**Bob Morris** 

PRINTED: 11/03/2023 FORM APPROVED OMB NO. 0938-039

10/30/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  A. BUILDING COMPLETED  B. WING 10/10/2023			
	PROVIDER OR SUPPLIE		6025 B	ADDRESS, CITY, STATE, ZIP COD UCKSKIN CT IAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
E 0000					
Bldg		0/23	E 0000		
	Provider Number: AIM Number: 100	15G465			
	Community Altern compliance with E Requirements for I	Preparedness survey, atives - Adept was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR			
	-	pertified beds. All 8 beds are aid. At the time of the survey,			
		mpleted on 10/13/23 42 CFR, Subpart 483.475 is enced by:			
E 0037 Bldg	441.184(d)(1), 484 483.73(d)(1), 484 485.68(d)(1), 485 486.360(d)(1), 485 EP Training Prog §403.748(d)(1), § §441.184(d)(1), § §483.73(d)(1), §4 §485.68(d)(1), §4				
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE

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

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QIDP Manager

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION	(X3) DA'	TE SURVEY  10/2023	
	PROVIDER OR SUPPLIED		6025 BI	ADDRESS, CITY, STATE, ZIP CO JCKSKIN CT APOLIS, IN 46250	D	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION	
PREFIX	·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE PROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY		DATE
	Hospitals at §482 HHAs at §484.103 §485.727, OPOs at §491.12:] (1) Training prog all of the following (i) Initial training in policies and proce existing staff, indi under arrangeme consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain document procedures at least every 2 ye (iii) Maintain document procedures at [facility] must consupdated policies at The hospice must (i) Initial training in policies and procedures and procedures at The hospice must (ii) Initial training in policies and procedures at the providing services consistent with the (ii) Demonstrate is emergency procedured (iii) Provide emergency procedured (iii) Provide emergency proper emergency proper emergency prepared (iv) Periodically reference (iv) Periodically r	n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. gency preparedness training ears. Immentation of all emergency ining. staff knowledge of dures. Incy preparedness policies are significantly updated, the duct training on the eard procedures.  §418.113(d):] (1) Training. It do all of the following: In emergency preparedness edures to all new and employees, and individuals is under arrangement, eir expected roles. Staff knowledge of dures. In gency preparedness training ears. Eview and rehearse its uredness plan with hospice				
		ding nonemployee staff),				

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with special emphasis placed on carrying out

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<del></del>	COMPLETED 10/10/2023	
		15G465	B. WI	NG			
NAME OF I	PROVIDER OR SUPPLIE	ZD.		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
	WIND OF TROUBLE OR SOFT ELEK				JCKSKIN CT		
COMMU	NITY ALTERNATI\	VES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ecessary to protect patients					
	and others.						
	` '	umentation of all emergency					
	preparedness tra	ency preparedness policies					
	. ,	are significantly updated, the					
	1	nduct training on the					
	updated policies						
	procedures.						
	*[For PRTFs at §441.184(d):] (1) Training						
	. •	RTF must do all of the					
	following:						
	. ,	in emergency preparedness					
	l	edures to all new and					
	•	ividuals providing services					
	_	ent, and volunteers, neir expected roles.					
		ining, provide emergency					
	1 ' '	nining every 2 years.					
	1 ' '	staff knowledge of					
	emergency proce	_					
	(iv) Maintain doci	umentation of all emergency					
	preparedness tra	ining.					
	. ,	ncy preparedness policies					
	1	are significantly updated, the					
		luct training on the updated					
	policies and proc	edures.					
	*IFOR DACE of SA	160.84(d):] (1) The PACE					
		st do all of the following:					
	_	in emergency preparedness					
	. ,	edures to all new and					
	1 '	ividuals providing on-site					
	I	rrangement, contractors,					
		volunteers, consistent with					
	their expected ro						
	(ii) Provide emerg	gency preparedness training					

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at least every 2 years.

