PRINTED: 02/28/2024 FORM APPROVED

CENTERS FO	R MEDICARE & MEDI	ICAID SERVICES				ON	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G449			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/05/2024	
	PROVIDER OR SUPPLII		STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 0000							
Bldg		reparedness Survey was Indiana Department of Health in 42 CFR 483.475.	E 00	000			
	Community Alter compliance with I Requirements for Participating Prov 483.475. The facility has 6 certified for Medithe census was 6.	000963 : 15G449					
		at 42 CFR, Subpart 483.475 is					
E 0039 Bldg	441.184(d)(2), 4 483.73(d)(2), 48 485.68(d)(2), 48 486.360(d)(2), 4 EP Testing Requ §416.54(d)(2), § §460.84(d)(2), § §483.475(d)(2),	16.54(d)(2), 418.113(d)(2), 82.15(d)(2), 483.475(d)(2), 4.102(d)(2), 485.625(d)(2), 5.727(d)(2), 485.920(d)(2), 91.12(d)(2), 494.62(d)(2) uirements 418.113(d)(2), §441.184(d)(2), 482.15(d)(2), §483.73(d)(2), §484.102(d)(2), §485.68(d)(2), §485.727(d)(2), §485.920(d)					

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

(2), §491.12(d)(2), §494.62(d)(2).

TITLE (X6) DATE

Bob Morris QIDP Manager 02/23/2024

Any defiencystatement 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.

FORM CMS-2567(02-99) Previous Versions Obsolete PQWG21 Facility ID: If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 02/05/2024 NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 02/05/2024 STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260	Y
15G449 B. WING O2/05/2024 STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR	
NAME OF PROVIDER OR SUPPLIER 7859 DELBROOK DR	
NAME OF PROVIDER OR SUPPLIER 7859 DELBROOK DR	
OOMINIONITY AETERNATIVEO-ADELT	
PROVIDER'S PLAN OF CORRECTION	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	PLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DA	ATE
"[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FCHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) if the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrasted, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed	

to challenge an emergency plan.

(iii) Analyze the [facility's] response to and

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	MENT OF DEFICIENCIES LAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY MPLETED 05/2024		
	OF PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260					
(X4) IE PREFE	K (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUGG DEFITITION OF DEFINITION OF THE PROPERTY OF THE P	ID PREFIX	PROVIDER'S PLAN OF CORR. (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PROPRIATE	(X5) COMPLETION		
TAG	maintain docume exercises, and en the [facility's] emeta (2) Testing for he the patient's home conduct exercises plan at least annuthe following: (i) Participate in a community based (A) When a commaccessible, condubased functional (B) If the hospice man-made emerge of the emergency exempt from engascale community-facility-based functional exercis of this section is of include, but is not (A) A second full community-based functional exercis of this section is of include, but is not (A) A second full community-based functional exercis (B) A mock disast (C) A tabletop exeled by a facilitator discussion using clinically-relevant set of problem stamessages, or preto challenge an exercises.	espices that provide care in e. The hospice must is to test the emergency cally. The hospice must do a full-scale exercise that is devery 2 years; or munity based exercise is not fuct an individual facility exercise every 2 years; or experiences a natural or gency that requires activation or plan, the hospital is aging in its next required full ebased exercise or individual ctional exercise following the regency event. In the difference of the year the full-scale or see under paragraph (d)(2)(i) conducted, that may the limited to the following: -scale exercise that is do r a facility based se; or ster drill; or the year the full-scale or see and includes a group an anarrated, a emergency scenario, and a fatements, directed epared questions designed	TAG			DATE		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		15G449	B. W	ING		02/05/	/2024
NAME OF I	PROVIDER OR SUPPLIER	}	_		ADDRESS, CITY, STATE, ZIP COD		
					ELBROOK DR		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN.	APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	hospice must conduct					
		he emergency plan twice					
	per year. The hospice must do the following:						
	(i) Participate in an annual full-scale exercise						
	that is community						
	, ,	nunity-based exercise is not act 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:	bat to flot inflitted to the					
	_	scale exercise that is					
	, ,	or a facility based					
	functional exercise	_					
	(B) A mock disas						
		ercise or workshop led by a					
	. ,	udes a group discussion					
	using a narrated,	- ·					
		rio, and a set of problem					
		ed messages, or prepared					
		ed to challenge an					
	emergency plan.	-					
		ospice's response to and					
		ntation of all drills, tabletop					
	exercises, and em	nergency events and revise					
	the hospice's eme	ergency plan, as needed.					
	*IFor PRFTs at 8/	141.184(d), Hospitals at					
	§482.15(d), CAHs						
	- , ,	PRTF, Hospital, CAH] must					
		to test the emergency					
		ar. The [PRTF, Hospital,					

