STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G486		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI  A. BUILDING COMPLETI  B. WING 07/23/20			ETED	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
COMMUN	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46256		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
E 0000							
Bldg	conducted by the In accordance with 42  Survey Date: 07/23  Facility Number: 00  Provider Number: 1002  At this Emergency I Community Alterna compliance with En Requirements for M Participating Provid 483.475.  The facility has eight	01000 15G486 245010  Preparedness survey, ttives-Adept was found not in nergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR  at certified beds. All eight r Medicaid. At the time of the was eight.	E 00	000			
E 0037 Bldg	441.184(d)(1), 482 483.73(d)(1), 484. 485.68(d)(1), 485. 486.360(d)(1), 491 EP Training Progres \$403.748(d)(1), §4 §441.184(d)(1), §4 §483.73(d)(1), §48 §485.68(d)(1), §4 (1), §485.920(d)(1) §491.12(d)(1).	am 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 33.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d) ), §486.360(d)(1),					
	*[For RNCHIs at §	403.748, ASCs at §416.54,					

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

TITLE (X6) DATE

Bob Morris QIDP Manager 08/09/2024

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	<del></del>	COMPL	ETED
		15G486	B. W	ING		07/23/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			AN RICARDO COURT		
COMMUI	NITY ALTERNATIV	'ES-ADEPT			APOLIS, IN 46256		
			-	L			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
		.15, ICF/IIDs at §483.475,					
	_	2, "Organizations" under					
	-	at §486.360, RHC/FQHCs					
	at §491.12:]	ram. The [facility] must do					
	all of the following						
		n emergency preparedness					
		edures to all new and					
		viduals providing services					
	-	nt, and volunteers,					
	-	eir expected roles.					
		ency preparedness training					
	at least every 2 ye						
	(iii) Maintain docu	mentation of all emergency					
	preparedness trai	ning.					
	(iv) Demonstrate s	staff knowledge of					
	emergency proced	dures.					
		cy preparedness policies					
	•	re significantly updated, the					
		duct training on the					
	updated policies a	and procedures.					
	*IFor Hoopiese et	\$440 442/d\\1 (4) Training					
		§418.113(d):] (1) Training. do all of the following:					
	·	n emergency preparedness					
		edures to all new and					
		employees, and individuals					
		s under arrangement,					
		eir expected roles.					
	(ii) Demonstrate s						
	emergency proce	<u> </u>					
		gency preparedness training					
	at least every 2 ye						
		eview and rehearse its					
	. ,	redness plan with hospice					
		ding nonemployee staff),					
		asis placed on carrying out					
		ecessary to protect patients					
	and others.						
	(v) Maintain docui	mentation of all emergency					
	i		1		İ		Ī

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Event ID:

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Facility ID: 001000

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15G486	A. BU B. W		<del></del>	07/23/2	
		130460	B. W			01/23/	2024
NAME OF I	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
COMMU	NITY ALTERNATIV	ES-ADEPT			AN RICARDO COURT APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	preparedness trai	•					
	. ,	ncy preparedness policies					
	1	re significantly updated, the					
		duct training on the					
	updated policies a procedures.	anu					
	procedures.						
	*[For PRTFs at §4	141.184(d):] (1) Training					
		TF must do all of the					
	following:						
	(i) Initial training ir	n emergency preparedness					
		edures to all new and					
	_	viduals providing services					
	_	nt, and volunteers,					
		eir expected roles.					
	1 ' '	ning, provide emergency					
	1 ' '	ning every 2 years.					
		staff knowledge of					
	emergency proce	uries. Imentation of all emergency					
	preparedness trai						
		icy preparedness policies					
	_ , ,	re significantly updated, the					
	•	uct training on the updated					
	policies and proce	- · · · · · · · · · · · · · · · · · · ·					
	#F D4.05	00.04/10.1/40.71					
		60.84(d):] (1) The PACE					
	_	t do all of the following:					
		n emergency preparedness					
	1 -	edures to all new and					
	_	viduals providing on-site rangement, contractors,					
		volunteers, consistent with					
	their expected role						
		ency preparedness training					
	at least every 2 ye						
	(iii) Demonstrate staff knowledge of						
		dures, including informing					
		at to do, where to go, and					
		n case of an emergency.					

LENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	A. BUILDING			COMPLETED	
		15G486	B. WING			07/23	/2024	
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD			
COMMU	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY)		DATE	
	(iv) Maintain docu	mentation of all training.						
	(v) If the emerger	ncy preparedness policies						
	and procedures a	re significantly updated, the						
	PACE must condu	uct training on the updated						
	policies and proce	edures.						
	*[For LTC Facilitie	es at §483.73(d):] (1)						
	Training Program	. The LTC facility must do all						
	of the following:							
	(i) Initial training ir	n emergency preparedness						
	1 .	edures to all new and						
	_	viduals providing services						
	_	nt, and volunteers,						
	consistent with the	•						
	, ,	ency preparedness training						
	at least annually.							
	' '	mentation of all emergency						
	preparedness trai	_						
	· '	staff knowledge of						
	emergency proce	dures.						
	*[For CORFs at §	485.68(d):](1) Training. The						
	CORF must do all	. , ,						
		raining in emergency						
	preparedness poli	icies and procedures to all						
	1 ' '	staff, individuals providing						
	services under an	rangement, and volunteers,						
	consistent with the	eir expected roles.						
	(ii) Provide emerg	ency preparedness training						
	at least every 2 ye	ears.						
	(iii) Maintain docu	mentation of the training.						
	(iv) Demonstrate	staff knowledge of						
	emergency proce	dures. All new personnel						
	must be oriented	and assigned specific						
	responsibilities re	garding the CORF's						
	emergency plan w	vithin 2 weeks of their first						
		ning program must include						
	I	ocation and use of alarm						
	systems and signa	als and firefighting						

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equipment.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G486	(X2) MULTIPLE CONSTRUC  A. BUILDING  B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 07/23/2024	
	PROVIDER OR SUPPLIER		•	7919 SA	DDRESS, CITY, STATE, ZIP COD AN RICARDO COURT APOLIS, IN 46256		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	(v) If the emerge and procedures a	ncy preparedness policies re significantly updated, the uct training on the updated					
	program. The CAI following:	85.625(d):] (1) Training H must do all of the n emergency preparedness					
	policies and proce reporting and exti	edures, including prompt					
	of patients, person prevention, and co	nnel, and guests, fire coperation with firefighting crities, to all new and					
	under arrangement consistent with the	viduals providing services nt, and volunteers, eir expected roles.					
	at least every 2 ye (iii) Maintain docu	mentation of the training.					
	emergency proce						
	and procedures a	ncy preparedness policies re significantly updated, the ct training on the updated					
	policies and proce	edures.					
	The CMHC must emergency prepa	485.920(d):] (1) Training. provide initial training in redness policies and					
	individuals providi	new and existing staff, ng services under volunteers, consistent with					
	documentation of must demonstrate	the training. The CMHC staff knowledge of					
	CMHC must provi	dures. Thereafter, the de emergency ning at least every 2 years.					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPLE	ETED	
		15G486	B. WI	NG		07/23/2	2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	R			AN RICARDO COURT			
COMMU	NITY ALTERNATIV	'ES-ADEPT			IAPOLIS, IN 46256			
		207.02. 1						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE	
		view and interview, the facility	E 00	037	CORRECTION:		08/22/2024	
		ff received training in regard to			The facility must have a trainir	-		
		dness policies and procedures.			program on place with (i) Initia	n/		
		y must do all of the following: (i)			training in emergency			
		ing in emergency preparedness			preparedness			
		ures to all new and existing			policies and procedures to all	new		
		roviding services under			and existing staff, individuals	.		
		olunteers, consistent with their			providing on-site services und	er		
	expected roles; (ii)	- ·			arrangement, and volunteers,			
	* *	ng at least every two years;			consistent with their expected			
	` ′	mentation of the training; (iv)			roles. (ii) Provide emergency			
		knowledge of emergency			preparedness training at least			
	_	rdance with 42 CFR 483.475(d)			annually. (iii) Maintain			
		practice could affect all			documentation of the training.	` '		
	occupants.				Demonstrate staff knowledge	of		
	F. 1				emergency procedures.			
	Findings include:				Specifically, supervisors will tr	ain		
	D 1	NUE (P)			all facility staff on the facility's			
		"Emergency/Disaster			current Emergency Preparedn			
	Preparedness Manu				Plan and will retain documenta			
		ed 01/01/24 and "Emergency,			of the training and competency	У		
		n Plans & Responses"			review.			
		ed 01/01/24 with the						
		nician (Tech) during record			PREVENTION:			
		on 07/23/24, the facility lacked			Members of the Operations Te	eam		
		taff training on the emergency			(comprised of the Executive			
		within the two-year period.			Director, Operations Manager	s,		
		at the time of record review,			Program Managers, Area			
		ech stated staff training			Supervisors, Quality Assurance			
		naintained on computer at the			Manager, QIDP Manager, QID			
	main office and agr	<del>-</del>			Quality Assurance Coordinato			
		emergency preparedness			Assistant Nurse Manager and			
		ures within the most recent			Nurse Manager) will incorpora			
		s not available for review at the			reviews of the facility's emerge	ency		
	time of the survey.				preparedness program into			
	This finding	wigwod with the Maintenance			scheduled monthly audits to	,		
		viewed with the Maintenance			assure all required component	เร		
	Tech during the exi	n comerence.			are present. Additionally, the			
					agency Safety Committee will			
	Ī				review and revise the plan as			

