STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G449	A. BUILDING -- B. WING	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/08/19 Facility Number: 000963 Provider Number: 15G449 AIM Number: 100244740 At this Emergency Preparedness survey, Community Alternatives-Adept was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 5. Quality Review completed on 03/11/19 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0015 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to	E 0015	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its	04/07/2019

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

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	15G449	A. BUILDING -- B. WING	03/08/2019

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	maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Delbrook" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 2:20 p.m. to 3:00 p.m. on 03/08/19, the plan did not address subsistence needs provisions for sewage and waste disposal. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in February 2019 and agreed the plan for the Delbrook facility did not address subsistence needs provisions for sewage and waste disposal.		emergency preparedness plan: the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: Sewage and waste disposal. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0022 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility in accordance with 42 CFR	E 0022	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the*	04/07/2019

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	483.475(b)(4). This deficient practice could affect all occupants. Findings included: Based on review of "Emergency/Disaster Preparedness Manual: Delbrook" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 2:20 p.m. to 3:00 p.m. on 03/08/19, documentation of emergency preparedness policies and procedures for sheltering in place clients, staff and volunteers who remain in the facility during an emergency was not available for review. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in February 2019 and agreed the emergency preparedness plan for the Delbrook facility did not include documentation of emergency preparedness policies and procedures for sheltering in place clients, staff and volunteers who remain in the facility during an emergency.		*emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: A means to shelter in place for patients, staff, and volunteers who remain in the facility or a means to shelter in place for patients, staff, and volunteers who remain in the facility. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0024 Bldg. -- Based on record review and interview, the facility		E 0024	**CORRECTION:**	04/07/2019

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	failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Delbrook" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 2:20 p.m. to 3:00 p.m. on 03/08/19, the emergency preparedness plan did not include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in February 2019 and agreed emergency preparedness documentation did not include emergency preparedness policies and procedures for the use of volunteers in an emergency.		*[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	15G449	A. BUILDING -- B. WING	03/08/2019

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E 0026 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Delbrook" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 2:20 p.m. to 3:00 p.m. on 03/08/19, the emergency preparedness plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in February 2019 and agreed the plan did not include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act.	E 0026	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: The role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential	04/07/2019

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			Manager, Direct Support Staff, Operations Team, Regional Director	
E 0030 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Delbrook" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 2:20 p.m. to 3:00 p.m. on 03/08/19, the emergency preparedness communication plan for the facility did not include names and contact information for volunteers. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in February 2019 and agreed the communication plan did not include names and contact information for volunteers.	E 0030	**CORRECTION:** *[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan.* Specifically, the facility will incorporate the following policies into its emergency preparedness plan: an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan will include names and contact numbers of volunteers. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise	04/07/2019

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			the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Delbrook" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 2:20 p.m. to 3:00 p.m. on 03/08/19, the emergency preparedness plan did not include a training and testing program on the emergency preparedness plan. Based on interview at the time of record review, the Maintenance Aide stated there has been no	E 0037	**CORRECTION:** *The facility must have a training program on place with (i) Initial training in emergency preparedness* *policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.* Specifically, the facility will provide an emergency preparedness training program that includes the following. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; and provide emergency preparedness training at least annually; and maintain	04/07/2019

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	change to emergency preparedness documentation since the review of the documentation for other group homes in February 2019 and agreed the emergency preparedness plan did not include a training and testing program which documented staff training in all emergency preparedness policies and procedures within the most recent twelve month period.		documentation of the training; and demonstrate staff knowledge of emergency procedures. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled twice monthly audits to assure all required components are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of the following: The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an	E 0039	**CORRECTION:** *The [facility] must conduct exercises to test the emergency plan at least annually.* Specifically, the agency's Quality Assurance Department has submitted a formal request to the Indianapolis Metropolitan Police	04/07/2019

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	individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency/Disaster Preparedness Manual: Delbrook" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 2:20 p.m. to 3:00 p.m. on 03/08/19, documentation of a community based disaster drill or table top exercise conducted within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Aide stated there has been no change to emergency preparedness documentation since the review of the documentation for other group homes in February 2019 and agreed the facility has not conducted a community based disaster drill, a		Department/Department of Homeland Security Community Emergency Response Team (CERT) to conduct an initial “table talk” disaster exercise, with bi-annual exercises thereafter. Additionally the ResCare Quality Assurance Department has requested assistance from the IMPD District Commander to coordinate with CERT to facilitate this process. ResCare Facility supervisors, the QIDP and administrative level management (Program Director, Program Managers, Quality Assurance Manager, QIDP Manager, Nurse Manager and Assistant Nurse Manager) will participate in the exercises to assure facility emergency preparedness protocols are consistent with community emergency management practices. **PREVENTION:** Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility’s emergency preparedness program into scheduled twice monthly audits to assure all required components, including but not limited to bi-annual community-based disaster	