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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	ILDING		COMPL	
		15G449	B. WI	NG		02/05/	/2024
NAME OF I	PROVIDER OR SUPPLIE	D.	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					ELBROOK DR		
COMMU	NITY ALTERNATI\	/ES-ADEPT		INDIANAPOLIS, IN 46260			
(X4) ID		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 APPROPR		COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	CAH] must do the	<u> </u>					
	(i) Participate in an annual full-scale exercise						
	that is community-based; or (A) When a community-based exercise is not						
	1 ' '	_					
		uct an annual individual,					
		ctional exercise; or Hospital, CAH] experiences					
		or man-made emergency					
		or man-made emergency ation of the emergency					
	1	is exempt from engaging in					
		ull-scale community based					
	or individual, facility-based functional exercise						
	following the onset of the emergency event.						
	(ii) Conduct an [additional] annual						
	, ,	nat may include, but is not					
	limited to the follo						
		-scale exercise that is					
	community-based	d or individual, a					
	facility-based fund	ctional exercise; or					
	(B) A mo	ock disaster drill; or					
	(C) A tableto	p exercise or workshop that					
	is led by a facilita	tor and includes a group					
	discussion, using						
		emergency scenario, and a					
	•	atements, directed					
		pared questions designed					
	to challenge an e						
		the [facility's] response to					
		umentation of all drills,					
		s, and emergency events					
	and revise the Ital needed.	cility's] emergency plan, as					
	neeueu.						
	*[For PACE at §4	60.84(d):1					
		PACE organization must					
	conduct exercises to test the emergency						
	plan at least annu						
	I -	t do the following:					
	•	an annual full-scale exercise					
	that is community						

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G449 B. WING		COMP	(X3) DATE SURVEY COMPLETED 02/05/2024			
	OF PROVIDER OR SUPPLIES MUNITY ALTERNATIN		STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON D BE DPRIATE	(X5) COMPLETION DATE
	(A) When a commaccessible, condutation facility-based functional exercise of this section is of this section	nunity-based exercise is not act an annual individual, ctional exercise; or experiences an actual natural ergency that requires emergency plan, the PACE ingaging in its next required nity based or individual, ctional exercise following the regency event. In additional exercise every the year the full-scale or se under paragraph (d)(2)(i) conducted that may include, to the following: -scale exercise that is dor individual, a facility exercise; or set drill; or sercise or workshop that is an annual full-scale dorest and revise gency plan, as needed. PACE's response to and intation of all drills, tabletop mergency events and revise gency plan, as needed. es at §483.73(d):] lity] must conduct exercises ency plan at least twice per mannounced staff drills using rocedures. The [LTC facility, the following: an annual full-scale exercise					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G449		A. BUILDING COMPLET B. WING 02/05/20						
	F PROVIDER OR SUPPLIEF UNITY ALTERNATIV		STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260					
(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 APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE	
	facility-based functions (B) If the [LTC facility is exerequired a full-scalind individual, facility-following the onset (ii) Conduct an act that may include, following: (A) A second full-community-based based functional (B) A mock disas (C) A tabletop exled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an er (iii) Analyze the [I response to and nall drills, tabletop events, and revise emergency plan, a *[For ICF/IIDs at § (2) Testing. The IC exercises to test to twice per year. The following: (i) Participate in a that is community (A) When a commaccessible, conductive facility-based functions.	ility] facility experiences an nan-made emergency that of the emergency plan, the mpt from engaging its next alle community-based or based functional exercise of the emergency event. In the diditional annual exercise and the exercise that is or an individual, facility exercise; or the diditional annual exercise or an individual, facility exercise; or the dill; or ercise or workshop that is includes a group an anarrated, emergency scenario, and a antements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency ethe [LTC facility] facility's as needed. [3483.475(d)]: CF/IID must conduct the emergency plan at least are ICF/IID must do the						