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AND PLAN OF CORRECTION IDENTIFICA		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY  COMPLETED  07/23/2024	
		15G486	B. W	ING		07/23	/2024
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 7919 SAN RICARDO COURT INDIANAPOLIS, IN 46256				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFFING INFORMATION		IAG	needed but no less than annu	ually.	DATE
					RESPONSIBLE PARTIES: Q Area Supervisor, Direct Supp Lead, Safety Committee, Hur Resources Department, Operations Team, Regional Director	IDP, ort	
E 0039	403.748(d)(2), 41	6.54(d)(2), 418.113(d)(2),					
Bldg	441.184(d)(2), 484 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § 485.625(d)(2), § (2), §491.12(d)(2) *[For ASCs at §4* OPO, "Organizati CMHCs at §485.9 §491.12, and ESF (2) Testing. The [if exercises to test to	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) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					
	community-based (A) When a commot accessible, confunctional exercis (B) If the [faction natural or man-material or the exercises activation of the exercises.	full-scale exercise that is a levery 2 years; or munity-based exercise is anduct a facility-based e every 2 years; or sility] experiences an actual eade emergency that requires emergency plan, the [facility] egaging in its next required					

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	IENT OF DEFICIENCIES AN OF CORRECTION	IDENTIFICATION NUMBER  15G486	ILDING	NSTRUCTION	COMPL 07/23/	ETED
	F PROVIDER OR SUPPLIEF		7919 SA	DDRESS, CITY, STATE, ZIP COD AN RICARDO COURT		
COMM	IUNITY ALTERNATIV	ES-ADEPT	INDIAN	APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	TE	(X5) COMPLETION DATE
TAG	community-based functional exercises actual event.  (ii) Conduct an ad every 2 years, oppor functional exercises (i) of this section is include, but is not (A) A second full-community-based functional exercises (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an erection (iii) Analyze the [famintain documer exercises, and emithe [facility's] emeithe [facility's] emeithe [facility's] emeithe [facility's] emeithe following:  (i) Participate in a community based (A) When a community based (B) If the hospice man-made emerging of the emergency exempt from engages.	or individual, facility-based e following the onset of the ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based e; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. acility's] response to and intation of all drills, tabletop mergency events, and revise regency plan, as needed.  418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is	IAG	DATKIENC!!		DATE

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Facility ID: 001000

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPLETED	
		15G486	B. WI	NG		07/23	/2024
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					AN RICARDO COURT		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE
		ctional exercise following the					
	onset of the emer						
		dditional exercise every 2					
	, ,	e year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
	The second secon	•					
	' '	scale exercise that is					
	_	or a facility based					
	functional exercise						
	(B) A mock disas						
	, ,	ercise or workshop that is					
		and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	mergency plan.					
	(3) Testing for hos	spices that provide inpatient					
		hospice must conduct					
	-	he emergency plan twice					
		spice must do the following:					
		an annual full-scale exercise					
	that is community						
	' '	nunity-based exercise is not					
		ict an annual individual					
		ctional 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					
	emergency event.						
	` '	dditional annual exercise					
		but is not limited to the					
	following:						
	(A) A second full-	scale exercise that is					

