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

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	03/04/2021

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/04/21 Facility Number: 000979 Provider Number: 15G465 AIM Number: 100244860 At this Emergency Preparedness survey, Community Alternatives - Adept was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 03/08/21 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients [(b) Policies and procedures. [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			

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 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.

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	03/04/2021

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
	paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting.			

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	03/04/2021

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
	(3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" dated 11/15/20 and "Emergency, Disaster, Evacuation Plans & Responses" dated 10/01/20 with the Maintenance Tech during record review from 9:45 a.m. to 11:05 a.m. on 03/04/20, documentation of subsistence needs for the emergency preparedness program was incomplete. Based on interview at the time of record review, the Maintenance Tech agreed the facility's emergency preparedness program did not include provisions for sewage and waste disposal. This finding was reviewed with the Maintenance Tech during the exit conference.	E 0015	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: Food, water, medical, and pharmaceutical Supplies; Alternate sources of energy to maintain temperatures to protect resident health and safety and for the safe and sanitary storage of provisions, emergency lighting fire detection, extinguishing, and alarm systems; and sewage and waste disposal. **PREVENTION:** Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice	04/03/2021

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	03/04/2021

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
			monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0026 Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary [(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).] 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			

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	03/04/2021

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
	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 facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID 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 in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" dated 11/15/20 and "Emergency, Disaster, Evacuation Plans & Responses" dated 10/01/20 with the Maintenance Tech during record review from 9:45 a.m. to 11:05 a.m. on 03/04/20, the emergency preparedness plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview at the time of record review, the Maintenance Tech agreed the plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. This finding was reviewed with the Maintenance Tech during the exit conference.	E 0026	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: 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. **PREVENTION:** Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually.	04/03/2021

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	03/04/2021

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
			RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0036 Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section,			

(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
	and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants.	E 0036	**CORRECTION:** *Facilities must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will complete an annual	04/03/2021

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	03/04/2021

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
	Findings include: Based on review of "Emergency/Disaster Preparedness Manual" dated 11/15/20 and "Emergency, Disaster, Evacuation Plans & Responses" dated 10/01/20 with the Maintenance Tech during record review from 9:45 a.m. to 11:05 a.m. on 03/04/20, the facility's training and testing policy documentation failed to include when existing staff will be trained on the emergency preparedness program. The facility's training and testing policy documentation stated "All staff must be trained on the disaster preparedness plan and ready to carry it out at any time. New employees must be oriented to the plan and procedures at the beginning of their employment". Based on interview at the time of record review, the Maintenance Tech agreed the facility's training and testing policy documentation failed to include how often existing staff will be trained on the emergency preparedness program. This finding was reviewed with the Maintenance Tech during the exit conference.		review and update of its training and testing program in its emergency preparedness plan, by 4/3/21. **PREVENTION:** Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1)			

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	03/04/2021

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
	Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness			

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	03/04/2021

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
	policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.			

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	03/04/2021

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
	*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected			

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	03/04/2021

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
	roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to ensure staff received training in regards to emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants.	E 0037	**CORRECTION:** *The facility must have a training program on place with (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of*	04/03/2021

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	03/04/2021

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
	Findings include: Based on review of "Emergency/Disaster Preparedness Manual" dated 11/15/20 and "Emergency, Disaster, Evacuation Plans & Responses" dated 10/01/20 with the Maintenance Tech during record review from 9:45 a.m. to 11:05 a.m. on 03/04/20, the facility lacked documentation of staff training on the emergency preparedness plan within the most recent two year period. Based on interview at the time of record review, the Maintenance Tech stated staff training documentation on emergency preparedness policies and procedures within the most recent two year period was not available for review at the time of the survey. This finding was reviewed with the Maintenance Tech during the exit conference.		*emergency procedures.* Specifically, the facility will provide an emergency preparedness training program that includes the following. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; and provide emergency preparedness training at least annually; and maintain documentation of the training; and demonstrate staff knowledge of emergency procedures. The QIDP Manager will work with the agency Training Coordinator to develop a specific emergency preparedness curriculum, including competency testing, that will be presented during new-hire orientation as will be included in the operation's annual retraining requirements. Development of the curriculum is in progress and will be completed by 4/3/21. **PREVENTION:** Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emergency preparedness	

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	03/04/2021

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
			program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety Committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Safety Committee, Human Resources Department, Operations Team, Regional Director	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] 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 community-based or individual, facility-based functional exercise following the onset of the actual event.

(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

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	03/04/2021

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
	(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or 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 to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice 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 hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in			

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	03/04/2021

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
	its next required full-scale community based or 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 a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that 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 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			

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	03/04/2021

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

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 to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, 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.

(B) If the [LTC facility] facility

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	03/04/2021

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
	experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a 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 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 [LTC facility] facility's response to and maintain documentation of 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.			

