS, CITY, STATE ZIP, CODE			(X3) DATE SURVEY COMPLETED 04/13/2022				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO COURT INDIANAPOLIS, IN 46256					
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TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE		
	exercises to test the least annually. The following: (i) Participate in a community-based (A) When a c is not accessible, individual, facility- every 2 years; or. (B) If the HH natural or man-man requires activation the HHA is exemp required full-scale individual, facility following the onse (ii) Conduct an ad years, opposite the functional exercises of this section is c include, but is not (A) A second community-based facility-based funct (B) A mock di (C) A tabletop is led by a facilitate discussion, using clinically-relevant a set of problem s messages, or prej to challenge an er (iii) Analyze the H maintain documer exercises, and err	e HHA must conduct he emergency plan at e HHA must do the full-scale exercise that is ; or ommunity-based exercise conduct an annual based functional exercise A experiences an actual ade emergency that of the emergency plan, of from engaging in its next community-based or based functional exercise et of the emergency event. ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, tional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and tatements, directed bared questions designed mergency plan. HA's response to and nation of all drills, tabletop hergency events, and revise ency plan, as needed.							

	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER: 15G486		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2022		
	PROVIDER OR SUPPLIEF		7919 \$	ADDRESS, CITY, STATE, ZIP CODE SAN RICARDO COURT NAPOLIS, IN 46256		
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TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
	(d)(2) Testing. Th	e OPO must conduct				
		he emergency plan. The				
	OPO must do the	• • •				
		er-based, tabletop exercise				
		ast annually. A tabletop				
		a facilitator and includes a				
	group discussion,	using a narrated, clinically				
	relevant emergen	cy scenario, and a set of				
	problem statemer	nts, directed messages, or				
	prepared question	ns designed to challenge an				
	emergency plan.	If the OPO experiences an				
	actual natural or r	nan-made emergency that				
	requires activation	n of the emergency plan,				
	the OPO is exemption	ot from engaging in its next				
	required testing e	xercise following the onset				
	of the emergency					
		PO's response to and				
		ntation of all tabletop				
		nergency events, and revise				
	-	OPO's] emergency plan,				
	as needed.					
	*[ RNCHIs at §403	3.748]: e RNHCI must conduct				
		he emergency plan. The				
	RNHCI must do th					
		er-based, tabletop exercise				
		A tabletop exercise is a				
		led by a facilitator, using a				
		/-relevant emergency				
	-	et of problem statements,				
		es, or prepared questions				
	-	enge an emergency plan.				
	-	NHCI's response to and				
		ntation of all tabletop				
		nergency events, and revise				
		rgency plan, as needed.				
		view and interview, the	E 0039	CORRECTION:		05/13/2
		nduct at least two exercises	2	The [facility] must conduct		
		cy plan on an annual basis		exercises to test the emerge		1