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION	(X3) DATE COMPL 02/05/	ETED		
	F PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE .	(X5) COMPLETION DATE		
	activation of the eis exempt from er full-scale communitacility-based functionset of the emer (ii) Conduct an activate may include, following: (A) A second full-community-based facility-based functions for problem start messages, or preto challenge an ei (iii) Analyze the IC maintain docume exercises, and entitle ICF/IID's emee *[For HHAs at §44 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a community-based (A) When a community-based (B) If the HH hatural or man-matural or man-matural or man-matural or fitted for the fitted	Iditional annual exercise but is not limited to the scale exercise that is I or an individual, ctional exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. CF/IID's response to and intation of all drills, tabletop inergency events, and revise rgency plan, as needed. 84.102] e HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is it; or community-based exercise conduct an annual chased functional exercise							

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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		COMPL	ETED
		15G449	B. W	NG		02/05	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	t.		7859 DI	ELBROOK DR		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46260		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ity-based or individual,					
		tional exercise following the					
	onset of the emer	-					
		ditional exercise every 2					
	years, opposite the year the full-scale or						
		e under paragraph (d)(2)(i)					
	of this section is conducted, that may						
	include, but is not limited to the following:						
	(A) A second full-scale exercise that is						
	community-based or an individual,						
	facility-based fund						
	(B) A mock disaster drill; or						
	(C) A tabletop 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	nergency plan.					
	(iii) Analyze the H	HA's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the HHA's emerge	ency plan, as needed.					
	*[For OPOs at §48	-					
	` ' ' '	e OPO must conduct					
	exercises to test the	he emergency plan. The					
	OPO must do the	following:					
	(i) Conduct a pape	er-based, tabletop exercise					
	or workshop at lea	ast annually. A tabletop					
	exercise is led by	a facilitator and includes a					
	group discussion,	using a narrated, clinically					
	1	cy scenario, and a set of					
	problem statemen	ts, directed messages, or					
		is designed to challenge an					
		f the OPO experiences an					
		nan-made emergency that					
		of the emergency plan, the					
		om engaging in its next					
		xercise following the onset					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING		COMPL	LETED
		15G449	B. WIN	G		02/05/	/2024
		-	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R		7859 DE	ELBROOK DR		
COMMU	NITY ALTERNATIV	'ES-ADEPT		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of the emergency						
		PO's response to and					
		ntation of all tabletop					
	exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed.						
	*[RNCHIs at §40	3 7/81.					
	-	e RNHCI must conduct					
	. , . ,						
	exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a						
	group discussion	led by a facilitator, using a					
	narrated, clinically	y-relevant emergency					
	scenario, and a se	et of problem statements,					
	directed message	es, or prepared questions					
	designed to challe	enge an emergency plan.					
		NHCI's response to and					
		ntation of all tabletop					
		nergency events, and revise					
		rgency plan, as needed.					00/00/00/
		view and interview, the facility	E 003	39	CORRECTION:		08/03/2024
		least two exercises to test the an annual basis using the			The [facility] must conduct	.	
		ares. The ICF/IID facility must			exercises to test the emergen	-	
		ing: (i) Participate in an annual			plan at least annually. Specific the agency has assigned a ris	-	
		that is community-based; or			management specialist from the		
		ity-based exercise is not			Quality Assurance Departmen		
		an annual individual,			(the QIDP Manager) to conduct		
	facility-based funct				exercise of choice table talk		
	-	cility experiences an actual			conference, with the provider's	S	
		le emergency that requires			Safety Committee. Participant		
		nergency plan, the ICF/IID			will include ResCare Departm		
		rom engaging its next required			Heads, the QIDP and other		