(iii) Demonstrate staff knowledge of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3	3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING	COMPLETED
15G465 B. WING	10/10/2023
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER  6025 BUCKSKIN CT	
COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46250	
WEIGHT ACTOM TO CONTROL OF THE CONTR	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
emergency procedures, including informing	
participants of what to do, where to go, and	
whom to contact in case of an emergency.	
(iv) Maintain documentation of all training.	
(v) If the emergency preparedness policies	
and procedures are significantly updated, the	
PACE 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.	
Cinargonoly procedures.	
*[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	

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	T OF HEALTH AND HO R MEDICARE & MEDIO					OMB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		CONSTRUCTION	COM	te survey Mpleted 10/2023	
	PROVIDER OR SUPPLIE		6025	T ADDRESS, CITY, STATE, ZIP CO BUCKSKIN CT ANAPOLIS, IN 46250	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)		(X5) COMPLETION DATE
	systems and sign equipment. (v) If the emergorand procedures a CORF must conceptions and procedures and procedu	location and use of alarm hals and firefighting ency preparedness policies are significantly updated, the duct training on the updated edures.  85.625(d):] (1) Training				
	program. The CA following:  (i) Initial training is policies and proceeding and extended protection, and work of patients, person prevention, and disaster authoristing staff, indunder arrangement consistent with the consistent	in emergency preparedness edures, including prompt inguishing of fires, where necessary, evacuation onnel, and guests, fire cooperation with firefighting norities, to all new and ividuals providing services ent, and volunteers, neir expected roles. Gency preparedness training rears.  Jumentation of the training. staff knowledge of edures.  Jency preparedness policies are significantly updated, the loct training on the updated				
	The CMHC must emergency preparage procedures to all individuals provide	§485.920(d):] (1) Training. provide initial training in aredness policies and new and existing staff, ling services under d volunteers, consistent with				

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their expected roles, and maintain

documentation of the training. The  $\ensuremath{\mathsf{CMHC}}$ must demonstrate staff knowledge of

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  G =-	(X3) DATE SURVEY COMPLETED 10/10/2023
	PROVIDER OR SUPPLIEI		6025	ET ADDRESS, CITY, STATE, ZIP COD 5 BUCKSKIN CT IANAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	ION (X5) D BE COMPLETION DATE
TAG	emergency proce CMHC must provi preparedness trai Based on record re- failed to ensure state emergency prepare The ICF/IID facility Provide initial train policies and proced staff, individuals preparedness train (iii) Maintain docum Demonstrate staff is procedures in accord (1). This deficient procedures in accord (1). This deficient procedures in accord (1). This deficient procedures Manu 05/01/23 and "Eme Plans & Responses 05/01/23 with the M review at 1:16 p.m. documentation of s preparedness plan v two-year period. Ba record review, the M training documenta preparedness policies most recent two-ye review at the time of	dures. Thereafter, the de emergency ning at least every 2 years. view and interview, the facility of received training regarding duess policies and procedures. It is must do all of the following: (i) ing in emergency preparedness ures to all new and existing roviding services under colunteers, consistent with their Provide emergency may at least every two years; mentation of the training; (iv) the converse of emergency dance with 42 CFR 483.475(d) conceived the facility lacked and the facility lacked that training on the emergency within the most recent ased on interview at the time of Maintenance Tech agreed staff tion on emergency es and procedures within the ar period was not available for of the survey.	E 0037	CORRECTION:  The facility must have a traprogram on place with (i) Itraining in emergency preparedness policies and procedures to all new and staff, individuals providing services under arrangeme volunteers, consistent with expected roles. (ii) Provide emergency preparedness at least annually. (iii) Main documentation of the train Demonstrate staff knowled emergency procedures.  Specifically, the facility has developed an emergency preparedness training current that includes the following training in emergency preparedness policies and procedures to all new and staff, individuals providing under arrangement, and volunteers, consistent with expected roles, included a the facility's on-the-job Traprogram; and provide emergency preparedness training at leannually; and maintain documentation of the train facility has also implement competency test to evaluate effectiveness of the training program.  Area Supervisors and Programs will turn in copies	aining initial  existing on-site ent, and in their entraining tain ing. (iv) edge of existing services  I their existing services

