PRINTED: 03/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í		NSTRUCTION	ì '	X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G465	A. BU B. W	JILDING ING			03/04/2021	
		130403	5			03/04/	2021	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE JCKSKIN CT			
COMMUI	NITY ALTERNATIVI	ES-ADEPT			APOLIS, IN 46250			
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION	
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
E 0000								
Bldg								
Ū		oaredness Survey was diana Department of Health 42 CFR 483.475.	E 0	000				
	Survey Date: 03/04	/21						
	Community Alterna compliance with En Requirements for M	15G465						
		ertified beds. All 8 beds are id. At the time of the was 8.						
	Quality Review con	npleted on 03/08/21						
	The requirement at 4 NOT MET as eviden	42 CFR, Subpart 483.475 is need by:						
E 0015 Bldg	(1), 482.15(b)(1), 4 (1), 485.625(b)(1) Subsistence Need [(b) Policies and prepared properties and properties and prepared properties and propertie	8.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b) s for Staff and Patients rocedures. [Facilities] implement emergency cies and procedures, rgency plan set forth in his section, risk ragraph (a)(1) of this communication plan at						
LABORATOR	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATUR	<u></u> Е	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.

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

LWO121

Facility ID:

000979

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/04/2021			
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO TAG TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION			
``	CROSS-REFERENCED TO THE APPRO	OPRIATE			
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.					

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Event ID:

LWO121 Facility ID: 000979

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/04/2021	
	PROVIDER OR SUPPLIER		<u> </u>	6025 B	ADDRESS, CITY, STATE, ZIP CODE UCKSKIN CT JAPOLIS, IN 46250	•	
(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)	ΛΤΕ	(X5) COMPLETION DATE
	and alarm system (C) Sewa Based on record revision of acility failed to ensipolicies and procedi (1) The provision of and residents, whether place, include, but a following: (i) Food, pharmaceutical support of energy to maintal protect resident health and sanitary storage Emergency lighting extinguishing, and a Sewage and waste of CFR 483.73(b)(1). affect all occupants Findings include: Based on review of Preparedness Manu "Emergency, Disast Responses" dated 1 Tech during record 11:05 a.m. on 03/04 subsistence needs for preparedness prograinterview at the tim Maintenance Tech a emergency prepared provisions for seware and record 1 seware and the times of the maintenance Tech a emergency prepared provisions for seware policies and provisions for seware and provisions for seware facility of the provision f	age and waste disposal. Friew and interview, the sure emergency preparedness ares include at a minimum, of subsistence needs for staff are they evacuate or shelter in are not limited to the water, medical, and plies. (ii) Alternate sources in - (A) Temperatures to lith and safety and for the safe of provisions; (B); (C) Fire detection, alarm systems; and (D) disposal in accordance with 42 This deficient practice could are; Evacuation Plans & 0/01/20 with the Maintenance review from 9:45 a.m. to by 20, documentation of for the emergency are was incomplete. Based on the of record review, the agreed the facility's disposal.	E 00	015	CORRECTION: [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan. Specifically, facility will incorporate the following policies into its emergency preparedness plan the provision of subsistence needs for staff and clients, whether they evacuate or she in place, include, but are not limited to the following: Food, water, medical, and pharmaceutical Supplies; Alternate sources of energy to maintain temperature to protect resident health and safety and for the safe and sanitary storage of provisions, emergency lighting fire detective extinguishing, and alarm system and sewage and waste disposence of the Executive Director, Operations Manager Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QID Quality Assurance Coordinate Nurse Manager and Assistant Nurse Manager) will incorporare views of the facility's emergency preparedness program into scheduled twice	fres ion, ems; sal. eam es, ce DP, ors,	04/03/2021

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Event ID:

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2021
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	6025 B	ADDRESS, CITY, STATE, ZIP CODE UCKSKIN CT IAPOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			monthly audits to assure all required components are pres Additionally, the agency Safet committee will review and revithe plan as needed but no les than annually. RESPONSIBLE PARTIES: QI Area Supervisor, Residential Manager, Direct Support Staff Operations Team, Regional Director	y se s DP,
E 0026	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			

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/04/2021	
	F PROVIDER OR SUPPLIER UNITY ALTERNATIV			6025 B	ADDRESS, CITY, STATE, ZIP CODE UCKSKIN CT IAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY 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)	ιΤΕ	(X5) COMPLETION DATE
	accordance with seprovision of care a identified by emer officials. Based on record responding facility failed to empolicies and proced ICF/IID facility under Secretary, in according the Act, in the provian alternate care sit management official 483.475(b)(8). This affect all occupants Findings include: Based on review of Preparedness Manus "Emergency, Disas Responses" dated 1 Tech during record 11:05 a.m. on 03/04 preparedness plant of facility under a wait in accordance with Based on interview the Maintenance Testinclude the role of the declared by the Secsection 1135 of the	"Emergency/Disaster al" dated 11/15/20 and ter, Evacuation Plans & 0/01/20 with the Maintenance review from 9:45 a.m. to 4/20, the emergency lid not include the role of the ver declared by the Secretary, section 1135 of the Act. at the time of record review, ech agreed the plan did not the facility under a waiver retary, in accordance with Act.	E 0	026	CORRECTION: [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan. Specifically, facility will incorporate the following policies into its emergency preparedness plan The role of the facility under a waiver declared by the Secret in accordance with section 11 of the Act, in the provision of and treatment at an alternate site identified by emergency management officials. PREVENTION: Members of the Operations To (comprised of the Executive Director, Operations Manager Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QID Quality Assurance Coordinate Nurse Manager and Assistant Nurse Manager) will incorporate the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present and an annually.	ary, 35 care care eam es, ce DP, ors, ate	04/03/2021

