STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G449	A. BUILDING 00 B. WING	01/11/2024

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
W 0000 Bldg. 00	This visit was for the pre-determined full 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 0000		
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES 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 sampled clients (client #1), the facility failed to ensure client #1 had a current hearing examination. Findings include: Client #1's record was reviewed on 1/9/24 at 10:10 AM. Client #1's record indicated documentation of a hearing examination completed on 10/7/22. Client #1's hearing examination completed on 10/7/22 indicated client #1 was to return in one year for a follow-up examination. Client #1's record did not indicate documentation of a current hearing examination. DON (Director of Nursing) #1 was interviewed on	W 0323	**CORRECTION:** *The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.* Specifically, client #1 will receive a hearing evaluation. An audit of facility medical charts indicated this deficient practice did not affect additional clients who reside in the facility. **PREVENTION:** · The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. · The Nurse Manager will	02/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bob Morris	QIDP Manager	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G449	A. BUILDING 00 B. WING	01/11/2024

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
	1/9/24 at 1:00 PM. DON #1 was asked how often client #1's record indicated he was to have a hearing examination. DON #1 stated, "Annually." DON #1 was asked if the facility had documentation of a current hearing examination for client #1. DON #1 indicated they did not and stated, "If it hasn't been scheduled, we will get it scheduled." 9-3-6(a)		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 brought to management attention. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that medical follow-along including but not limited to hearing evaluations take place as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Heath Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0327 Bldg. 00	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G449	A. BUILDING 00 B. WING	01/11/2024

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
	American Academy of Pediatrics, or both. Based on record review and interview for 1 of 3 sampled clients (client #2), the facility failed to ensure client #2 had current Mantoux screenings. Findings include: Client #2's record was reviewed on 1/9/24 at 11:01 AM. Client #2's record did not indicate documentation of a current Mantoux screening. DON (Director of Nursing) #1 was interviewed on 1/9/24 at 1:00 PM. DON #1 was asked how often clients were expected to have Mantoux screenings completed. DON #1 stated, "Annually." DON #1 was asked about client #2's current Mantoux screening. DON #1 stated, "I don't believe [client #2] was able to get one at the time the other clients received theirs. I'm not certain if he returned to get his. I will check and if not we will get him in as soon as possible." 9-3-6(a)	W 0327	**CORRECTION:** *The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.* Specifically, client #2 will receive a tuberculosis screening. An audit of facility medical charts indicated this deficient practice did not affect additional clients who reside in the facility. **PREVENTION:** · The Facility nurse will 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 brought to management attention. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality	02/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G449	A. BUILDING 00 B. WING	01/11/2024

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
			Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that clients receive tuberculosis screenings as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Heath Services Team, Direct Support Staff, Operations Team, Regional Director	
W 9999 Bldg. 00	State Findings: The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met. 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux tuberculosis skin test or chest x-ray was completed. The results of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. This state rule was not met as evidenced by: Based on record review and interview for 2 of 3 sampled employees, the facility failed to ensure	W 9999	*Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the*	02/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G449	A. BUILDING 00 B. WING	01/11/2024

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
	staff #1 and staff #2's Mantoux screenings were completed annually. Findings include: The facility's Employee Records were reviewed on 1/9/24 at 12:11 PM and indicated the following: Staff #1's record indicated a hire date of 6/2022. Staff #1's record did not indicate documentation of a current completed Mantoux screening. Staff #2's record indicated a hire date of October 2023. Staff #2's record did not indicate documentation of a current completed Mantoux screening. QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 1/9/24 at 1:00 PM. QIDPM #1 was asked how often staff were expected to have Mantoux screenings completed. QIDPM #1 stated, "When they start and then annually after." QIDPM #1 was asked if the facility had documentation of current Mantoux screenings for staff #1 and staff #2. QIDPM #1 indicated they could not locate documentation of the Mantoux screenings being completed. 9-3-3(e)		*physician.* Specifically, Staff #1 and #2 will receive an annual Tuberculosis screening. The Human Resources Department will review the files of all remaining facility staff and any additional staff who lack appropriate documentation will receive Tuberculosis screenings. **PREVENTION:** The health services team will re-establish a bi-annual tuberculosis testing process that will assure all staff receive annual screening. Health Services personnel will track employee compliance and staff who do not comply with the testing procedure will be removed from the work schedule until such time as they complete the required PPD or chest X-Ray. Additionally, the agency's Safety Committee will coordinate with Health Services to follow-up and ensure compliance. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Human Resources Team, Health Services Team, Direct Support Lead, Direct Support Staff, Operations Team, Safety Committee	