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/10/2023
	ROVIDER OR SUPPLIER		6025 B	ADDRESS, CITY, STATE, ZIP COD UCKSKIN CT IAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	(X5) COMPLETION DATE
				competency-based training documentation to the QIDP Manager for filing and tracking This documentation will be available for review during Emergency Preparedness surveys. Area Supervisors and Program Managers will be tratoward proper implementation the current process.  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 and Nurse Manager) will incorporate reviews of the fact emergency preparedness profinto scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safet Committee will review and revithe plan as needed but no less than annually.  RESPONSIBLE PARTIES: QIA Area Supervisor, Direct Suppolead, Safety Committee, Hum Resources Department, Operations Team, Regional Director	d ined of eam s, ce DP, ors, dility's gram  y rise s DP, ort
E 0039 Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485.	5.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2)			

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		15G465	B. WING		10/10/2023		
NAME OF F	PROVIDER OR SUPPLIER	<del>.</del>		ADDRESS, CITY, STATE, ZIP COD	_		
				UCKSKIN CT			
COMMU	NITY ALTERNATIV	E9-ADEP1	INDIAN	NAPOLIS, IN 46250			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE CONTENTION		
TAG	i e	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	EP Testing Requi	rements 18.113(d)(2), §441.184(d)(2),					
	§460.84(d)(2), §482.15(d)(2), §483.73(d)(2),						
	- , , , , -	484.102(d)(2), §485.68(d)(2),					
		485.727(d)(2), §485.920(d)					
	(2), §491.12(d)(2)	, §494.62(d)(2).					
		6.54, CORFs at §485.68,					
		ons" under §485.727,					
	_	20, RHCs/FQHCs at					
	§491.12, and ESF	RD Facilities at §494.62]:					
	(2) Testing. The [facility] must conduct exercises to test the emergency plan						
	annually. The [fac	ility] must do all of the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based	every 2 years; or					
	(A) When a comm	nunity-based exercise is					
	not accessible, co	nduct a facility-based					
		e every 2 years; or					
	` '	lity] experiences an actual					
		ade emergency that requires					
		mergency plan, the [facility]					
	· ·	gaging in its next required					
	1	or individual, facility-based					
		e following the onset of the					
	actual event.	ditional eversion at least					
		ditional exercise at least					
		posite the year the full-scale					
		cise under paragraph (d)(2) s conducted, that may					
		limited to the following:					
	· ·	scale exercise that is					
	, ,	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
	, ,	ercise or workshop that is					
		and includes a group					

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	OF CORRECTION	IDENTIFICATION NUMBER  15G465	A. BUILDING B. WING		COMP	PLETED 0/2023
	PROVIDER OR SUPPLIER		6025 B	ADDRESS, CITY, STATE, ZIP CO UCKSKIN CT IAPOLIS, IN 46250	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	set of problem star messages, or prepto challenge an en (iii) Analyze the [farmaintain document exercises, and em the [facility's] emeth the [facility's] emeth the [facility's] emeth the [facility's] emeth the patient's home conduct exercises plan at least annuate the following:  (i) Participate in a community based (A) When a community based (A) When a community based functional emergency exempt from engals scale community-facility-based functionset of the emergency exempt from engals scale community-facility-based functional exercises of this section is conclude, but is not (A) A second full-community-based functional exercises (B) A mock disast (C) A tabletop	emergency scenario, and a tements, directed pared questions designed nergency plan. acility's] response to and atation of all drills, tabletop regency events, and revise regency plan, as needed.  418.113(d):] spices that provide care in the hospice must to test the emergency ally. The hospice must do full-scale exercise that is every 2 years; or unity based exercise is not examinative to test an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is ging in its next required full pased exercise or individual tional exercise following the gency event. Iditional exercise every 2 e year the full-scale or ender paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY  IPLETED  10/2023
	PROVIDER OR SUPPLIER		6025 B	ADDRESS, CITY, STATE, ZIP O UCKSKIN CT IAPOLIS, IN 46250	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	set of problem sta	pared questions designed				
	care directly. The exercises to test to per year. The hose (i) Participate in a that is community (A) When a community (A) When a community-based functional exercise emergency exempt from engage full-scale community-based functional exercise emergency event. (ii) Conduct an act that may include, following:  (A) A second full-community-based functional exercise (B) A mock disass (C) A tabletop extenditation for the emergency scenaric statements, direct questions designed emergency plan. (iii) Analyze the functional exercises, and emergency and the exercises, and emergency and the exercises in the exercise	nunity-based exercise is not an annual individual extional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the additional annual exercise but is not limited to the escale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared				