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED		
		15G465	B. WING	O3/04/2021				
					DDDDGG GUTU GTATE TIP GODE			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	UT) (AL TEDALATI) (JCKSKIN CT			
COMMU	NITY ALTERNATIV	ES-ADEPT		NDIAN	APOLIS, IN 46250			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES]	ID	DROWINED BY AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Т	ΓAG	DEFICIENCY)	_	DATE	
					RESPONSIBLE PARTIES: QII	DP,		
					Area Supervisor, Residential			
					Manager, Direct Support Staff,			
					Operations Team, Regional			
					Director			
E 0036	403.748(d), 416.54	4(d), 418.113(d),		į			'	
	441.184(d), 482.1	5(d), 483.475(d),						
Bldg	483.73(d), 484.102	2(d), 485.625(d),						
	485.68(d), 485.72	7(d), 485.920(d),						
	486.360(d), 491.12	2(d), 494.62(d)						
	EP Training and T	esting						
	*[For RNCHIs at §	403.748, ASCs at						
	§416.54, Hospice	at §418.113, PRTFs at						
	§441.184, PACE a	at §460.84, Hospitals at						
	§482.15, HHAs at	§484.102, CORFs at						
	§485.68, CAHs at	§486.625, "Organizations"						
	under 485.727, CN	MHCs at §485.920, OPOs						
	at §486.360, RHC	/FHQs at §491.12:]						
	(d) Training and te	esting. The [facility] must						
		tain an emergency						
	•	ning and testing program						
		e emergency plan set forth						
	in paragraph (a) of	- · · ·						
	,	agraph (a)(1) of this						
	section, policies a							
	-	nis section, and the						
	,	an at paragraph (c) of this						
	•	ing and testing program						
		and updated at least every						
	2 years.	,						
	,							
	*[For LTC at §483	.73(d):] (d) Training and						
	-	facility must develop and						
	•	gency preparedness						
		g program that is based on						
	-	an set forth in paragraph						
		risk assessment at	1					
	• •	of this section, policies and						
		agraph (b) of this section,						
	ri o o o di pare							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING		COMPLETED		
		15G465	B. WING		03/04/2021		
NAME OF F	ROVIDER OR SUPPLIEF	3	STREE	T ADDRESS, CITY, STATE, ZIP CODE			
			6025 BUCKSKIN CT				
COMMUI	NITY ALTERNATIV	ES-ADEPT	INDIA	ANAPOLIS, IN 46250			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
		cation plan at paragraph (c)					
		ne training and testing					
		reviewed and updated at					
	least annually.						
	*IFor ICE/IIDo ot 9	§483.475(d):] Training and					
		ID must develop and					
	-	gency preparedness					
		g program that is based on					
	-	an set forth in paragraph					
		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)							
		ne training and testing					
		reviewed and updated at					
		s. The ICF/IID must meet					
	•	for evacuation drills and					
	training at §483.4	70(1).					
	*ſFor FSRD Facili	ties at §494.62(d):]					
	-	and orientation. The					
		ıst develop and maintain an					
	emergency prepa	redness training, testing					
	and patient orient	ation program that is based					
		plan set forth in paragraph					
	` '	risk assessment at					
		of this section, policies and					
		agraph (b) of this section,					
		cation plan at paragraph (c)					
		ne training, testing and m must be evaluated and					
	updated at every						
		view and interview, the	E 0036	CORRECTION:	04/03/2021		
		velop and maintain an	E 0030	Facilities must develop and	04/03/2021		
	-	dness training and testing		implement emergency			
	~	eviewed and updated at least		preparedness policies and			
		accordance with 42 CFR		procedures, based on the			
		eficient practice could affect		emergency plan. Specifically	. the		
	all occupants.			facility will complete an annu-	l l		
1			1	·	ı		

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	OF CORRECTION OF CORRECTION 15G465	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2021
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	6025 B	ADDRESS, CITY, STATE, ZIP CODE UCKSKIN CT IAPOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	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 plant 4/3/21. PREVENTION: Members of the Operations Telescore (comprised of the Executive Director, Operations Manager Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, QID Quality Assurance Coordinated 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 Safet committee will review and review the plan as needed but no less than annually. RESPONSIBLE PARTIES: QIA Area Supervisor, Residential Manager, Direct Support Staff Operations Team, Regional Director	eam s, ee DP, rs, te eent. y se s
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),			
. 2.ag. =	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)			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MUL A. BUIL B. WIN	LDING	NSTRUCTION	(X3) DATE COMPI 03/04	LETED
	PROVIDER OR SUPPLIER			6025 BL	DDRESS, CITY, STATE, ZIP CODE JCKSKIN CT APOLIS, IN 46250	•	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	PI	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		O BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DPRIATE	DATE
1AG	Training programs the following:	The [facility] must do all of ing in emergency icies and procedures to all staff, individuals providing er arrangement, and stent with their expected mergency preparedness very 2 years. documentation of all redness training. rate staff knowledge of dures. regency preparedness edures are significantly lity] must conduct training policies and procedures. §418.113(d):] (1) Training. In the following: in emergency icies and procedures to all thospice employees, and oviding services under sistent with their expected late staff knowledge of dures. If yeview and rehearse its redness plan with hospice ding nonemployee staff), hasis placed on carrying out excessary to protect patients.		IAG	DEFICIENCY		DATE
	(vi) if the eme	ergency preparedness					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì		INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		15G465	B. W			03/04/	/2021
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
			6025 BUCKSKIN CT				
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 '	edures are significantly					
		ice must conduct training					
	on the updated p	policies and procedures.					
	*IFor DDTFs at 8/	l41.184(d):] (1) Training					
	_	TF must do all of the					
	following:	Threat do an or the					
		ing in emergency					
	` '	icies and procedures to all					
	new and existing	staff, individuals providing					
		er arrangement, and					
volunteers, consistent with their expected							
roles.							
	(ii) After initial training, provide emergency preparedness training every 2						
	years.	ediless training every 2					
	l *	ate staff knowledge of					
	emergency proced	-					
		documentation of all					
	emergency prepa	redness training.					
		rgency preparedness					
		edures are significantly					
		F must conduct training on					
	tne updated p	policies and procedures.					
	*IFor LTC Facilitie	es at §483.73(d):] (1)					
	_	. The LTC facility must do					
	all of the following	• • • • • • • • • • • • • • • • • • •					
	(i) Initial traini	ing in emergency					
	preparedness poli	icies and procedures to all					
		staff, individuals providing					
		er arrangement, and					
		stent with their expected					
	role.	morgonov proporadaca					
	(II) Provide er training at least ar	mergency preparedness					
	_	documentation of all					
	emergency prepa						
		rate staff knowledge of					
	emergency proced						
	l , , , ,		1				

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Event ID:

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			JLTIPLE CO JILDING	DNSTRUCTION	COMPI		
ANDILAN	OI CORRECTION	15G465	B. WI			03/04	
		100700			ADDRESS OF THE STREET	00/04/	2021
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY ALTERNATIV	FS-ADEPT	6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
	Т		1	<u> </u>			(VE)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	*[For CORFs at §4	485.68(d):](1) Training.					
	The CORF must of	lo all of the following:					
	(i) Provide ini	tial training in emergency					
	preparedness poli	cies and procedures to all					
	new and existing	staff, individuals					
	providing serv	vices under arrangement,					
	and volunteers, co	onsistent with their expected					
	roles.						
		nergency preparedness					
training at least every 2 years.							
(iii) Maintain documentation of the							
training.							
	(iv) Demonstrate staff knowledge of						
		dures. All new personnel					
		and assigned specific					
		es regarding the CORF's					
		vithin 2 weeks of their first					
		ning program must include ocation and use of alarm					
	systems and signa						
	equipment.	als and mengining					
		ergency preparedness					
		edures are significantly					
	1	RF must conduct training on					
		policies and procedures.					
	' '	•					
	*[For CAHs at §48	85.625(d):] (1) Training					
		H must do all of the					
	following:						
	(i) Initial traini	ng in emergency					
	preparedness poli	cies and procedures,					
	including prompt r	eporting and extinguishing					
	1	on, and where necessary,					
		ents, personnel, and					
	1 -	ntion, and cooperation with					
	"	d disaster authorities, to all					
	_	staff, individuals providing					
	services under an	•					
	volunteers, co	onsistent with their expected					

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	15G465	A. BUILDING B. WING		03/04/2021		
		13G403	B. WING		03/04/2021		
NAME OF I	PROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP CODE			
0011111			6025 BUCKSKIN CT				
СОММО	NITY ALTERNATIV	ES-ADEPT	INDIAN	IAPOLIS, IN 46250			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	roles.						
	, ,	mergency preparedness					
	training at least e						
	training.	documentation of the					
		rate staff knowledge of					
	emergency proced	-					
		ergency preparedness					
	` '	edures are significantly					
		must conduct training on					
	the updated policies and procedures.						
		485.920(d):] (1) Training.					
	The CMHC must provide initial training in						
		redness policies and					
		new and existing staff,					
	individuals providi	· ·					
	_	volunteers, consistent with					
	their expected role	the training. The CMHC					
		e staff knowledge of					
		dures. Thereafter, the					
	CMHC must provi						
		ning at least every 2 years.					
	1 ' '	view and interview, the	E 0037	CORRECTION:	04/03/2021		
	facility failed to ens	sure staff received training in		The facility must have a trainii			
	regards to emergen	cy preparedness policies and		program on place with (i) Initia	a/		
		F/IID facility must do all of		training in emergency			
		rovide initial training in		preparedness policies and			
		dness policies and procedures		procedures to all new and			
		ing staff, individuals providing		existing staff, individuals			
		ngement, and volunteers,		providing on-site services und	er		
		r expected roles; (ii) Provide dness training at least every		arrangement, and volunteers,			
		ntain documentation of the		consistent with their expected			
		nstrate staff knowledge of		roles. (ii) Provide emergency			
		res in accordance with 42		preparedness training at least			
		. This deficient practice		annually. (iii) Maintain			
	could affect all occi	-		documentation of the training.	` '		
		-		Demonstrate staff knowledge	of		
	I		1	I	<u> </u>		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2021
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROP DEFICIENCY)	(X5) COMPLETION DATE
	Preparedness Manu "Emergency, Disass Responses" dated 1 Tech during record 11:05 a.m. on 03/04 documentation of si emergency prepared recent two year per time of record revies stated staff training emergency prepared within the most record available for review	dness plan within the most and. Based on interview at the law, the Maintenance Tech documentation on the dness policies and procedures are two year period was not at the time of the survey.		emergency procedures. Specifically, the facility will provide an emergency preparedness training progrithat includes the following. It training in emergency preparedness policies and procedures to all new and estaff, individuals providing services under arrangement volunteers, consistent with the expected roles; and provide emergency preparedness training the demonstrate staff knowledgemergency procedures. The QIDP Manager will wore the agency Training Coording to develop a specific emerging preparedness curriculum, including competency testing will be included the operation's annual retrained in the operation's annual retrained in the operation's annual retrained in the operation of the Executive Director, Operations Manager, Comprised of the Executive Director, Operations Manager, Quality Assurance Coordination Manager, Quality Assurance Coordination of the facility's emergency preparedness	xisting t, and heir aining ain g; and e of k with hator ency g, that v-hire ed in ining of the d will Team ers, ince DIDP, ators, int

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	r í	JILDING	NSTRUCTION	COMP	E SURVEY LETED 1/2021
	PROVIDER OR SUPPLIER		•	6025 Bl	ADDRESS, CITY, STATE, ZIP CODE JCKSKIN CT APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
E 0039 Bldg	441.184(d)(2), 482. 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 495. EP Testing Requir *[For RNCHI at §4 HHAs at §484.102 "Organizations" ur §485.920, RHC/F0 Facilities at §494.6 (2) Testing. The [facilities at §494.6 (2) Testing. The [facilities at §494.6 (2) Testing. The [facilities at §494.6 (3) Testing. The [facilities at §494.6 (4) Testing. The [facilities at §494.6 (5) Testing. The [facilities at §494.6 (6) Testing. The [facilities at §494.6 (6) Testing. The [facilities at §494.6 (6) Testing. The [facilities at §494.6 (7) Testing. The [facilities at §494.6 (8) Testing. The [facilities at §494.6 (9) Testing. The [facilities at §494.6 (10) Testing. The [facilities at §494.6 (11) Testing. The [facilities at §494.6 (12) Testing. The [facilities at §494.6 (13) Testing. The [facilities at §494.6 (14) Testing. The [facilities at §494.6 (15) Testing. The [facilities at §494.6 (15) Testing. The [facilities at §494.6 (16) Testing. The [facilities at §494.6 (17) Testing. The [facilities at §494.6 (18) Testing. The [facilities at §494.6 (18) Testing. The [facilities at §494.6 (19) Testing. The [facilities	03.748, ASCs at §416.54, 2, CORFs at §485.68, OPO, ader §485.727, CMHC at QHC at §491.12, ESRD 62]: acility] must conduct the emergency plan lity] must do all of the in a full-scale exercise that acid every 2 years; or a community-based tessible, conduct a tional exercise every 2 [facility] experiences an an-made emergency that			program into scheduled twe monthly audits to assure a required components are proposed and the plan as needed but not than annually. RESPONSIBLE PARTIES Area Supervisor, Resident Manager, Safety Committed Human Resources Depart Operations Team, Regional Director	I rresent. afety revise less QIDP, al e, ment,	

