

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/13/2018
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
{W 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a post certification revisit (PCR) to the PCR completed on 1/12/18 to the investigation of complaint #IN00244442 completed on 11/17/17.</p> <p>This visit was done in conjunction with the PCR to the pre-determined full annual recertification and state licensure survey completed on 1/12/18.</p> <p>Complaint #IN00244442: Corrected.</p> <p>Dates of Survey: 2/12/18 and 2/13/18.</p> <p>Facility Number: 000963 Provider Number: 15G449 AIMS Number: 100244740</p> <p>Community Alternatives Adept was found to be in compliance with 42 CFR Part 483, Subpart I and 460 IAC 9 in regard to the PCR to the PCR to the investigation of complaint #IN00244442.</p> <p>Quality Review of this report completed by #15068 on 3/1/18.</p>	{W 000}	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.