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	table top exercise or experienced an actual natural or man-made emergency within the most recent twelve month period and agreed testing documentation was not available for review at the time of the survey.		exercises, are present. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/08/19 Facility Number: 000963 Provider Number: 15G449 AIM Number: 100244740 At this Life Safety Code survey, Community Alternatives - Adept was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has a capacity of 6 and had a census of 5 at the time of this survey.	K 0000		

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	Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.2. Quality Review completed on 03/11/19			
K S711 Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan The administration of every resident board and care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility. All residents participating in the emergency plan shall be trained in the proper actions to be taken in the event of fire. Training shall include proper actions to be taken if the primary escape route is blocked. If the resident is given rehabilitation or habilitation training, training in fire prevention and the actions to be taken in the event of a fire shall be part of the training program. Residents shall be trained to assist each other in case			

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	of fire to the extent that their physical and mental abilities permit them to do so without additional personal risk. 32.7.1, 32.7.2, 33.7.1, 33.7.2 Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under 1 of 1 written fire safety plan. Such instruction is reviewed by the staff not less than every 2 months. This deficient practice affects all clients in the facility. Findings include: Based on review of "Emergency Evacuation Drill: Fire" with the Maintenance Aide and the House Manager during record review from 2:20 p.m. to 3:00 p.m. on 03/08/19, documentation of staff training records to show all first, second and third shift employees have been instructed of their duties and responsibilities at least every two months for 1 of 4 calendar quarters during the most recent twelve month period was not available for review. Based on interview during record review, the House Manager stated the facility operates three shifts per day and additional staff training documentation was not available for review. Furthermore, documentation of a fire drill conducted on the first, second and third shift in the second quarter (April, May, June) 2018 was not available for review. Based on interview at the time of record review, the House Manager stated he started working at the facility after June 2018, additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the aforementioned shifts in the second quarter 2018 was not available for review.	K S711	**CORRECTION:** *The administration of every resident board and care facility shall have in effect and available to all supervisory personnel written copies of a plan for protecting all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan shall include special staff response, including fire protection procedures needed to ensure the safety of any resident, and shall be amended or revised whenever any resident with unusual needs is admitted to the home. All employees shall be periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction shall be reviewed by the staff not less than every two months. A copy of the plan shall be readily available at all times within the facility.* Specifically, the facility will conduct additional evacuation drills on the each shift during the current quarter, assuring that all facility employees are retrained on their responsibilities under the plan. **PREVENTION:**	04/07/2019

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	15G449	A. BUILDING 01 B. WING	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	7859 DELBROOK DR INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Professional staff will be retrained regarding the need to conduct evacuation drills at varied times on each shift for all staff each quarter to assure the staff's competency in implementing the protection plan. Training will also focus on proper completion of evacuation drill forms and assessment of individual drill compliance. The Operations Team comprised of the Program Managers, Training Coordinator, Nurse Manager, Quality Assurance Manager, Quality Assurance Coordinator and Executive Director will review and track all facility evacuation drill reports and follow up with professional staff as needed to assure drills and training occurs as scheduled and follow up with the agency Safety Committee accordingly. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's			

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	emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of 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 and interview, the facility failed to provide documentation of a fire drill conducted on the first, second and third shift for 1 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Emergency Evacuation Drill: Fire" with the Maintenance Aide and the House Manager during record review from 2:20 p.m. to 3:00 p.m. on 03/08/19, documentation of a fire drill conducted on the first, second and third shift in the second quarter (April, May, June) 2018 was not available for review. Based on interview at the time of record review, the House Manager stated he started working at the facility after June 2018, additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the aforementioned shifts	K S712	**CORRECTION:** *The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions.* Specifically, the facility will conduct additional evacuation drills on the each shift during the current quarter. **PREVENTION:** Professional staff will be retrained regarding the need to conduct evacuation drills at varied times on each shift for all staff each quarter. Training will also focus on proper completion of evacuation drill forms and assessment of individual drill compliance. The Operations Team comprised of the Program Managers, Training	04/07/2019

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	in the second quarter 2018 was not available for review.		Coordinator, Nurse Manager, Quality Assurance Manager, Quality Assurance Coordinator and Executive Director will review and track all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled and follow up with the agency Safety Committee accordingly. **Responsible Parties:** Environmental Services Team, Area Supervisor, Residential Manager, Direct Support Staff, QIDP, Operations Team	