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				INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING		COMPL	
		15G465	B. W	ING		03/04/	/2021
NAME OF I	PROVIDER OR SUPPLIER	•	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF I	ROVIDER OR SUPPLIER			6025 BU	JCKSKIN CT		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	engaging in its ne	•					
		or individual, facility-based					
		tional exercise following the					
	onset of the actua						
	` '	n additional exercise at					
		s, opposite the year the					
		onal exercise under					
		(2)(i) of this section is					
		ay include, but is not					
	limited to the follo	•					
	` '	cond full-scale exercise that					
	is community-base						
	<u>-</u>	tional exercise; or					
	` '	ck disaster drill; or letop exercise or workshop					
	` '	cilitator and includes a					
	group discussion						
		vant emergency scenario,					
		em statements, directed					
	messages, or pre						
		hallenge an emergency					
	plan.						
	•	/ze the [facility's] response					
	, ,	ocumentation of all drills,					
	tabletop exercises	s, and emergency					
	•	evise the [facility's]					
	emergency plan, a	as needed.					
	*[For Hospices at	` <i>'</i> -					
		spices that provide care in					
	·	e. The hospice must					
		to test the emergency plan					
	_	The hospice must do the					
	following:	o in a full goole evereine					
		e in a full-scale exercise based every 2 years; or					
		n a community based					
	, ,	cessible, conduct an					
		pased functional exercise					
	every 2 y						
	every 2 y	rcais, Oi					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUI		(X2) MULTIPLE CO A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/04/2021	
	OF PROVIDER OR SUPPLIEF MUNITY ALTERNATIV		6025 BI	ADDRESS, CITY, STATE, ZIP CODI UCKSKIN CT APOLIS, IN 46250	3	
(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) COMPLETION DATE
	natural or man-marequires activation the hospital its next required frexercise or individuational exercise emergency event. (ii) Conduct and 2 years, opposite functional exercise (i) of this section include, but is not (A) A see is community-base functional exercise (B) A mare (C) A tathat is led by a fact group discussion clinically-relevant a set of problemessages, or predesigned to complan. (3) Testing for hose care directly. The exercises to test the per year. The hose (i) Participate exercise that is contained individual exercise (B) If the natural or man-marequires activation.	e following the onset of the an additional exercise every the year the full-scale or e under paragraph (d) (2) s conducted, that may limited to the following: cond full-scale exercise that ed or a facility based e; or ock disaster drill; or bletop exercise or workshop cilitator and includes a using a narrated, vant emergency scenario, em statements, directed pared questions challenge an emergency spices that provide inpatient e hospice must conduct the emergency plan twice spice must do the following: e in an annual full-scale ommunity-based; or in a community-based cessible, conduct an facility-based functional				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/04/2021	
	OF PROVIDER OR SUPPLIED		6025 B	ADDRESS, CITY, STATE, ZIP CODE BUCKSKIN CT NAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	its next required for facility-based for exercise follonemergency event (ii) Conduct exercise that may to the following: (A) A set is community-base functional exercise (B) A monotonic (C) A talled by a facilitation discussion using a clinically-rele and a set of problemessages, or predesigned to complan. (iii) Analyze and maintain doct tabletop exercises and revise the plan, as needed. *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [If conduct exercises twice per year. The must do the follow (i) Participate exercise that is concept (A) When exercise is not accept and individual, exercise (B) If the experiences an accept the exercise is not accept (B) If the experiences an accept the exercise is not accept (B) If the experiences an accept the exercise is not accept (B) If the experiences an accept (C) in the experience (C) in the exercise following (C) in the experience (C) in the exercise following (C) in the experience (C) in the exercise following (C) in the exercise following (C) in the exercise is not accept (C) in the experience (C) in the exercise (C) in the exercise is not accept (C) in the experience (C) in the exercise (C) in the	ull-scale community based unctional wing the onset of the an additional annual cinclude, but is not limited econd full-scale exercise that ed or a facility based e; or ock disaster drill; or bletop exercise or workshop that includes a group a narrated, vant emergency scenario, em statements, directed pared questions challenge an emergency the hospice's response to umentation of all drills, s, and emergency events e hospice's emergency 441.184(d), Hospitals at a stat §485.625(d):] PRTF, Hospital, CAH] must as to test the emergency plan the [PRTF, Hospital, CAH] wing: e in an annual full-scale ommunity-based; or a community-based cessible, conduct an facility-based functional				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION G	COM	te survey ipleted 04/2021
	PROVIDER OR SUPPLIER		6025	EET ADDRESS, CITY, STATE, ZIP 5 BUCKSKIN CT IANAPOLIS, IN 46250	CODE	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the emergence exempt from engate full-scale communication individual, face exercise following emergency event. (ii) Conduct and exercise or and the limited to the following of the facility-based function (B) A monomorphism (C) A tabe that is led by a face group discussion, clinically-relevant and a set of problem essages, or present designed to complan. (iii) Analyze the and maintain docutabletop exercises and revise the plan, as needed. *[For LTC Facilities (2) The [LTC facilit	ey plan, the [facility] is ging in its next required ity based or illity-based functional the onset of the in [additional] annual at may include, but is not wing: cond full-scale exercise that ed or individual, a tional exercise; or ck disaster drill; or letop exercise or workshop illitator and includes a using a narrated, want emergency scenario, em statements, directed or duestions hallenge an emergency events e [facility's] response to imentation of all drills, and emergency events e [facility's] emergency s at §483.73(d):] ty] must conduct exercises ncy plan at least twice per announced staff drills ncy procedures. The [LTC ust do the following: a in an annual full-scale in an annual full-scale in an annual full-scale in a community-based; or a community-based functional				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í		INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING		COMPL	
		15G465	B. WI	inG		03/04/	2021
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
NAME OF I	ROVIDER OR SUPPLIER			6025 BI	JCKSKIN CT		
COMMU	NITY ALTERNATIV	ES-ADEPT	•	INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ctual natural or man-made					
		equires activation of the					
		cy plan, the LTC facility is					
		iging its next required a					
	full-scale commun						
		cility-based functional					
	exercise following						
	emergency event.						
	` '	an additional annual					
	-	include, but is not limited					
	to the following:	and full and a system to a that					
	` '	cond full-scale exercise that ed or an individual, facility					
	based functional e						
		ock disaster drill; or					
	` '	oletop exercise or workshop					
	, ,	cilitator includes a group					
	discussion, using	.					
		vant emergency scenario,					
	-	em statements, directed					
	messages, or prep						
		hallenge an emergency					
	plan.	3 3 7					
	iii) Analyze t	the [LTC facility] facility's					
	response to and n	naintain documentation of					
	all drills, tabletop	exercises, and emergency					
	events, and revise	the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	(483.475(d)]:					
		CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					
	following:						
		in an annual full-scale					
		ommunity-based; or					
		n a community-based					
		cessible, conduct an					
		facility-based functional					
	exercise;	or.					