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	03/04/2021

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
	(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. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise 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			

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	03/04/2021

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
	questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, 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 facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID	E 0039	**CORRECTION:** *The [facility] must conduct exercises to test the emergency plan at least annually.* Specifically, the agency's Quality Assurance Department has submitted a formal request to the Indianapolis Metropolitan Police Department/Department of Homeland Security Community Emergency Response Team (CERT) to conduct an initial "table talk" disaster exercise, with bi-annual exercises thereafter. Additionally the ResCare Quality Assurance Department has requested assistance from the IMPD District Commander to coordinate with CERT to facilitate this process. ResCare Facility supervisors, the QIDP and administrative level management (Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will participate in the	04/03/2021

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	03/04/2021

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
	facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual" dated 11/15/20 and "Emergency, Disaster, Evacuation Plans & Responses" dated 10/01/20 with the Maintenance Tech during record review from 9:45 a.m. to 11:05 a.m. on 03/04/20, documentation of a community based disaster drill within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Tech agreed the facility is currently experiencing an actual natural emergency due to Covid-19 and Covid-19 policy and procedures currently in effect for the pandemic are stated in the emergency preparedness documentation but agreed the facility has not conducted a second community based disaster drill or conducted a tabletop exercise within the most recent twelve month period and agreed additional testing documentation was not available for review at the time of the survey. This finding was reviewed with the Maintenance Tech during the exit conference.		exercises to assure facility emergency preparedness protocols are consistent with community emergency management practices. The facility will reach out to local emergency management officials to schedule a full-scale exercise, by 4/3/21 using the current state of emergency as a platform. At the time of this exercise, a “table talk exercise will be scheduled within 6 months of the full-scale event. **PREVENTION:** Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility’s emergency preparedness program into scheduled twice monthly audits to assure all required components, including but not limited to bi-annual community-based disaster exercises, are present. Additionally, the agency Safety Committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional	

