STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING _____ B. WING _____	C 03/03/2021

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

(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)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This visit was for the investigation of complaint #IN00328554. Complaint #IN00328554: Unsubstantiated, due to lack of sufficient evidence. This visit was in conjunction with the pre-determined full recertification and state licensure survey. This visit included a Covid-19 focused infection control survey. Dates of Survey: February 22, 23, 24, 25, 26, and March 3, 2021. Facility Number: 000979 Provider Number: 15G465 Aims Number: 100244860 Community Alternatives-Adept was found to be in compliance with 42 CFR Part 483, Subpart I and 460 IAC 9 in regard to the investigation of complaint #IN00328554. Quality Review of this report completed by #15068 on 3/18/21.	W 000		

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