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2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/04/2021
STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250	
TAG CROSS-REFERENCED TO THE APPROPRIATION OF THE A	TE DATE
	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING COMPLETEI B. WING 03/04/202			ETED	
	PROVIDER OR SUPPLIER			6025 BU	DDRESS, CITY, STATE, ZIP CODE JCKSKIN CT APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	actual natural o requires activation the OPO is exemply required testing onset of the emergency (ii) Analyze the maintain documer exercises, and emergency the [RNHCl's plan, as needed. Based on record reversed facility failed to contour to test the emergency using the emergency facility must do allow participate in a full-community-based of exercise is not access facility-based. If the experiences an acture emergency plan, the from engaging in a sindividual, facility-1 year following the (ii) conduct an additinclude, but is not lissecond full-scale excommunity-based of (B) a tabletop exercise discussion led by a clinically-relevant experience of problem statements of problem statements of problem statements of problem statements of accommendation of all facility's response to documentation of all facility response to the facility resp	If the OPO experiences an ar man-made emergency that a first of the emergency plan, but from engaging in its next and exercise following the gency event. If the OPO's response to and attation of all tabletop dergency events, and revise and OPO's] emergency events, and revise and OPO's] emergency exercises by plan on an annual basis by procedures. The ICF/IID of the following: (i) scale exercise that is a rwhen a community-based assible, an individual, the ICF/IID facility all natural or man-made exercise that is a respectively and interview of the exercise for the actual event; the community-based or based full-scale exercise for the actual event; the conset of the actual event	E 00	39	CORRECTION: The [facility] must conduct exercises to test the emergence plan at least annually. Specifically, the agency's Qualent Assurance Department has submitted a formal request to fundianapolis Metropolitan Polici Department/Department of Homeland Security Community Emergency Response Team (CERT) to conduct an initial "tatalk" disaster exercise, with bi-annual exercises thereafter. Additionally the ResCare Qualent Assurance Department has requested assistance from the IMPD District Commander to coordinate with CERT to facility this process. ResCare Facility supervisors, the QIDP and administrative level management (Operations Managers, Programmanagers, Quality Assurance Manager, Quality Assurance Manager, Quality Assurance Manager and Assistant Nurse Manager will participate in the	lity he he he hole ity able ity ate ent m lity e	04/03/2021

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CURRECTION		A. BUILDING B. WING			
		15G465	b. wind			4/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZI	IP CODE	
				BUCKSKIN CT		
COMMUI	NITY ALTERNATIV	ES-ADEPT	INDIA	NAPOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	n	DATE
	facility's emergency			exercises to assure	•	
		CFR 483.475(d)(2). This		emergency prepare		
	deficient practice co	ould affect all occupants.		protocols are consis		
				community emerger	-	
	Findings include:			management praction		
		THE AD' :		The facility will reac		
		"Emergency/Disaster		emergency manage		
	-	al" dated 11/15/20 and		to schedule a full-so by 4/3/21 using the		
		ter, Evacuation Plans & 0/01/20 with the Maintenance		of emergency as a p		
		review from 9:45 a.m. to		the time of this exer		
		4/20, documentation of a		talk exercise will be		
		isaster drill within the most		within 6 months of the		
	-	h period was not available for		event.	no ran ocaro	
		nterview at the time of record		PREVENTION:		
	review, the Mainter	nance Tech agreed the facility		Members of the Ope	erations Team	
		ncing an actual natural		(comprised of the Ex		
		Covid-19 and Covid-19 policy		Director, Operations	Managers,	
	and procedures curi	rently in effect for the		Program Managers,	Area	
	pandemic are stated	l in the emergency		Supervisors, Quality	/ Assurance	
	preparedness docum	nentation but agreed the		Manager, QIDP Mai	nager, QIDP,	
	facility has not con-	ducted a second community		Quality Assurance (
		or conducted a tabletop		Nurse Manager and		
		most recent twelve month		Nurse Manager) will	•	
	period and agreed a	Č		reviews of the facilit	-	
		not available for review at the		emergency prepare		
	time of the survey.			program into schedu		
	This finding was so	viewed with the Maintenance		monthly audits to as required component		
	Tech during the exi			but not limited to bi-		
	1 cen during the ext	t comprehec.		community-based d		
				exercises, are prese		
				Additionally, the age		
				Committee will revie	•	
				the plan as needed		
				than annually.		
				RESPONSIBLE PA	RTIES: QIDP,	
				Area Supervisor, Re	esidential	
				Manager, Direct Su		
				Operations Team, F	Regional	
1	l		Ī	1		i .

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING COMPLETED			
		15G465	B. W	ING		03/04/	2021
	PROVIDER OR SUPPLIER			6025 B	ADDRESS, CITY, STATE, ZIP CODE UCKSKIN CT		
СОММОГ	NITY ALTERNATIVI	ES-ADEPT		INDIAN	IAPOLIS, IN 46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)					DATE
					Director		
K 0000							1
Bldg. 01							
Blug. 01	-	Recertification Survey was diana Department of Health 42 CFR 483.470(j).	K 0	000			
	Survey Date: 03/04	/21					
	Facility Number: 00	00979					
	Provider Number: 1						
	AIM Number: 1002						
	At this I ife Safety (Code survey, Community					
	-	t was found not in compliance					
	_	for Participation in Medicaid,					
	-	3.470(j), Life Safety from					
	Fire and the 2012 ed	lition of the National Fire					
		ion (NFPA) 101, Life Safety					
		er 33, Existing Residential					
	Board and Care Occ	cupancies.					
	•	ling was determined to be					
		he facility has a fire alarm					
	-	detection in corridors and all					
	-	tic was not used for living					
		fuel-fired equipment and heat detection system to					
	_	m system. The facility has a					
		id a census of 8 at the time of					
	this survey.						
	Calculation of the E	vacuation Difficulty Score					
		PA 101A, Alternative					
		Safety, Chapter 6, rated the					
	facility Prompt with	an E-Score of 0.1.					
	Quality Review com	npleted on 03/08/21					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G465		A. BUILDING B. WING	Onstruction 01	COMPLETED 03/04/2021
	PROVIDER OR SUPPLIER	6025 B	ADDRESS, CITY, STATE, ZIP CODE UCKSKIN CT IAPOLIS, 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 APPROPRIA 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 escal 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:	5