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Event ID:

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Facility ID: 000979

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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	JILDING	<del></del>	COMPI	LETED	
		15G465	B. Wl	B. WING		10/10	/2023	
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIEF	8			UCKSKIN CT			
СОММИ	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46250			
							1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	***							
	*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]							
	, ,	PRTF, Hospital, CAH] must						
		to test the emergency						
	CAH] must do the	ar. The [PRTF, Hospital,						
	-	an annual full-scale exercise						
	that is community							
	-	nunity-based exercise is not						
		ct an annual individual,						
		ctional exercise; or						
	(B) If the [PRTF, Hospital, CAH] experiences							
	. , -	or man-made emergency						
		ation of the emergency						
		is exempt from engaging in						
		ull-scale community based						
	·	ty-based functional exercise						
		et of the emergency event.						
	_	an [additional] annual						
	, ,	at may include, but is not						
	limited to the follo	wing:						
	(A) A second full-	scale exercise that is						
	community-based	or individual, a						
	facility-based fund	ctional exercise; or						
	, ,	ock disaster drill; or						
	(C) A tabletor	exercise or workshop that						
	-	or and includes a group						
	discussion, using							
		emergency scenario, and a						
	set of problem sta							
	-	pared questions designed						
	to challenge an er						1	
		he [facility's] response to						
		umentation of all drills,						
	•	s, and emergency events						
	·	cility's] emergency plan, as						
	needed.							
	*[For PACE at §46	60.84(d):1						
ı	,	/	1		i e		Ī.	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/10/2023	
	PROVIDER OR SUPPLIEI			6025 BU	DDRESS, CITY, STATE, ZIP COD ICKSKIN CT APOLIS, IN 46250		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	PI	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	(2) Testing. The F	PACE organization must					
	conduct exercises	s to test the emergency					
	plan at least annu	-					
	organization must						
		an annual full-scale exercise					
	that is community						
	l ` '	nunity-based exercise is not					
		ıct an annual individual,					
		ctional exercise; or					
	(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required						
	full-scale community based or individual,						
	facility-based functional exercise following the						
	onset of the emer	<del>-</del> -					
	, ,	an additional exercise every					
	1	the year the full-scale or					
		e under paragraph (d)(2)(i)					
	but is not limited t	conducted that may include,					
		-scale exercise that is					
	1 ' '	l or individual, a facility					
	based functional	_					
	(B) A mock disas						
	l ` '	ercise or workshop that is					
	` '	and includes a group					
	discussion, using						
		emergency scenario, and a					
		atements, directed					
	-	pared questions designed					
	to challenge an e	·					
	_	PACE's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events and revise					
	the PACE's emer	gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):]					
	(2) The [LTC facil	ity] must conduct exercises					
	to test the emerge	ency plan at least twice per					

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Event ID:

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	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465		JILDING	NSTRUCTION	COMP	ESURVEY LETED 0/2023
	OF PROVIDER OR SUPPLIE		•	6025 BL	DDRESS, CITY, STATE, ZIP COD JCKSKIN CT APOLIS, IN 46250	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	year, including unthe emergency processible in a that is community (A) When a community (A) When a community-based functional individual, facility-based functional individual, facility-following the onse (ii) Conduct an arthat may include, following:  (A) A second full-community-based based functional individual, facility-following individual, facility-following individual, facility-following individual, facility-following individual, facility-following individual, facility-following individual, facility-following:  (A) A second full-community-based based functional individual, facility-based individual,	rannounced staff drills using rocedures. The [LTC facility, the following: an annual full-scale exercise r-based; or nunity-based exercise is not uct an annual individual, ctional exercise. Cility] facility experiences an man-made emergency that in of the emergency plan, the empt from engaging its next ale community-based or electronal exercise at of the emergency event. In other exercise that is a for an individual, facility exercise; or exercise or workshop that is includes a group a narrated, emergency scenario, and a exements, directed pared questions designed mergency plan.  LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed.					

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/10/2023	
NAME OF P	PROVIDER OR SUPPLIEF	·		ADDRESS, CITY, STATE, ZIP COD	• •
COMMUI	NITY ALTERNATIV	ES-ADEPT		UCKSKIN CT IAPOLIS, IN 46250	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	' '	n annual full-scale exercise			
	that is community				
	' '	nunity-based exercise is not let an annual individual,			
		ctional exercise; or.			
		experiences an actual			
	' '	ade emergency that requires			
		mergency plan, the ICF/IID			
		gaging in its next required			
	-	nity-based or individual,			
		tional exercise following the			
	onset of the emer	_			
		ditional annual exercise			
	that may include,	but is not limited to the			
	following:				
	(A) A second full-s	scale exercise that is			
	community-based	or an individual,			
	facility-based fund	ctional exercise; or			
	(B) A mock disast	er drill; or			
	(C) A tabletop exe	ercise 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 sta				
		pared questions designed			
	to challenge an er	• • • • • • • • • • • • • • • • • • • •			
		CF/IID's response to and			
		ntation of all drills, tabletop			
		nergency events, and revise			
	tne ICF/IID's emei	rgency plan, as needed.			
	*[For HHAs at §48	34.102]			
	-	e HHA must conduct			
	. , . ,	he emergency plan at			
	least annually. Th	e HHA must do the			
	following:				
	(i) Participate in a	full-scale exercise that is			
	community-based	; or			
	(A) When a c	ommunity-based exercise			
	is not accessible.	conduct an annual			