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community-based or a facility based

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER  15G486	A. BUILDING B. WING		COMP	LETED B/2024		
NAME OF PROVIDER OR SUPPLI		STREET ADDRESS, CITY, STATE, ZIP COD 7919 SAN RICARDO COURT INDIANAPOLIS, IN 46256					
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE		
facilitator that in using a narrated emergency scer statements, dire questions desig emergency plan (iii) Analyze the maintain docum exercises, and e	ster drill; or xercise or workshop led by a cludes a group discussion , clinically-relevant ario, and a set of problem cted messages, or prepared ned to challenge an						
§482.15(d), CAI (2) Testing. The conduct exercis plan twice per y CAH] must do th (i) Participate in that is communi (A) When a com accessible, cond facility-based fu (B) If the [PRTF an actual natura that requires act plan, the [facility its next required or individual, fact following the on (ii) Conduct exercise or and limited to the fol (A) A second fu community-base	an annual full-scale exercise y-based; or munity-based exercise is not luct an annual individual, nctional exercise; or Hospital, CAH] experiences I or man-made emergency ivation of the emergency I is exempt from engaging in full-scale community based ility-based functional exercise set of the emergency event. It an [additional] annual that may include, but is not						

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Facility ID: 001000

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		15G486	B. W	ING		07/23	/2024
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	3			AN RICARDO COURT		
COMMU	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46256		
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		o 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						
	, , ,	he [facility's] response to					
		umentation of all drills, s, and emergency events					
	•	cility's] emergency plan, as					
	needed.	clifty of emergency plan, as					
	necaca.						
	*[For PACE at §40	60.84(d):1					
		PACE organization must					
	. ,	s to test the emergency					
	plan at least annu						
	organization must	-					
	-	an annual full-scale exercise					
	that is community						
	(A) When a comm	nunity-based exercise is not					
	accessible, condu	ıct an annual individual,					
	facility-based fund	ctional exercise; or					
	(B) If the PACE ex	xperiences an actual natural					
		ergency that requires					
		mergency plan, the PACE					
	is exempt from en	gaging in its next required					
		nity based or individual,					
		ctional exercise following the					
	onset of the emer						
		n additional exercise every					
		the year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted that may include,					
	but is not limited t	_					
	' '	scale exercise that is					
		or individual, a facility					
	based functional						
	(B) A mock disas						
	(∪) A tabletop ex	ercise or workshop that is	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	<del></del>	COMPL	ETED	
		15G486	B. W	B. WING			07/23/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			AN RICARDO COURT			
COMMU	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46256			
OOMMO				II VDI/ (I V	711 OLIO, 11 <b>1</b> 40200			
(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 APPROPRIA	TE	COMPLETION	
TAG	i	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		and includes a group						
	discussion, using							
	· ·	emergency scenario, and a						
	set of problem sta							
		pared questions designed						
	to challenge an er							
		PACE's response to and						
		ntation of all drills, tabletop						
		nergency events and revise						
	the PACE's emero	gency plan, as needed.						
	*[For LTC Facilitie	- , , -						
	. , –	ty] must conduct exercises						
	_	ency plan at least twice per						
		announced staff drills using						
		ocedures. The [LTC facility,						
	ICF/IID] must do t	_						
		an annual full-scale exercise						
	that is community							
	' '	nunity-based exercise is not						
		ct an annual individual,						
	facility-based fund							
	· , , =	ility] facility experiences an						
		nan-made emergency that						
		of the emergency plan, the						
		mpt from engaging its next						
		lle community-based or						
	-	based functional exercise						
	_	et of the emergency event.						
	` '	dditional annual exercise						
		but is not limited to the						
	following:							
	` '	scale exercise that is						
	-	or an individual, facility						
	based functional e	,						
	(B) A mock disas							
	` '	ercise or workshop that is						
	led by a facilitator	- · · · · · · · · · · · · · · · · · · ·						
	discussion, using							
	clinically-relevant	emergency scenario, and a						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING COM			COMPL	ETED		
15G486		B. W	ING		07/23/	/2024			
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>			
NAME OF PROVIDER OR SUPPLIER					AN RICARDO COURT				
COMMUNITY ALTERNATIVES-ADEPT				INDIANAPOLIS, IN 46256					
001111110		20 / 102   1		11100111	711 0210, 117 10200				
(X4) ID		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 APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE		
	set of problem sta								
		pared questions designed							
	to challenge an er								
		LTC facility] facility's							
	•	naintain documentation of							
	· ·	exercises, and emergency							
		e the [LTC facility] facility's							
	emergency plan, a	as needed.							
	*[For ICF/IIDs at §	\$483 475(d)]·							
		CF/IID must conduct							
	` '	he emergency plan at least							
		e ICF/IID must do the							
	following:								
	_	n annual full-scale exercise							
	that is community								
		nunity-based exercise is not							
	, ,	ict an annual individual,							
		ctional exercise; or.							
		experiences an actual							
	' '	ade emergency that requires							
		mergency plan, the ICF/IID							
	is exempt from en	gaging in its next required							
	full-scale commun	nity-based or individual,							
	facility-based fund	tional exercise following the							
	onset of the emer	gency event.							
	(ii) Conduct an ad	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	tional exercise; or							
	(B) A mock disast	er drill; or							
	(C) A tabletop exercise or workshop that is								
	led by a facilitator and includes a group								
	discussion, using a narrated,								
		emergency scenario, and a							
	set of problem sta								
		pared questions designed							
	to challenge an er	mergency plan.							

