STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 00 B. WING	04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	6025 BUCKSKIN CT INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00370492 completed on 2/10/22. This visit was in conjunction to a pre-determined full recertification and state licensure survey. Complaint #IN00370492: Not corrected. Dates of Survey: March 28, 29, 30, 31 and April 1, 2022. Facility Number: 000979 Provider Number: 15G465 AIMS Number: 100244860 This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/13/22.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C) plus 5 additional clients (D, E, F, G and H), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure a fire exit/egress door was not dead-bolted and to ensure clients A, B, C, D, E, F, G and H had the ability to exit through the fire exit/egress door. Findings include:	W 0104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically, the dead bolt lock has been removed from the fire escape egress door in client D and G's bedroom and replaced with a standard entry lock to facilitate exit from the facility in the event of an emergency.	05/01/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is 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.

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	Observations were conducted at the group home on 3/28/22 from 3:00 PM through 6:15 PM and on 3/29/22 from 6:08 AM through 8:20 AM. Clients A, B, C, D, E, F, G and H were observed throughout the observation periods. On 3/28/22 at 3:23 PM the surveyor entered client B and client G's bedroom. Above their bedroom door was a white sign with red lettering which indicated "Exit". Inside the bedroom was a standard size, white door which exited to the backyard. There was no door knob, only a circular, dead bolt lock which could be opened with a key only. DSL (Direct Support Lead) #1 stated, "I'm not sure how long the knob's been off. I'm not even sure if we have a key to that." DSL #1 proceeded to try all of the keys on the group home's key ring and indicated she did not have a key to open the fire exit/egress door. The Life Safety Plan of Correction (POC), not dated, was reviewed on 3/30/22 at 10:00 AM. The Life Safety POC indicated the following: -"K 222" -"Correction:" -"No door in any means of escape shall be locked against egress when the building is occupied." -"Specifically, the facility will remove the deadbolt lock from bedroom #4 that provides emergency escape...". -"Corrections Completed By: 4/3/21...". A review of the Life Safety POC form indicated the Life Safety had directed the facility to remove the deadbolt lock from bedroom #4/client B and G's bedroom, to be removed and completed by 4/3/21.		**PREVENTION:** Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emergency egresses into scheduled monthly audits to assure prompt evacuation can occur. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	Client B was interviewed on 3/29/22 at 8:02 AM. Client B was asked if a client had previously eloped through the egress/fire exit door in his bedroom. Client B stated, "Yes, he did, before I was in that room. [FC A (Former Client) A], he ran away every day. That's the reason they took the door knob. [FDSL (Former Direct Support Lead)] #1 said it was a runaway risk." AS (Area Supervisor) #1 was interviewed on 3/28/22 at 3:39 PM. AS #1 was asked for how long the egress/fire exit door had been locked. AS #1 stated, "It's been like this since I ever had this site. We never have been able to access that door. I don't even have a key for that." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 3/30/22 at 12:40 PM. QIDPM #1 was asked if there was currently a deadbolt lock on the egress/fire exit door of the group home. QIDPM #1 stated, "Yes." QIDPM #1 indicated the facility completed a Life Safety POC and agreed to remove the deadbolt lock on the egress/fire exit door by 4/3/21. QIDPM #1 indicated the facility had not removed the deadbolt lock on the egress/fire exit door as indicated in the POC. This deficiency was cited on 2/10/22. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint #IN00370492. 9-3-1(a)			