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			
		15G465	B. WING 10/10/2023				
NAME OF F	PROVIDER OR SUPPLIER	· }		ADDRESS, CITY, STATE, ZIP COD	-		
				BUCKSKIN CT			
COMMU	NITY ALTERNATIV	'ES-ADEPT	INDIAN	NAPOLIS, IN 46250			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
	-	based functional exercise					
	every 2 years; or.	A experiences an actual					
	, ,	ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
		tional exercise following the					
	onset of the emer	•					
		ditional exercise every 2					
	` '	e year the full-scale or					
	•	e under paragraph (d)(2)(i)					
	of this section is c						
	include, but is not	limited to the following:					
	(A) A second	full-scale exercise that is					
	community-based	or an individual,					
	facility-based fund	ctional exercise; or					
	(B) A mock di	isaster drill; or					
	(C) A tabletor	exercise or workshop that					
	-	or and includes a group					
	discussion, using						
	· ·	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	- · · ·					
	. ,	HA's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	ine HHA's emerge	ency plan, as needed.					
	*[For OPOs at §48	86.360]					
		e OPO must conduct					
		he emergency plan. The					
	OPO must do the	- · · · · · · · · · · · · · · · · · · ·					
		er-based, tabletop exercise					
		ast annually. A tabletop					
	-	a facilitator and includes a					
		using a narrated, clinically					
		cy scenario, and a set of					
	_	nts directed messages or	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			) DATE SURVEY	
		A. BU	A. BUILDING COMPLETED			ETED	
	15G465		B. W	NG _	10/10/	/2023	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			UCKSKIN CT		
COMMU	NITY ALTERNATIV	ES ADEDT			APOLIS, IN 46250		
COMMO				INDIAN	AI OLIO, III 40200		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	prepared question	ns designed to challenge an					
	emergency plan. I	If the OPO experiences an					
	actual natural or n	nan-made emergency that					
	requires activation	n of the emergency plan, the					
	OPO is exempt fro	om engaging in its next					
	required testing ex	xercise following the onset					
	of the emergency	event.					
	(ii) Analyze the Ol	PO's response to and					
		ntation of all tabletop					
	exercises, and em	nergency events, and revise					
	the [RNHCI's and	OPO's] emergency plan, as					
	needed.						
	*[ RNCHIs at §403	<del>-</del>					
		e RNHCI must conduct					
		he emergency plan. The					
	RNHCI must do th	•					
		er-based, tabletop exercise					
		A tabletop exercise is a					
		led by a facilitator, using a					
		-relevant emergency					
		et of problem statements,					
	_	s, or prepared questions					
	_	enge an emergency plan.					
		NHCI's response to and					
		ntation of all tabletop					
		nergency events, and revise					
	i	rgency plan, as needed.					
		view and interview, the facility	E 0	039	CORRECTION:		11/09/2023
		least two exercises to test the			The [facility] must conduct		
		an annual basis using the			exercises to test the emergence	-	
		res. The ICF/IID facility must			plan at least annually. Specific	-	
		ing: (i) participate in a full-scale			the agency has assigned a ris		
		nmunity-based or when a			management specialist from the		
		exercise is not accessible, an			Quality Assurance Departmen		
		based. If the ICF/IID facility			(the QIDP Manager) to conduc	et an	
		al natural or man-made			exercise of choice table talk		
		uires activation of the			conference. Participants will		
		e ICF/IIC facility is exempt from			include ResCare facility		
	engaging in a comn	nunity-based or individual,			supervisors, the QIDP and		

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

PRINTED: 11/03/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	COMP	E SURVEY LETED 0/2023
	PROVIDER OR SUPPLIER		6025 E	ADDRESS, CITY, STATE, ZIPBUCKSKIN CT NAPOLIS, IN 46250	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
TAG	facility-based full-s following the onset conduct an addition but is not limited to full-scale exercise to individual, facility-that includes a grouf facilitator, using a remergency scenariod statements, directed questions designed plan; (iii) analyze thand maintain docur exercises, and emer ICF/IID facility's end accordance with 42 deficient practice of Findings include:  Based on review of Preparedness Manu 05/01/23 and "Emer Plans & Responses 05/01/23 with the Noreview at 1:19 p.m. a community-based recent twelve-mont review. Based on ir review, the Mainten has not conducted a disaster drill or con within the most recent available for review available for review.	of the actual event; (ii) nal exercise that may include, the following: (A) a second that is community-based or based. (B) a tabletop exercise up discussion led by a narrated, clinically-relevant to, and a set of problem It messages, or prepared to challenge an emergency the ICF/IID facility's response to mentation of all drills, tabletop regency events, and revise the mergency plan, as needed in CFR 483.475(d)(2). This could affect all occupants.  The mergency/Disaster tall documentation dated regency, Disaster, Evacuation documentation also dated Maintenance Tech during record on 10/10/23, documentation of disaster drill within the most the period was not available for merciew at the time of record mance Tech agreed the facility a second community-based ducted a tabletop exercise ent twelve-month period and esting documentation was not very at the time of the survey.  Viewed with the Maintenance	TAG	administrative level in (Program Manager, Cassurance Manager, Assurance Coordinat Manager) will particip exercises to assure for emergency prepared protocols are consists community emergency management practice department will assure completion of these of The facility will develop documentation of the the Emergency Prepared protocols are consists community emergency management practice department will assure completion of these of The facility will develop documentation of the the Emergency Prepared in place by "table talk exercise was cheduled within 6 m full-scale event.  PREVENTION:  Members of the Oper (comprised of the Exemplement of the Exemple	nanagement, Quality Quality tor, and Nurse pate in the racility ness ent with cy es. The QA re biannual exercises. op a activation of aredness 23 severe ass power ch the facility 11/9/23. A vill be nonths of the rations Team ecutive Managers, Area Assurance ager, QIDP, oordinators, will of the facility's ness program monthly equired ng but not saster nt.	DATE