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPLETED	
		15G486	B. W	ING		07/23	/2024
				CENTER	ADDRESS SITE STATE SID SOD		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
COMMU	NUTY ALTERNATIV	VEC ADEDT			AN RICARDO COURT		
COMMUNITY ALTERNATIVES-ADEPT			INDIAN	APOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(iii) Analyze the IC	CF/IID's response to and					
	maintain docume	ntation of all drills, tabletop					
	exercises, and emergency events, and revise						
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	84.102]					
	(d)(2) Testing. Th	e HHA must conduct					
	exercises to test t	the emergency plan at					
	least annually. Th	e HHA must do the					
	following:						
	(i) Participate in a	full-scale exercise that is					
	community-based	l; or					
	(A) When a c	community-based exercise					
	is not accessible,	conduct an annual					
	individual, facility-	-based functional exercise					
	every 2 years; or.						
	(B) If the HH	IA experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	emergency plan, the HHA is					
	exempt from enga	aging in its next required					
	full-scale commun	nity-based or individual,					
	facility based fund	ctional exercise following the					
	onset of the emer	gency event.					
	(ii) Conduct an ac	lditional exercise every 2					
	years, opposite th	ne year the full-scale or					
	functional exercis	e under paragraph (d)(2)(i)					
	of this section is of	conducted, that may					
	include, but is not	limited to the following:					
	(A) A second	full-scale exercise that is					
	community-based	l or an individual,					
	facility-based fund	ctional exercise; or					
	(B) A mock d	lisaster drill; or					
	(C) A tableto	p exercise or workshop that					
	is led by a facilitat	tor and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	-	atements, directed					
messages, or prepared questions designed							

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to challenge an emergency plan. (iii) Analyze the HHA's response to and

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	OF CORRECTION	IDENTIFICATION NUMBER  15G486		UILDING		COMPL 07/23/	ETED	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP COD 7919 SAN RICARDO COURT INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		TE	(X5) COMPLETION DATE	
	exercises, and em	ntation of all drills, tabletop nergency events, and revise ency plan, as needed.						
	exercises to test the OPO must do the (i) Conduct a paper or workshop at least exercise is led by group discussion, relevant emergency problem statement prepared questions emergency plan. It actual natural or material requires activations OPO is exempt from the emergency (ii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises, and emergency (iii) Analyze the OF maintain document exercises (iii) Analyze the OF maintain document exercises (iiii) Analyze the OF maintain document exercises (iiii) Analyze the OF maintain document exercises (iiii) Analyze the OF maintain document exercises (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ts, directed messages, or as designed to challenge an of the OPO experiences an man-made emergency that a of the emergency plan, the om engaging in its next exercise following the onset						
	exercises to test the RNHCl must do the (i) Conduct a paper at least annually. If group discussion I narrated, clinically scenario, and a second	e RNHCI must conduct he emergency plan. The						
	(ii) Analyze the RN	enge an emergency plan. NHCI's response to and ntation of all tabletop						

