PRINTED: 02/20/2024 /ED 039

CPARTMENT OF HEALTH AND HU	FORM APPROV		
ENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-0
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00	COMPLETED

15G449 B. WING 01/11/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7859 DELBROOK DR COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS. IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE W 0000 Bldg. 00 This visit was for the pre-determined full W 0000 recertification and state licensure survey. Dates of Survey: January 8, 9, and 11, 2024. Facility Number: 000963 Provider Number: 15G449 AIMS Number: 100244740 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/29/24. W 0323 483.460(a)(3)(i) PHYSICIAN SERVICES Bldg. 00 The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 W 0323 **CORRECTION:** 02/10/2024 sampled clients (client #1), the facility failed to The facility must provide or obtain ensure client #1 had a current hearing annual physical examinations of examination. each client that at a minimum includes an evaluation of vision Findings include: and hearing. Specifically, client #1 will receive a hearing evaluation. Client #1's record was reviewed on 1/9/24 at 10:10 An audit of facility medical charts AM. Client #1's record indicated documentation indicated this deficient practice did of a hearing examination completed on 10/7/22. not affect additional clients who Client #1's hearing examination completed on reside in the facility. 10/7/22 indicated client #1 was to return in one PREVENTION: year for a follow-up examination. Client #1's record The Facility nurse will did not indicate documentation of a current complete monthly audits of all hearing examination. charts and turn in the audits to the Nurse Manager for review. DON (Director of Nursing) #1 was interviewed on The Nurse Manager will

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

TITLE

(X6) DATE

Bob Morris QIDP Manager 02/09/2024

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
15G449		B. WING 01/11/2024			/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ELBROOK DR		
COMMUNITY ALTERNATIVES-ADEPT		<u>_</u>	INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		DON #1 was asked how often			review issues revealed in aud		
		dicated he was to have a		with the Executive Di		d	
	_	n. DON #1 stated, "Annually."			Department heads weekly for	(ly for	
	DON #1 was asked				follow-up.		
		current hearing examination			· The Executive Director	and	
		#1 indicated they did not and			will follow-up with the Nurse		
		been scheduled, we will get it			Manager as needed to addres	ss	
	scheduled."				issues raised through audits,		
					incident reports or other conce		
	9-3-6(a)				brought to management atten		
					Members of the Operations To	eam	
					(comprised of the Executive		
					Director, Operations Manager	S,	
					Program Managers, Quality		
					Assurance Manager, QIDP		
					Manager, QIDP, Quality		
					Assurance Coordinators, Area		
					Supervisors, and Nurse Mana	- ,	
					and nursing staff will incorpora		
					medical chart reviews into the		
					formal audit process, which w	III	
					occur no less than monthly to		
					assure that medical follow-alo	•	
					including but not limited to hea	_	
					evaluations take place as requ RESPONSIBLE PARTIES: QI		
					Area Supervisor, Direct Suppo	•	
					'')I L	
					Lead, Heath Services Team, Direct Support Staff, Operation	ne	
					Team, Regional Director	113	
					Todin, Regional Director		
W 0327	483.460(a)(3)(iv)						
	PHYSICIAN SER	VICES					
Bldg. 00		provide or obtain annual					
		ions of each client that at a					
	1 ' '	tuberculosis control,					
		facility's population, and in					
		he recommendations of the					
		of Chest Physicians or the					
		es of the chest of the					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/11/2024 15G449 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7859 DELBROOK DR COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE American Academy of Pediatrics, or both. Based on record review and interview for 1 of 3 W 0327 CORRECTION: 02/10/2024 sampled clients (client #2), the facility failed to The facility must provide or obtain ensure client #2 had current Mantoux screenings. annual physical examinations of each client that at a minimum Findings include: includes tuberculosis control, appropriate to the facility's Client #2's record was reviewed on 1/9/24 at 11:01 population, and in accordance with AM. Client #2's record did not indicate the recommendations of the documentation of a current Mantoux screening. American College of Chest Physicians or the section on DON (Director of Nursing) #1 was interviewed on diseases of the chest of the 1/9/24 at 1:00 PM. DON #1 was asked how often American Academy of Pediatrics, clients were expected to have Mantoux screenings or both. Specifically, client #2 will completed. DON #1 stated, "Annually." DON #1 receive a tuberculosis screening. was asked about client #2's current Mantoux An audit of facility medical charts screening. DON #1 stated, "I don't believe [client indicated this deficient practice did #2] was able to get one at the time the other not affect additional clients who clients received theirs. I'm not certain if he reside in the facility. returned to get his. I will check and if not we will get him in as soon as possible." PREVENTION: The Facility nurse will 9-3-6(a) complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. The Nurse Manager will review issues revealed in audits with the Executive Director and Department heads weekly for follow-up. The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns

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brought to management attention. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G449			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/11/2024			
		A. BUILDING B. WING	00				
NAME OF I	PROVIDER OR SUPPLIEF			ET ADDRESS, CITY, STATE, ZIP COD DELBROOK DR			
COMMU	NITY ALTERNATIV	ES-ADEPT		ANAPOLIS, IN 46260			
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		RIATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG			DATE	
				Assurance Manager, QIDP			
				Manager, QIDP, Quality			
				Assurance Coordinators, Are			
				Supervisors, and Nurse Man			
				and nursing staff will incorpo			
				medical chart reviews into th			
				formal audit process, which			
				occur no less than monthly to	5		
				assure that clients receive			
				tuberculosis screenings as			
				required. RESPONSIBLE PARTIES: 0	אטט		
				Area Supervisor, Direct Sup			
				Lead, Heath Services Team,			
				Direct Support Staff, Operati			
				Team, Regional Director	OHS		
W 9999							
Bldg. 00							
	State Findings:		W 9999	Prior to assuming residential	job	02/10/2024	
				duties and annually thereafte	∍r,		
	_	munity Residential Facilities for		each residential staff person	shall		
	Persons with Devel	opmental Disabilities Rules		submit written evidence that	а		
	were not met.			Mantoux (5TU, PPD) tubercu	ılosis		
				skin (TB) test or chest x-ray	was		
	460 IAC 9-3-3 Faci	lity Staffing		completed. The result of the			
				Mantoux shall be recorded in			
		g residential job duties and		millimeter of induration with			
	1	each residential staff person		date given, date read, and b	•		
		evidence that a Mantoux		whom administered. If the sk			
		st or chest x-ray was		test result is significant (ten			
		alts of the Mantoux shall be		millimeters or more), then a			
		ter of induration with the date		film shall be done with other			
	given, date read, an	d by whom administered.		physical and laboratory	,		
				examinations as necessary t	O		
	This state rule was	not met as evidenced by:		complete a diagnosis.			

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Based on record review and interview for 2 of 3

sampled employees, the facility failed to ensure

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Prophylactic treatment shall be

provided as per diagnosis for the

length of time prescribed by the

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	K MEDICAKE & MEDIC		_			_	IB NO. 0930-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPL	LETED
15G449		B. WING			01/11/2024		
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
					ELBROOK DR		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	G DEFICIENCY) D.		DATE
	staff #1 and staff #2's Mantoux screenings were				physician. Specifically, Staff	# 1	
	completed annually	7.			and #2 will receive an annual		
				Tuberculosis screening. The			
	Findings include:				Human Resources Departme	nt will	
					review the files of all remaining		
	The facility's Empl	oyee Records were reviewed on			facility staff and any additiona	al	
	1/9/24 at 12:11 PM and indicated the following:				staff who lack appropriate		
					documentation will receive		
	Staff #1's record indicated a hire date of 6/2022.				Tuberculosis screenings.		
	Staff #1's record did not indicate documentation						
	of a current completed Mantoux screening.				PREVENTION:		
					The health services team will		
	Staff #2's record indicated a hire date of October				re-establish a bi-annual		
	2023. Staff #2's record did not indicate				tuberculosis testing process t	hat	
	documentation of a current completed Mantoux				will assure all staff receive ar	nual	
	screening.				screening. Health Services		
					personnel will track employee	Э	
	QIDPM (Qualified Intellectual Disabilities				compliance and staff who do not		
	Professional Manager) #1 was interviewed on				comply with the testing proce		
	1/9/24 at 1:00 PM. QIDPM #1 was asked how				will be removed from the wor		
	often staff were expected to have Mantoux				schedule until such time as th		
screenings completed. QIDPM #1 stated, "When				complete the required PPD o	-		
they start and then annually after." QIDPM #1				chest X-Ray. Additionally, the			
was asked if the facility had documentation of				agency's Safety Committee v			
current Mantoux screenings for staff #1 and staff				coordinate with Health Service			
#2. QIDPM #1 indicated they could not locate				follow-up and ensure complia			
		he Mantoux screenings being			,,		
	completed.	2 2			RESPONSIBLE PARTIES:		
] ^				QIDP, Area Supervisor, Hum	an	
	9-3-3(e)				Resources Team, Health Ser		
					Team, Direct Support Lead, I		
					Support Staff, Operations Te		
					Safety Committee	,	

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