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Event ID:

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Facility ID: 000979

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

PRINTED: 11/03/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15G465	A. BUILDING B. WING		COMPLETED 10/10/2023
	PROVIDER OR SUPPLIER		6025 B	ADDRESS, CITY, STATE, ZIP COD JUCKSKIN CT JAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
				Committee will review and rethe plan as needed but no lethan annually.  RESPONSIBLE PARTIES: Carea Supervisor, Direct Suplead, Direct Support Staff, Operations Team, Regional Director	SS QIDP,
K 0000					
Bldg. 01	conducted by the In- accordance with 42  Survey Date: 10/10  Facility Number: 00 Provider Number: 1002  At this Life Safety C Alternatives - Adept with Requirements of 42 CFR Subpart 483 and the 2012 edition Protection Associati Code (LSC), Chapte Board and Care Occ  This one-story build fully sprinklered. The system with smoke of living areas. The att purposes, storage or provided with a hear the fire alarm system	200979 15G465 244860 Code survey, Community t was found not in compliance for Participation in Medicaid, 3.470(j), Life Safety from Fire n of the National Fire fon (NFPA) 101, Life Safety er 33, Existing Residential	K 0000		

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Event ID:

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Facility ID: 000979

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COM	te survey pleted 0/2023
	ROVIDER OR SUPPLIER		6025 BI	ADDRESS, CITY, STATE, ZIP COD UCKSKIN CT APOLIS, IN 46250		_
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	(X5) COMPLETION
TAG	Calculation of the E (E-Score) using NF	PA 101A, Alternative Safety, Chapter 6, rated the	TAG	DEFICIENCY)		DATE
	Quality Review con					
K S353	NFPA 101 Sprinkler System -	- Maintenance and Testing				
Bldg. 01	Sprinkler System - 2012 EXISTING (INFPA 13 and 13R All sprinkler system with NFPA 13, Sta Sprinkler Systems for the Installation Residential Occup Four Stories in He and maintained in Standard for Inspendintenance of W System.  NFPA 13D System Sprinkler systems with NFPA 13D, Sof Sprinkler System Dwellings and Mainspected, tested accordance with the NFPA 25:  1. Control valves 25, section 13.3.2  2. Gauges inspensed in the System of System 13.2.71).  3. Alarm devices (NFPA 25, section 4. Alarm devices (NFPA 25, section 5).	- Maintenance and Testing Prompt) (a Systems Installed in accordance and Art He Installation of (b), and NFPA 13R, Standard (of Sprinkler Systems in prancies Up To and Including (sight, are inspected, tested (accordance with NFPA 25, (action, Testing and (ater Based Fire Protection (as) (installed in accordance (itandard for the Installation (itandard for the				

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Event ID:

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>			COMPLETED	
		15G465	B. WING		10/10	10/10/2023	
NAME OF A			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C		6025 BI	JCKSKIN CT		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	-	lers inspected annually					
	((NFPA 25, sectio	n 5.2.1). rspected annually (NFPA					
	25, section 5.2.2).						
	,	angers inspected annually					
	(NFPA 25, section						
		pected annually prior to					
		for adequate heat for water					
	filled piping (NFP)	A 25, section 5.2.5).					
		ative sample of fast					
		rs are tested at 20 years					
	(NFPA 25, section	•					
	11. A representative sample of dry pendant						
	-	ed at 10 years (NFPA 25,					
	section 5.3.1.1.15	•					
	(NFPA 25, section	olutions are tested annually					
		es are operated through					
		d returned to normal					
	_	5, section 13.3.3.1).					
		tems of OS&Y valves are					
		y (NFPA 25, section					
	13.3.4).	, ,					
	· /	stems extending into					
		of the building are					
	inspected, tested	and maintained (NFPA 25,					
	section 13.4.4).						
	A. Date sprinkler s	system last checked and					
	necessary mainte	nance provided.					
	B. Show who prov	vided the service.					
	C. Note the sourc	e of the water supply for the er system.					
	(Provide in REMA	RKS information on					
		non-required or partial					
	automatic sprinkle						
		.5.8, 9.7.5, 9.7.7, 9.7.8,					
	and NFPA 25						I