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l ´		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		15G465	B. W	B. WING			2021	
					_			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
					JCKSKIN CT			
COMMU	NITY ALTERNATIV	/ES-ADEPT		INDIAN	APOLIS, IN 46250			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE	
ing				1710			DATE	
	•	tice could affect all clients,			Members of the Operations Te	am		
	staff and visitors.				(comprised of the Executive			
	Findings include:				Director, Operations Managers	5,		
					Program Managers, Area			
					Supervisors, Quality Assurance			
		ons with the Maintenance			Manager, QIDP Manager, QID			
	Tech and the House Manager during a tour of the facility from 11:05 a.m. to 11:35 a.m., the exit				Quality Assurance Coordinato	rs,		
					Nurse Manager and Assistant			
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					Nurse Manager) will incorpora	te		
					reviews of the facility's			
					emergency egresses into			
					scheduled monthly audits to			
	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				assure prompt evacuation can			
					occur.			
					RESPONSIBLE PARTIES: QII	OP,		
		#4 was a severe elopement			Area Supervisor, Residential			
		vas installed because of the			Manager, Direct Support Staff	,		
		enance Tech stated the key to			Operations Team, Regional			
		e Med Room key ring for			Director, contracted maintenar	nce		
		e access to the key at all times.			provider.			
		Tech unlocked the door with						
	the Med Room key	y. Based on interview at the						
	time of the observa	tions, the House Manager						
	stated the facility d	oes not use this facility exit						
	on fire drills but ag	reed the exit door was not						
	arranged such that	it can be readily opened in						
	case of an emergen	icy.						
	This finding was re	eviewed with the Maintenance						
	Tech during the ex	it conference.						
K S345	NFPA 101							
	Fire Alarm Syster	n - Testing and						
Bldg. 01	Maintenance							
	Fire Alarm Syster	n - Testing and						
	Maintenance							
	2012 EXISTING ((Prompt)						
	A fire alarm syste	m is tested and maintained						
	in accordance wit	h an approved program						
	complying with th	e requirements of NFPA 70,						
1								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLETE			ETED		
		15G465	B. W	B. WING			03/04/2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER							
COMMU	NITY ALTERNATIV	ES ADEDT		6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
	MILL ALILINATIV			INDIAN				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ГЕ	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		Code, and NFPA 72,						
National Fire Alarm and Signaling Code.								
	Records of system acceptance, maintenance							
	and testing are rea	-						
	9.7.5, 9.7.7, 9.7.8,							
		view, observation and	KS	345	CORRECTION:		04/03/2021	
		ty failed to ensure all fire			A fire alarm system is tested a			
	alarm system initiating devices were inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72.				maintained in accordance with	an		
					approved program complying	vith		
					the requirements of NFPA 70,			
		.4.1 states a manual fire			National Electric Code, and			
	alarm system shall be provided in accordance				NFPA 72, National Fire Alarm			
	with Section 9.6, unless the provisions of				and Signaling Code. Records	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				system acceptance,			
					maintenance and testing are			
		ety shall be installed, tested,			readily available. Specifically,	the		
		ccordance with the applicable			facility's contracted Environme	ntal		
	-	PA 70, National Electric			Services Specialist will conduc	t		
		, National Fire Alarm and			semi-annual inspections of the	;		
		FPA 72, 2010 Edition, Table			facility's alarm system, as			
		heat detectors shall be			required.			
		emiannually. NFPA 72, 2010 4.5 states testing shall be			PREVENTION:			
		lance with the schedules in			The facility's contracted			
	•	l/Reacceptance testing shall			Environmental Services Specia	alist		
		time of installation. Table			will utilize a form provided by t	he		
	-	s the requirements of			alarm company for semi-annua	al		
	` '	to heat detectors. Section			visual inspections to assure the	at all		
	***	rable fixed-temperature,			components of the facility's			
		etors shall be tested in			system are inspected			
		.4.5.5.1 through 14.4.5.5.4.			appropriately			
		ors shall be tested on each			The QIDP will retrain members			
		nually. Different detectors			the Operations Team (compris	ed		
		year. NFPA 72, 2010			of the Executive Director,			
		2.2 at 14(d)(2) states			Operations Managers, Program	n		
		nonrestorable line type heat			Managers, Area Supervisors,			
	detectors functional				Quality Assurance Manager,			
		ectrically. Loop resistance			QIDP Manager, QIDP, Quality			
		nd recorded. Changes from			Assurance Coordinators, Nurs	е		
		l be investigated. Records			Manager and Assistant Nurse			
	1	0			Manager) to assure their			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	01	COMPL	
		15G465	B. W	ING		03/04/	2021
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>		6025 BI	JCKSKIN CT		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E APPROPRIATE DATE	
1110		building owner specifying	+	1110	familiarity with Life Safety cod		DATE
		re been tested. Within 5			requirements for semi-annual	C	
		shall have been tested. This			visual inspections of the facilit	V	
	1 -	ould affect all clients, staff,			alarm systems. Members of the	-	
	and visitors.	and affect an elicitis, starr,			Operations Team will review a		
	and visitors.				system inspection records to	шанн	
	Findings include:				assure all required componen	ts of	
					the system are tested as requ		
	Based on review of the fire alarm system				as part of a routine audit proce		
	inspection contractor's "Periodic Fire Alarm				that will occur no less than	300	
		g Report" documentation			monthly.		
	_	the Maintenance Tech and			RESPONSIBLE PARTIES:		
	the House Manager during record review from				Contracted Environmental		
	9:45 a.m. to 11:05 a.m. on 03/04/21,				Services Specialist, Area		
	documentation of fire alarm system heat				Supervisor, Operations Team		
		nin the most recent twelve					
		ot available for review. The					
		ed there were three heat					
	detectors in the faci	lity with one of the heat					
		n the attic. In addition,					
	smoke detectors and	d heat detectors were not					
	documented as bein	g visually inspected					
	semiannually six m	onths after 06/23/20. Based					
	on interview at the	time of record review, the					
	Maintenance Tech s	stated he has created an					
	inspection sheet to i	temize semiannual initiating					
	device inspections b	out has not yet performed					
	them for the facility	and agreed semiannual					
	_	ocumentation for all smoke					
		letector initiating devices in					
	1	available for review. Based					
		h the Maintenance Tech					
	~	facility from 11:05 a.m. to					
		1/21, two heat detectors were					
		and one heat detector was					
		as observed from the attic					
	access door in the g	arage.					
	This find:	viewed with the M-inter-					
		viewed with the Maintenance					
	Tech during the exi	i comerence.					