	full-scale communi	ty-based or individual,			administrative level managem	ent,	
	facility-based full-s	scale functional exercise for 1			(Program Manager, Quality		
	year following the	onset of the actual event.			Assurance Manager, Quality		
	1 1	litional exercise that may			Assurance Coordinator, and N	lurse	
	include, but is not l	imited to the following:			Manager) will participate in the	e	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G449		A. BUILDING COMPLE			(X3) DATE SURVEY COMPLETED 02/05/2024		
NAME OF I	PROVIDER OR SUPPLIEI	· }	-		ADDRESS, CITY, STATE, ZIP COD		
					ELBROOK DR		
COMMU	NITY ALTERNATIV	'ES-ADEPT		INDIAN	NAPOLIS, IN 46260		
(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	COMPLETION	1
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	a. A second full-sca				exercises to assure facility		
		or an individual, facility-based			emergency preparedness		
	functional exercise.				protocols are consistent with		
	b. A mock disaster drill; or				community emergency		
	c. A tabletop exercise or workshop that is led by a				management practices. The		
	facilitator that includes a group discussion led by				Safety Committee chairperson		
	a facilitator, using a narrated, clinically relevant				assure biannual completion o		
	emergency scenario, and a set of problem				these exercises. The facility w		
	statements, directed messages, or prepared				develop documentation of the		
	questions designed to challenge an emergency				activation of the Emergency		
	plan. (iii) Analyze the ICF/IID facility's response to and				Preparedness Plan during the		
	maintain documentation of all drills, tabletop				11/7/23 mass power outage e		
	exercises, and emergency events, and revise the				in which the facility sheltered	n	
	in Exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in				place by 3/6/24. A "table talk	Lin O	
					exercise will be scheduled wit		
		CFR 483.475(d)(2). This			months of the full-scale event		
	deficient practice c	ould affect all occupants.			PREVENTION:		
	Findings include:				Members of the Operations To (comprised of the Executive	eam	
	Findings include.				•		
	Rosed on review of	"Emergency/Disaster			Director, Operations Manager Program Managers, Area	5,	
		al" documentation updated			Supervisors, Quality Assurance	<u>,</u>	
	_	mergency, Disaster, Evacuation			Manager, QIDP Manager, QI		
		" documentation also updated			Quality Assurance Coordinate		
	_	Maintenance Tech during record			and Nurse Manager) will	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		n. on 02/05/24, documentation of			incorporate reviews of the fac	ilitv's	
	•	or a community-based disaster			emergency preparedness pro	· 1	
	-	st recent twelve-month period			into scheduled monthly audits	-	
		or review. Based on interview			assure all required componen		
		d review, the Maintenance			including but not limited to		
		cility has not conducted a			bi-annual community-based		
	_	lisaster drill or conducted a			disaster exercises, are preser	nt.	
		ithin the most recent			Additionally, the agency Safet		
	twelve-month perio				Committee will review and rev	•	
	_	not available for review at the			the plan as needed but no les		
	time of the survey.				than annually.		
]				RESPONSIBLE PARTIES: QI	DP,	
	This finding was re	viewed with the Maintenance			Area Supervisor, Direct Suppo		
	Aide during the exi				Lead, Direct Support Staff,		
					Operations Team, Regional		

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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. BUILDING COMPLET			
		15G449	B. WI	NG		02/05/	2024
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T.E.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	A Life Safety Code conducted by the Inducted by the Inducted Survey Date: 02/05 Facility Number: 00 Provider Number: 1002 At this Life Safety Conducted Safe	Recertification Survey was diana Department of Health in CFR 483.470(j). /24 20963 15G449	K 00	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) Director	TE	
	Board and Care Occ This one-story build fully sprinklered. The system with smoke of living areas. The fact installed in the attic. 6 and had a census of Calculation of the E (E-Score) using NFI	supancies. ling was determined to be ne facility has a fire alarm detection in corridors and all cility has heat detectors. The facility has a capacity of of 6 at the time of this survey. vacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the an E-Score of 0.2.					

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