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	AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G486		A. BUILDING  B. WING			COMPLETED 07/23/2024		
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP COD 7919 SAN RICARDO COURT INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TE	(X5) COMPLETION DATE	
IAG	exercises, and emergency plan on emergency procedured do all of the following exercise that is community-based emergency plan, the engaging in a community-based full-semergency scenarios tatements, directed questions designed plan; (iii) analyze the and maintain docume exercises, and emer ICF/IID facility's enaccordance with 42 deficient practice community-based on review of Preparedness Manu 06/05/24 and "Emer Plans and Response 01/01/24 with the New Market Plans and Response 01/01/24 wit	deregency events, and revise regency plan, as needed. View and interview, the facility least two exercises to test the an annual basis using the res. The ICF/IID facility must ing: (i) participate in a full-scale amunity-based or when a exercise is not accessible, an accessible, an accessible in a full-scale amunity-based or individual, cale exercise for 1 year of the actual event; (ii) and exercise that may include the following: (A) a second that is community-based or based. (B) a tabletop exercise p discussion led by a community-based or based. (B) a tabletop exercise p discussion led by a community and a set of problem and a set of problem and a set of problem are ICF/IID facility's response to contact of all drills, tabletop gency events, and revise the mergency plan, as needed in CFR 483.475(d)(2). This could affect all occupants.  The Emergency/Disaster all documentation dated frames are recommended for the decommendation dated for	E 00		CORRECTION:  The [facility] must conduct exercises to test the emergency plan at least annually. Specific the agency has assigned a ris management specialist from the Quality Assurance Departmen (the QIDP Manager) to conduct exercise of choice table talk conference, with the provider's Safety Committee. Participant will include ResCare Department Heads, the QIDP and other administrative level managem (Program Manager, Quality Assurance Manager, Quality Assurance Coordinator, and Nanager) will participate in the exercises to assure facility emergency preparedness protocols are consistent with community emergency management practices. The Safety Committee chairperson assure biannual completion of these exercises.  The facility will provide documentation of the activation the Emergency Preparedness Plan during the 3/14/24 severe weather event, in which the fasheltered in place. This documentation will be uploaded the IDOH Gateway at the time this plan of correction's submission. The Agency's Saf Committee conducted a table exercise on 7/24/24.	cally, k ne t tct an s s s ent ent, lurse e cility ed to of	08/22/2024	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G486	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/23/2024			
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP COD 7919 SAN RICARDO COURT INDIANAPOLIS, IN 46256					
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	drill within the mos was not available for at the time of record Tech agreed the fac community-based dexercise within the period and agreed a documentation was time of the survey.	not available for review at the		Documentation of this exercis will be uploaded to the IDOH Gateway at the time of this please or correction's submission.  PREVENTION:  Members of the Operations Tocomprised of the Executive Director, Operations Manage Program Managers, Area Supervisors, Quality Assurant Manager, QIDP Manager, Q	an of  Team  rs,  ce DP, ors, d ate gency  nts,  nt. ty vise ss			
K 0000								
Bldg. 01	_	-	K 0000					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G486	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/23/2024	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP COD 7919 SAN RICARDO COURT INDIANAPOLIS, IN 46256				
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			ΓE	
TAG	REGULATORY OF Facility Number: 0	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
	Provider Number: AIM Number: 100  At this Life Safety of Alternatives - Adep with Requirements 42 CFR Subpart 48 and the 2012 edition	15G486 245010  Code survey, Community of was found in compliance for Participation in Medicaid, 3.470(j), Life Safety from Fire on of the National Fire					
	Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.						
	fully sprinklered. T system with heat de detection in corrido	ding was determined to be the facility has a fire alarm etection in the attic, smoke ers, and all living areas. The fity of eight and had a census of this survey.					
	(E-Score) using NF Approaches to Life facility Prompt with	Evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the n an E-Score of 0.32.  mpleted on 07/24/24					

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