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	03/04/2021

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
			Director	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/04/21 Facility Number: 000979 Provider Number: 15G465 AIM Number: 100244860 At this Life Safety Code 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 smoke detection in corridors and all living areas. The attic was not used for living purposes, storage or fuel-fired equipment and was provided with a heat detection system to activate the fire alarm system. The facility has a capacity of 8 and had a census of 8 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 03/08/21	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation and interview, the facility failed to ensure 1 of 3 exit doors to the outside of the facility were arranged such that they can be readily opened from the inside in case of an emergency. LSC Section 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions.	K S222	**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 prevents emergency escape. **PREVENTION:**	04/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Maintenance Tech and the House Manager during a tour of the facility from 11:05 a.m. to 11:35 a.m., the exit door to the outside of the facility in Bedroom #4 was marked as a facility exit with an exit sign. The door had one deadbolt lock on the door with no door handle to pull the door open and required a key to unlock the door. Based on interview at the time of the observations, the Maintenance Tech and the House Manager stated the former client in Bedroom #4 was a severe elopement risk, the deadbolt was installed because of the risk and the Maintenance Tech stated the key to the door was on the Med Room key ring for which all staff have access to the key at all times. The Maintenance Tech unlocked the door with the Med Room key. Based on interview at the time of the observations, the House Manager stated the facility does not use this facility exit on fire drills but agreed the exit door was not arranged such that it can be readily opened in case of an emergency. This finding was reviewed with the Maintenance Tech during the exit conference.		Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, 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, contracted maintenance provider.	
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to ensure all fire alarm system initiating devices were inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Table 14.3.1 at 9(f) states heat detectors shall be visually inspected semiannually. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Initial/Reacceptance testing shall be performed at the time of installation. Table 14.4.5 at 15(e) states the requirements of 14.4.5.5 shall apply to heat detectors. Section 14.4.5.5 states restorable fixed-temperature, spot-type heat detectors shall be tested in accordance with 14.4.5.5.1 through 14.4.5.5.4. Two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year. NFPA 72, 2010 Edition, Table 14.4.2.2 at 14(d)(2) states fixed-temperature, nonrestorable line type heat detectors functionality shall be tested mechanically and electrically. Loop resistance shall be measured and recorded. Changes from acceptance test shall be investigated. Records	K S345	**CORRECTION:** *A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.* Specifically, the facility's contracted Environmental Services Specialist will conduct semi-annual inspections of the facility's alarm system, as required. **PREVENTION:** The facility's contracted Environmental Services Specialist will utilize a form provided by the alarm company for semi-annual visual inspections to assure that all components of the facility's system are inspected appropriately The QIDP will retrain members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) to assure their	04/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	shall be kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Periodic Fire Alarm Inspection & Testing Report" documentation dated 06/23/20 with the Maintenance Tech and the House Manager during record review from 9:45 a.m. to 11:05 a.m. on 03/04/21, documentation of fire alarm system heat detector testing within the most recent twelve month period was not available for review. The 06/23/20 documented there were three heat detectors in the facility with one of the heat detectors installed in the attic. In addition, smoke detectors and heat detectors were not documented as being visually inspected semiannually six months after 06/23/20. Based on interview at the time of record review, the Maintenance Tech stated he has created an inspection sheet to itemize semiannual initiating device inspections but has not yet performed them for the facility and agreed semiannual visual inspection documentation for all smoke detectors and heat detector initiating devices in the facility was not available for review. Based on observations with the Maintenance Tech during a tour of the facility from 11:05 a.m. to 11:35 a.m. on 03/04/21, two heat detectors were noted in the facility and one heat detector was installed in the attic as observed from the attic access door in the garage. This finding was reviewed with the Maintenance Tech during the exit conference.		familiarity with Life Safety code requirements for semi-annual visual inspections of the facility alarm systems. Members of the Operations Team will review alarm system inspection records to assure all required components of the system are tested as required, as part of a routine audit process that will occur no less than monthly. **RESPONSIBLE PARTIES:** Contracted Environmental Services Specialist, Area Supervisor, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
K S351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with Section 9.6, as modified below. The adequacy of the water supply shall be documented. In Prompt Evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	Residential Occupancies up to and including Four Stories in Height, shall be permitted. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.1, 33.2.3.5.3.3, 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7			
	Based on observation and interview, the facility failed to ensure the sprinkler system was installed per NFPA 13D. NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, 2010 Edition, Section 6.5.3 states a warning sign, with minimum 1/4 inch letters, shall be affixed adjacent to the main shut off valve and state the following: Warning: The water system for this home supplies fire sprinklers that require certain flows and pressure to fight a fire. Devices that restrict the flow or decrease the pressure or automatically shut off the water to the fire sprinkler system, such as water softeners, filtration systems, and automatic shutoff valves, shall not be added to this system without a review of the fire sprinkler system by a	K S351	**CORRECTION:** *Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7.* Specifically, the missing signage for the sprinkler shut-off valve will be replaced. **PREVENTION:** The QIDP manager will retrain Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP,	04/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	fire protection specialist. Do not remove this sign. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Maintenance Tech during a tour of the facility from 11:05 a.m. to 11:35 a.m. on 03/04/21, no warning signage was affixed adjacent to the main shut off valve for the sprinkler system riser located in the garage. Based on interview at the time of the observations, the Maintenance Tech agreed the sprinkler system shutoff control valve was not marked with an identification sign. This finding was reviewed with the Maintenance Aide during the exit conference.		Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) to assure their familiarity with Life Safety code requirements for Sprinkler systems. The Operations Team will incorporate reviews of the facility's sprinkler system into monthly environmental audits, to assure compliance. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 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 Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	necessary maintenance provided. __________________________ B. Show who provided the service. _________________________ C. Note the source of the water supply for the automatic sprinkler system. __________________________________ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, except as discussed in 14.2.1.1 and 14.2.1.4, an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review with the Maintenance Tech from 9:45 a.m. to 11:05 a.m. on 03/04/21, documentation of an internal pipe inspection within the most recent five year period was not available for review. Based on interview at the time of record review, the Maintenance Tech stated sprinkler piping in the facility was metal	K S353	**CORRECTION:** *NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced.* Specifically, the facility's contracted environmental specialist will arrange an inspection of piping and branch line conditions in the facility's sprinkler system. **PREVENTION:** The facility's contracted environmental specialist will meet with the QIDP Manager no less than annually to review sprinkler system inspection documentation to assure compliance. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Environmental Services	04/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	and stated documentation of an internal pipe inspection within the most recent five year period was not available for review. Based on observations with the Maintenance Tech during a tour of the facility from 11:05 a.m. to 11:35 a.m. on 03/04/21, sprinkler piping in the attic was metal as observed from the attic access door in the garage. This finding was reviewed with the Maintenance Tech during the exit conference.		Staff, Operations Team	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review, observation and interview; the facility failed to conduct fire drills under varied conditions on the first, second and third shift for 4 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Emergency Evacuations Drill - Fire" documentation with the Maintenance Tech and the House Manager during record review from 9:45 a.m. to 11:05 a.m. on 03/04/21, no first, second or third shift fire drill conducted within the most recent twelve month period documented the use of the exit door to the outside of the facility in Bedroom #4. Based on observations with the Maintenance Tech and the House Manager during a tour of the facility from 11:05 a.m. to 11:35 a.m., the exit door to the outside of the facility in Bedroom #4 was marked as a facility exit with an exit sign. The door had one deadbolt lock on the door with no door handle and required a key to unlock the door. Based on interview at the time of the observations, the Maintenance Tech and the House Manager stated the former client in Bedroom #4 was a severe elopement risk, the deadbolt was installed because of the risk and the Maintenance Tech stated the key to the door was on the Med Room key ring for which all staff have access to the key at all times. The Maintenance Tech unlocked the door. Based on interview at the time of the observations, the House Manager stated the facility does not practice utilizing this exit on fire drills which were conducted within the most recent twelve month period.	K S712	**CORRECTION:** *The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions.* Specifically, the facility will conduct additional evacuation drills on the each shift during the current quarter. **PREVENTION:** Professional staff will be retrained regarding the need to conduct evacuation drills at varied times on each shift for all staff each quarter. Training will also focus on proper completion of evacuation drill forms and assessment of individual drill compliance. The Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will review and track all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled and follow up with the agency Safety Committee accordingly. **Responsible Parties:** Environmental Services Team, Area Supervisor, Residential Manager, Direct Support Staff, QIDP, Operations Team	04/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 01 B. WING	03/04/2021

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
	This finding was reviewed with the Maintenance Tech during the exit conference.			