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED 04/13/2022	
		15G486	B. WING			
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NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
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		cy procedures. The ICF/IID		plan at least annually.		
	facility must do all	l of the following: (i)		Specifically, the agency's Qu	ality	
	participate in a full	l-scale exercise that is		Assurance Department has		
	community-based	or when a community-based		submitted a formal request to	o the	
	exercise is not acco	essible, an individual,		Indianapolis Metropolitan Po	lice	
	facility-based. If t	he ICF/IID facility		Department/Department of		
	experiences an act	ual natural or man-made		Homeland Security Commun	ity	
	emergency that rec	quires activation of the		Emergency Response Team	-	
		ne ICF/IIC facility is exempt		(CERT) to conduct an initial		
	from engaging in a	a community-based or		talk" disaster exercise, with		
individual, facility-based full-scale exercise fo 1 year following the onset of the actual event; (ii) conduct an additional exercise that may		-based full-scale exercise for		bi-annual exercises thereafter	er.	
		ne onset of the actual event;		Additionally, the ResCare Qu	uality	
				Assurance Department has	2	
	include, but is not limited to the following: (A) a			requested assistance from the	ne	
	second full-scale exercis			IMPD District Commander to		
	community-based	or individual, facility-based.		coordinate with CERT to faci	litate	
		cise that includes a group		this process. ResCare Facilit	V	
		a facilitator, using a narrated,		supervisors, the QIDP and		
		emergency scenario, and a set		administrative level manager	ment	
		ents, directed messages, or		(Operations Managers, Prog		
	-	designed to challenge an		Managers, Quality Assuranc		
	emergency plan; (i	ii) analyze the ICF/IID		Manager, QIDP Manager, Q		
	facility's response			Assurance Coordinators, Nu	•	
		all drills, tabletop exercises,		Manager and Assistant Nurs		
		ents, and revise the ICF/IID		Manager) will participate in t		
		y plan, as needed in		exercises to assure facility		
		2 CFR 483.475(d)(2). This		emergency preparedness		
		could affect all occupants.		protocols are consistent with		
	-			community emergency		
	Findings include:			management practices.		
				The facility will develop		
	Based on review o	f "Emergency/Disaster		documentation of the activat	ion of	
		ual" documentation dated		the Emergency Preparednes		
	-	ergency, Disaster, Evacuation		Plan during the 2020-2021		
		s" documentation dated		COVID-19 epidemic, by 3/20	/22	
	-	Maintenance Aide during		using the current state of		
		n 10:40 a.m. to 11:00 a.m. on		emergency as a platform. At	the	
		ntation of a community based		time of this exercise, a "table		
		n the most recent twelve		exercise will be scheduled w		
		not available for review.	1	local emergency manageme		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/13/2022	
	PROVIDER OR SUPPLIE		STREET 7919 S INDIA			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) v at the time of record review,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) officials within 6 months of the	DATE	
< 0000	currently experien emergency due to and procedures cu pandemic are state preparedness docu facility has not con based disaster dril exercise within the period and agreed documentation wa time of the survey This finding was r Aide during the ex This deficiency wa	s not available for review at the eviewed with the Maintenance tit conference. as cited on 02/18/22. The nplement a systemic plan of		full-scale event. The QIDP Manager will collaborate with other resident providers to determine a functional approach to correct deficient practice. <b>PREVENTION:</b> Members of the Operations Te (comprised of the Executive Director, Operations Manager 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 emergency preparedness program into scheduled twice monthly audits to assure all required components, includin but not limited to bi-annual community-based disaster exercises, are present. Additionally, the agency Safet Committee will review and rev the plan as needed but no less than annually. <b>RESPONSIBLE PARTIES:</b> QI Area Supervisor, Residential Manager, Direct Support Staff Operations Team, Regional Director	this eam s, ce DP, ors, ate g y rise s DP,	
( 0000						
Bldg. 01		visit (PSR) to the Life Safety on Survey conducted on	K 0000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 15G486 B. WING 04/13/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7919 SAN RICARDO COURT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) 02/18/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 04/13/22 Facility Number: 001000 Provider Number: 15G486 AIM Number: 100245010 At PSR survey, Community Alternatives - Adept was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 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 heat detection in the attic; smoke detection in corridors and all living areas. The facility has a capacity of 8 and had a census of 6 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.1. Quality Review completed on 04/13/22 K S353 **NFPA 101** Sprinkler System - Maintenance and Testing Bldg. 01 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			CO	(X3) DATE SURVEY COMPLETED 04/13/2022	
NAME OF	PROVIDER OR SUPPLIEI	R			DDRESS, CITY, STATE, ZII N RICARDO COURT			
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		s, and NFPA 13R, Standard						
		of Sprinkler Systems in						
		pancies Up To and						
	-	ories in Height, are						
		and maintained in						
		NFPA 25, Standard for						
		g and Maintenance of						
		Protection System.						
	NFPA 13D System	installed in accordance						
		Standard for the Installation						
	of Sprinkler Syste							
		lings and Manufactured						
	-	cted, tested and maintained						
	in accordance wit							
	requirements of N	-						
		s inspected monthly (NFPA						
	25, section 13.3.2							
		ected monthly (NFPA 25,						
	section 13.2.71).	,						
		s inspected quarterly						
	(NFPA 25, section							
		s tested semiannually						
	(NFPA 25, section	-						
		isory switches tested						
		PA 25, section 13.3.3.5).						
	6. Visible sprink	lers inspected annually						
	((NFPA 25, sectio							
	7. Visible pipe in	nspected annually (NFPA						
	25, section 5.2.2)							
		angers inspected annually						
	(NFPA 25, section							
		pected annually prior to						
	-	for adequate heat for water						
		A 25, section 5.2.5).						
		ative sample of fast						
		ers are tested at 20 years						
	(NFPA 25, section							
		ative sample of dry pendant						
	I sprinklers are test	ted at 10 years (NFPA 25,	1				1	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	. ,	JILDING	DINSTRUCTION	(X3) DATE S COMPLI 04/13/2	
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					AFOLIS, IN 40250		
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	(NFPA 25, section 13. Control value their full range are annually (NFPA 2 14. Operating se lubricated annual 13.3.4). 15. Dry pipe sy unheated portion inspected, tested section 13.4.4). A. Date sprinkler necessary mainter B. Show who proceed C. Note the source the automatic sprinkler automatic sprinkler (Provide in REM, coverage for any automatic sprinkler 33.2.3.5.3, 33.2.2 and NFPA 25 Based on record re- interview; the faci automatic sprinkler for internal obstruct that could cause of NFPA 25, 2011 Ed Inspection, Testing Water-Based Fire 14.2.1. Section 14 discussed in 14.2.1 of piping and bran- conducted every 5 connection at the effective section at the section 14 of the section at the section conducted every 5	solutions are tested annually in 5.3.4). ves are operated through ad returned to normal 25, section 13.3.3.1). stems of OS&Y valves are lly (NFPA 25, section stems extending into s of the building are and maintained (NFPA 25, system last checked and enance provided. vided the service. ce of the water supply for rinkler system. ARKS information on non-required or partial	KS	353	CORRECTION: 1. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 201 Edition, NFPA 25, section 14. states an inspection of piping branch line conditions shall b conducted every 5 years. 2. facility must ensure the spray pattern for sprinkler heads an not obstructed. Specifically, t facility's contracted alarm pro- has conducted a test of the	d 1 21) g and pe The / re he	05/13/202

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED	
JAME OF PROVIDER OR SUPF			ADDRESS, CITY, STATE, ZIP COD		3/2022
COMMUNITY ALTERNATIVES-ADEPT		7919 S INDIAN			
PREFIX       (EACH DEFIX         TAG       REGULATOR         branch line for       presence of formaterial. This         clients, staff an       Findings include         Based on record       Aide from 10:4         documentation       within the most available for retime of record a provided a letter inspection containspection has agreed docume inspection with period was not         This finding was and       This finding was and         This deficiency       This deficiency		ID PREFIX TAG	PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY) sprinkler system's interna <b>PREVENTION:</b> The facility's contracted environmental specialist with the QIDP Manager r than annually to review s system inspection docum to assure compliance. Ins will include checking the piping for organic and inc obstructions no less than five years. <b>RESPONSIBLE PARTIES</b> Area Supervisor, Resider Manager, Environmental Staff, Operations Team	LI DE ROPRIATE al piping. will meet no less prinkler nentation spections internal organic every S: QIDP, ntial	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

3DUS22 Facility ID: 001000

If continuation sheet

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