

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

PRINTED: 12/04/2019
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 11/18/2019	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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. --	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 11/18/19</p> <p>Facility Number: 000979 Provider Number: 15G465 AIM Number: 100244860</p> <p>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.</p> <p>The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8.</p> <p>Quality Review completed on 11/19/19</p> <p>The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:</p>			E 0000			
E 0015 Bldg. --	<p>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</p>			E 0015	<p>CORRECTION: <i>[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</i></p>		12/18/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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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E 0022 Bldg. --	<p>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.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 9:10 a.m. to 10:15 a.m. on 11/18/19, 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 emergency preparedness documentation has been updated in September 2019 since the review of the documentation for other group homes in the Summer of 2019, he was not sure if the updated plan addressed previous concerns but agreed the emergency preparedness plan for the facility did not address subsistence needs provisions for sewage and waste disposal.</p> <p>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 483.475(b)(4). This deficient practice could affect all occupants.</p>			E 0022	<p>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.</p> <p>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.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> <p>CORRECTION: <i>[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan. Specifically, the facility will incorporate the</i></p>		12/18/2019

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E 0024 Bldg. --	<p>Findings included:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 9:10 a.m. to 10:15 a.m. on 11/18/19, 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 emergency preparedness documentation has been updated in September 2019 since the review of the documentation for other group homes in the Summer of 2019, he was not sure if the updated plan addressed previous concerns but agreed the emergency preparedness plan for the 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.</p> <p>Based on record review and interview, the facility 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</p>		E 0024	<p>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.</p> <p>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.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> <p>CORRECTION: <i>[Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan. Specifically, the</i></p>		12/18/2019	

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E 0026 Bldg. --	<p>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.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 9:10 a.m. to 10:15 a.m. on 11/18/19, 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 emergency preparedness documentation has been updated in September 2019 since the review of the documentation for other group homes in the Summer of 2019, he was not sure if the updated plan addressed previous concerns but agreed emergency preparedness documentation did not include emergency preparedness policies and procedures for the use of volunteers in an emergency.</p> <p>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID</p>			E 0026	<p>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.</p> <p>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.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> <p>CORRECTION: <i>[Facilities] must develop and implement emergency</i></p>		12/18/2019

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E 0030 Bldg. --	<p>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.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 9:10 a.m. to 10:15 a.m. on 11/18/19, 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 emergency preparedness documentation has been updated in September 2019 since the review of the documentation for other group homes in the Summer of 2019, he was not sure if the updated plan addressed previous concerns but 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.</p> <p>Based on record review and interview, the facility</p>		E 0030	<p><i>preparedness policies and procedures, based on the emergency plan.</i> 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.</p> <p>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.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> <p>CORRECTION:</p>		12/18/2019	

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	<p>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.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 9:10 a.m. to 10:15 a.m. on 11/18/19, 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 emergency preparedness documentation has been updated in September 2019 since the review of the documentation for other group homes in the Summer of 2019, he was not sure if the updated plan addressed previous concerns but agreed the communication plan did not include names and contact information for volunteers.</p>				<p><i>[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.</i></p> <p>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.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p>		

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E 0037 Bldg. --	<p>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.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 9:10 a.m. to 10:15 a.m. on 11/18/19, 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 emergency preparedness documentation has been updated in September 2019 since the review of the documentation for other group homes in the Summer of 2019, he was not sure if the updated plan addressed previous concerns but 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.</p>			E 0037	<p>CORRECTION: <i>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.</i></p> <p>Specifically, the facility will provide an emergency preparedness training program that includes the following. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; and provide emergency preparedness training at least annually; and maintain documentation of the training; and demonstrate staff knowledge of emergency procedures.</p> <p>PREVENTION: Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance</p>		12/18/2019

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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 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	E 0039	<p>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.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> <p>CORRECTION: <i>The [facility] must conduct exercises to test the emergency plan at least annually. Specifically, the facility will conduct a full-scale facility-based exercise that includes outside community emergency management agency(s) and will conduct similar exercises no less than annually. Additionally the facility will work with local law enforcement and emergency personnel to arrange "table talk" disaster exercises on a no less than an annual basis.</i></p> <p>PREVENTION: Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance</p>	12/18/2019	

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K 0000 Bldg. 01	<p>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.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Disaster Preparedness Manual" and "Emergency, Disaster, Evacuation Plans & Responses" with the Maintenance Aide during record review from 9:10 a.m. to 10:15 a.m. on 11/18/19, 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 emergency preparedness documentation has been updated in September 2019 since the review of the documentation for other group homes in the Summer of 2019, he was not sure if the updated plan addressed previous concerns but agreed the facility has not conducted a community based disaster drill, a 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.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p>		K 0000	<p>Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate reviews of the facility's emergency preparedness program into scheduled monthly audits to assure all required components, including but not limited to assuring full scale facility and community based disaster exercises occur as required. Additionally, the agency Safety committee will review and revise the plan as needed but no less than annually.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p>			

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K S100 Bldg. 01	<p>Survey Date: 11/18/19</p> <p>Facility Number: 000979 Provider Number: 15G465 AIM Number: 100244860</p> <p>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.</p> <p>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 8 and had a census of 8 at the time of this survey.</p> <p>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 0.3.</p> <p>Quality Review completed on 11/19/19</p> <p>NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Aide during a tour of the facility from 10:15 a.m. to 10:35 a.m. on 11/18/19, the portable fire extinguisher located in the Laundry area had an affixed maintenance tag which did not document a monthly inspection for January and February 2019. Based on interview at the time of the observations, the Maintenance Aide stated the fire extinguisher inspection contractor performed the annual inspection in December 2018,</p>			K S100	<p>CORRECTION: <i>The facility must document inspections of portable fire extinguishers no less than monthly. Specifically, a fire extinguisher inspection has been completed for the current month and will take place monthly thereafter.</i></p> <p>PREVENTION: Supervisory personnel will assure that monthly portable fire extinguisher inspections are conducted as required. The Operations Team comprised of the Program Managers, Training Coordinator, Nurse Manager, Quality Assurance Manager, Quality Assurance Coordinator and Executive Director will conduct reviews of the home environment no less than monthly to assure equipment testing occurs as required</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Environmental Services Team, Direct Support Staff, Operations Team, Regional Director</p>		12/18/2019

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

PRINTED: 12/04/2019

FORM APPROVED

OMB NO. 0938-039

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	additional monthly fire extinguisher inspection documentation was not available for review and agreed documentation of monthly portable fire extinguisher inspections for the Laundry area portable fire extinguisher for the aforementioned monthly periods was not available for review.						