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250 (X5)	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. JILDING	onstruction 01	COMPI			
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Bldg. 01 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				B. W	ING	<u>01</u>			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVA ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVA ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVA ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (AS THE APPROPRIATE DEFICIENCY) (COMPLETION DEACH CHOOL SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMPLETION DEACH CHOOL SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMPLETION DEACH CHOOL SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMPLETION DEACH CHOOL SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMPLETION DEACH CHOOL SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMPLETION DEACH CHOOL SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMPLETION DEFICIENCY) (COMPLETI				6025 BUCKSKIN CT					
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	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
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 25 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		Sprinkler System - Sprinkler System - Sprinkler System - Where an automa installed, for either building coverage, accordance with S shall initiate the fir accordance with S modified below. Th supply shall be do In Prompt Evacual sprinkler system in with NFPA 13D, S of Sprinkler System and two Family Do Homes, shall be p Automatic sprinkler closets not exceed feet and in bathrood square feet, provid spaces are finished materials providing thermal barrier. In Prompt Evacual where an automat system is in accord Standard for the In Sprinkler Systems not be required in exceeding 24 squa not exceeding 24 squa not exceeding 25 sprovided that such lath and plaster or providing a 15-mir In Prompt Evacual buildings four or fe above grade plane with NFPA 13R, S	- Installation tic sprinkler system is r total or partial , the system shall be in Section 9.7 and re alarm system in Section 9.6, as he adequacy of the water recumented. Ition facilities, an automatic in accordance Standard for the Installation in in One wellings and Manufactured bermitted. ers shall not be required in ding 24 square oms not exceeding 55 ded that such ed with lath and plaster or ig a 15-minute Ition Capability facilities tic sprinkler redance with NFPA 13, installation of is, automatic sprinklers shall closets not are feet and in bathrooms square feet, in spaces are finished with in material inute thermal barrier. Ition Capability facilities in ewer stories ie, systems in accordance standard for the						

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		15G465	B. WING 03/04/2021		
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹			
COMMU		TE ADEDT		BUCKSKIN CT	
COMMO	NITY ALTERNATIV	ES-ADEPT	INDIA	NAPOLIS, IN 46250	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	DATE
	Residential Occup	pancies up to and			
	including Four Sto	ories in Height, shall be			
	permitted.				
	Initiation of the fire	e alarm system shall not be			
	required for existing	ng			
	installations in acc	cordance with 33.2.3.5.6.			
	Where an automa	itic sprinkler is installed,			
	attics used for livi	ng purposes,			
	storage, or fuel-fir	ed equipment are sprinkler			
	protected by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired				
	equipment meet o	one of the following:			
	Protected by heat detection system to activate the fire alarm system				
	according to 9.6.				
		utomatic sprinkler system			
	according to 9.7.				
	3. Constructed of	noncombustible or			
	limited-combustib	le construction; or			
		fire-retardant-treated wood			
	according to NFP				
		.5.3.1, 33.2.3.5.3.3,			
		.3.5.3.6, 33.2.3.5.7			
		on and interview, the facility	K S351	CORRECTION:	04/03/2021
		sprinkler system was		Where an automatic sprinkler	
	-	13D. NFPA 13D, Standard		system is installed, for either	
		of Sprinkler Systems in One		total or partial building coverag	ge,
		vellings and Manufactured		the system shall be in	
		on, Section 6.5.3 states a		accordance with Section 9.7.	
		minimum 1/4 inch letters,		Specifically, the missing signa	
	-	acent to the main shut off		for the sprinkler shut-off valve	will
		following: Warning: The		be replaced.	
	-	is home supplies fire		PREVENTION:	
		ire certain flows and pressure ices that restrict the flow or		The QIDP manager will retrain	
	~	re or automatically shut off		Members of the Operations Te	eam
		e sprinkler system, such as		(comprised of the Executive	
		ration systems, and automatic		Director, Operations Manager	S,
	· ·	l not be added to this system		Program Managers, Area	
		The fire sprinkler system by a		Supervisors, Quality Assurance	
	without a feview of	the me spinikler system by a		Manager, QIDP Manager, QID)P,