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. Building <u>01</u>			COMPLETED	
		15G465	B. W	B. WING 10/10			2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIER	8			UCKSKIN CT			
COMMU	NITY ALTERNATIV	ES-ADEPT			IAPOLIS, IN 46250			
	Т		1		, I			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION view, interview, and	17.0	TAG			DATE	
			KS	353	CORRECTION:		11/09/2023	
		lity failed to ensure 1 of 1 piping systems was examined			All sprinkler systems must be	IEDA		
	_	tions where conditions exist			installed in accordance with N 13. Specifically, the facility's	IFPA		
		structed piping as required by			contracted Environmental Ser	vicee		
		ition, the Standards for the			Specialist will work with the	VICES		
		and Maintenance of			facility's alarm and sprinkler			
	-	rotection Systems, Section			service provider conduct an			
		2.1 states, "except as discussed			inspection automatic sprinkler			
		2.1.4 an inspection of piping and			piping systems was examined			
		ons shall be conducted every 5			internal obstructions where	1 101		
					conditions exist that could cau	100		
	years by opening a flushing connection at the end of one main and by removing a sprinkler toward				obstructed piping, and ongoin			
		ch line for the purpose of			inspections as required. Detail	-		
		resence of foreign organic and			itemized records of the	icu		
		This deficient practice affects		inspections will be kept on han		nd at		
	all clients in the hor	-			the facility.	iid dt		
					PREVENTION:			
	Findings include:				The QIDP Manager will retrain	า		
					members of the Operations To			
	Based on record rev	view with the Maintenance			(comprised of the Executive			
		t 2:02 p.m., the Sprinkler			Director, Operations Manager	S.		
		ation entitled "Sprinkler			Program Managers, Area	-,		
		Forms" dated:03/15/23,			Supervisors, Quality Assurance	ce		
		and 12/30/23, documentation of			Manager, QIDP Manager, QIE			
	· · · · · · · · · · · · · · · · · · ·	pection could not be located.			Quality Assurance Coordinate			
		ew with the Maintenance Tech			Nurse Manager and Assistant			
	at the time of record	d review, he stated that he			Nurse Manager) to assure the			
		er pipe was plastic or P.V.C.			familiarity with Life Safety Coo			
		to do in internal pipe			requirements for inspections of			
	inspection. Based of	n observations made during a			facility sprinkler system. Mem			
	tour of the facility a	at 2:32 p.m., the piping on the			of the Operations Team will			
	sprinkler system go	ing up into the attic space was			conduct reviews of sprinkler			
		stigation by going up into the			inspection documentation no l	less		
	hatch in the garage	into the attic space showed			than monthly to assure			
	the piping in the att	ic was indeed metallic. This			compliance.			
	was confirmed by the	he Maintenance Tech who			RESPONSIBLE PARTIES: QI	DP,		
	added that he would	d contact his vendor			Area Supervisor, Residential			
	immediately to get	the inspection completed.			Manager, Environmental Serv	rices		
		_	1		Staff Operations Team			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/03/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			NSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>			COMPLETED		
		15G465	B. WING			10/10/2023		
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT				6025 Bl	ADDRESS, CITY, STATE, ZIP COD JCKSKIN CT APOLIS, IN 46250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
			ı	ı				

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