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/04/2021			
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIA DEFICIENCY)	DATE			
K S353 Bldg. 01	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. 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 Occupancies Up To and Including Four Stories in Height, are	IAG	Quality Assurance Coordinato Nurse Manager and Assistant Nurse Manager) to assure the familiarity with Life Safety code requirements for Sprinkler systems. The Operations Teal will incorporate reviews of the facility's sprinkler system into monthly environmental audits, assure compliance. RESPONSIBLE PARTIES: QI Area Supervisor, Residential Manager, Direct Support Staff Operations Team, Regional Director	rs, eir e m to DP,			
	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						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPLETED	
		15G465	B. W	ING	.=	03/04/2021	
				CENTER	ADDRESS OF A STATE OF SORE		
NAME OF P	PROVIDER OR SUPPLIER	t		1	ADDRESS, CITY, STATE, ZIP CODE		
					UCKSKIN CT		
COMMUNITY ALTERNATIVES-ADEPT			INDIAN	APOLIS, IN 46250			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	1
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	in accordance with	n the following					
requirements of NFPA 25:							
	1. Control valves	s inspected monthly (NFPA					
	25, section 13.3.2).					
	2. Gauges inspected monthly (NFPA 25, section 13.2.71).						
	Alarm devices inspected quarterly						
	(NFPA 25, section 5.2.6).						
	4. Alarm devices tested semiannually						
	(NFPA 25, section 5.3.3).						
	Valve supervisory switches tested						
	semiannually (NFPA 25, section 13.3.3.5).						
	Visible sprinklers inspected annually						
	((NFPA 25, sectio	•					
	1	spected annually (NFPA					
	25, section 5.2.2).						
		angers inspected annually					
	(NFPA 25, section	•					
		pected annually prior to					
	_	or adequate heat for water					
		A 25, section 5.2.5).					
	I	ative sample of fast					
		rs are tested at 20 years					
	(NFPA 25, section	•					
	· •	ative sample of dry pendant					
	•	ed at 10 years (NFPA 25,					
	section 5.3.1.1.15	,					
		olutions are tested annually					
	(NFPA 25, section	•					
		es are operated through					
		d returned to normal					
		5, section 13.3.3.1).					
		ems of OS&Y valves are					
		y (NFPA 25, section					
	13.3.4).	tomo ovtondina into					
		tems extending into					
		of the building are					
		and maintained (NFPA 25,					
	section 13.4.4).	oveten leet ebankad and					
	A. Date sprinkler s	system last checked and	1			1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLETED			ETED	
		15G465	B. W	B. WING 03/04/2			2021
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L					
00040411		EO ADEDT	6025 BUCKSKIN CT				
COMMO	NITY ALTERNATIV	ES-ADEPT		INDIAN	IAPOLIS, IN 46250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	necessary mainte	nance 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		KS	353	CORRECTION:		04/03/2021
				333	NFPA 25, Standard for the		01/03/2021
					Inspection, Testing, and		
	_	ions where conditions exist			Maintenance of Water-Based		
		structed piping as required by					
		tion, the Standards for the			Fire Protection Systems, 2011		
		and Maintenance of			Edition, Section 5.4.1.4 states		
		rotection Systems, Section			supply of spare sprinklers (nev	/er	
	14.2.1. Section 14.2	-			fewer than six) shall be		
		-			maintained on the premises so)	
		1 and 14.2.1.4, an inspection			that any sprinklers that have		
		h line conditions shall be			been operated or damaged in	any	
		years by opening a flushing			way can be promptly replaced.		
		nd of one main and by			Specifically, the facility's		
		er toward the end of one			contracted environmental		
		purpose of inspecting for the			specialist will arrange an		
		organic and inorganic			inspection of piping and branc	h	
		eient practice affects all			line conditions in the facility's		
	clients, staff and vis	sitors.			sprinkler system.		
					PREVENTION:		
	Findings include:				The facility's contracted		
					environmental specialist will m	eet	
		view with the Maintenance			with the QIDP Manager no les		
		. to 11:05 a.m. on 03/04/21,			than annually to review sprinkl		
		n internal pipe inspection			system inspection documentat		
		ent five year period was not			to assure compliance.		
		. Based on interview at the			RESPONSIBLE PARTIES: QII	ne l	
		w, the Maintenance Tech			Area Supervisor, Residential	-· ,	
	stated sprinkler pipi	ng in the facility was metal			Manager, Environmental Servi	ices	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G465		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 01	COM	TE SURVEY MPLETED 04/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO TH	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	inspection within the period was not avail observations with the tour of the facility for 03/04/21, sprink metal as observed fit the garage. This finding was retreech during the exist	tation of an internal pipe e most recent five year lable for review. Based on ne Maintenance Tech during a rom 11:05 a.m. to 11:35 a.m. ler piping in the attic was rom the attic access door in viewed with the Maintenance t conference.		Staff, Operations Te	am			
K S712	NFPA 101 Fire Drills							
Bldg. 01	Fire Drills 1. The facility mus least quarterly for and under varied of a. Ensure that a trained to perform b. Ensure that a familiar with the use emergency and diprocedures. 2. The facility muse a. Actually evacuone drill each year b. Make special evacuation of clier disabilities; c. File a report a drill; d. Investigate all drills, including acaction; and e. During fire drievacuated to a sarunder the Health of the Life Safety	Il personnel on all shifts are assigned tasks; Il personnel on all shifts are se of the facility's saster plans and It: Luate clients during at least on each shift; provisions for the least with physical Ind evaluation on each Problems with evacuation cidents and take corrective Ils, clients may be fe area in facilities certified Care Occupancies Chapter						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>01</u> CC			ETED
		15G465	B. W	NG		03/04/	/2021
				CTREET	ADDRESS SITY STATE ZIR CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
0014141	NUTY AT TERMATIN	YEO ADEDT			UCKSKIN CT		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	IAPOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1.	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		KS	K S712 CORRECTION:			04/03/2021
	interview; the facility failed to conduct fire drills				The facility must hold evacuate	ion	
	under varied conditions on the first, second and				drills at least quarterly for each	'n	
	third shift for 4 of 4 quarters. This deficient				shift of personnel and under		
	practice affects all clients, staff and visitors.				varied conditions. Specifically,		
					the facility will conduct addition		
	Findings include:				evacuation drills on the each s		
					during the current quarter.		
	Based on review of "Emergency Evacuations				PREVENTION:		
	Drill - Fire" documentation with the Maintenance				Professional staff will be retrai	ned	
	Tech and the House Manager during record				regarding the need to conduct		
		.m. to 11:05 a.m. on			evacuation drills at varied time	s on	
		second or third shift fire drill			each shift for all staff each		
		ne most recent twelve month			quarter. Training will also focu	s on	
	_	the use of the exit door to			proper completion of evacuation	on	
		ncility in Bedroom #4. Based			drill forms and assessment of		
		th the Maintenance Tech and			individual drill compliance. The	9	
		during a tour of the facility			Operations Team (comprised	of	
		11:35 a.m., the exit door to			the Executive Director, Operat		
		acility in Bedroom #4 was			Managers, Program Managers	5,	
		exit with an exit sign. The			Area Supervisors, Quality		
		oolt lock on the door with no			Assurance Manager, QIDP		
		quired a key to unlock the			Manager, QIDP, Quality		
		erview at the time of the			Assurance Coordinators, Nurs	e	
		faintenance Tech and the			Manager and Assistant Nurse		
		ted the former client in			Manager) will review and trac		
		severe elopement risk, the			facility evacuation drill reports		
		led because of the risk and the			follow up with professional sta		
		stated the key to the door was			needed to assure drills occur a		
		key ring for which all staff			scheduled and follow up with t	he	
		key at all times. The unlocked the door. Based on			agency Safety Committee		
					accordingly.		
		e of the observations, the			Responsible Parties:		
		ted the facility does not is exit on fire drills which			Environmental Services Team	,	
		thin the most recent twelve			Area Supervisor, Residential		
		min the most recent twenve			Manager, Direct Support Staff	,	
	month period.				QIDP, Operations Team		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPI	COMPLETED	
		15G465	B. WI	NG		03/04	/2021	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT (YALID SUMMARY STATEMENT OF DEFICIENCIES				6025 B	ADDRESS, CITY, STATE, ZIP CODE UCKSKIN CT APOLIS, IN 46250	•		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	\TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	This finding was re Tech during the ex	eviewed with the Maintenance it conference.						

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