

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
W000000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00146832.</p> <p>Complaint #IN00146832: UNSUBSTANTIATED, due to lack of sufficient evidence.</p> <p>Dates of survey: 4/14, 4/15, 4/16, and 4/17/2014</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>Facility Number: 000979 Provider Number: 15G465 AIMS Number: 100244860</p>	W000000		
W000249	<p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/28/14 by Ruth Shackelford, QIDP.</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and four (4) additional clients (clients E, F, G, and H), the facility failed to</p>	W000249	<p>CORRECTION: <i>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program</i></p>	05/17/2014

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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>implement ISP (Individual Support Plan) and BSP (Behavior Support Plan) programs/goals during formal and informal opportunities.</p> <p>Findings include:</p> <p>1. On 4/14/14 from 3:52pm until 6:30pm and on 4/15/14 from 5:25am until 7:55am, observations and interviews were completed for clients A, B, C, D, E, F, G, and H. During the two observation periods client E directed clients A, B, C, D, F, and G at the group home and client E was not redirected by the group home staff.</p> <p>-During both observation periods client E directed other clients regarding where clients B, F, and G sat on the furniture in the living room. On 4/14/14 at 4:06pm, client B got up from the sofa in the living room and went to her bedroom.</p> <p>-During both observation periods client E redirected clients A, C, G, and H for their tone of voice used and information verbally discussed.</p> <p>-On 4/14/14 at 4:06pm, clients A, B, C, D, E, F, G, and H cleaned and put away their lunch boxes. At 4:06pm, client C watched each client complete cleaning their lunch boxes and where each client placed their clean lunch box inside the garage. At 4:06pm, client E watched client C watch the other clients, client E walked in front of client C to a staff person within an arms reach of client C, and stated out loud "[client C] bothers me" when client C watched her put her lunch box away. Client C raised his voice to a yell and screamed at client E. The unidentified group home staff person redirected client C and did not redirect client E.</p>		<p><i>consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</i></p> <p>Specifically, all direct support staff will be retrained regarding the need to provide continuous active treatment including but not limited to implementing client E's proactive and reactive behavior support strategies and Client G's dining plan.</p> <p>PREVENTION: The QIDP will be expected to observe no less than one morning and one evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff implement behavior supports and risk plans as written. Similarly the Residential Manager will be expected to monitor no less than five active treatment sessions per week –assuring that oversight, training and coaching occurs on all shifts. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure staff implement behavior supports and risk plans as written. The Clinical Supervisor will also conduct periodic reviews of the facility</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>-On 4/14/14 at 4:35pm, client E directed client G on how to set the table. Client G placed plates on the table and client E redirected client G to center each plate on the table in front of each of eight chairs around the table. Client G stopped to pull up his pants and client E began to talk to staff in the kitchen about client G's habits. Client E was overheard to say to staff that she questioned client G's habits. Client G began to yell and scream. Staff redirected client G and did not redirect client E.</p> <p>-On 4/15/14 at 6:20am, client E stated in front of clients A, D, F, and G "I'm higher functioning than anyone else" without redirection from the facility staff. Clients A and D walked away from client E. Client F sat on the sofa with his head in a downward position.</p> <p>-On 4/15/14 at 7:45am, client E stated in a loud tone of voice at the dining room table and pointed at client G "He has on [client F's] shirt." Client E yelled for the group home staff without redirection, yelled at the staff and then pointed at client G who sat at the dining room table eating "You have to change [client G's] shirt now." Client G began to yell at client E. The Group Home Staff redirected client G and did not redirect client E.</p> <p>On 4/16/14 at 12noon, client E's record was reviewed. Client E's 10/26/13 ISP (Individual Support Plan) and 10/26/13 BSP (Behavior Support Plan) indicated client E had targeted behaviors of Manipulation, Verbal Aggression, Attention Seeking behaviors, and Non Compliance. Client E's BSP indicated group home staff should redirect each behavior and offer an alternate activity</p>		<p>Visitor's Log to monitor QIDP and Residential Manager compliance with supervisory expectations.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>or a different topic to discuss.</p> <p>On 4/15/14 at 9:00am, an interview with Clinical Director (CD) #1 was conducted. CD #1 indicated client E should have been redirected not to direct clients A, B, C, D, F, G, and H. CD #1 stated "Staff are afraid of [client E]. [Client E] intimidates them [the staff]" and the group home staff were afraid of their employment being terminated from client E's expressed allegations.</p> <p>On 4/16/14 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the group home staff should have redirected client E at each opportunity.</p> <p>2. On 4/15/14 from 7:25am until 7:45am, client G served himself, fed himself, and no staff were present at the dining room table and/or within eye sight of client G while dining. At 7:25am, client G fed himself cereal and drank milk. Client G did not lay his spoon down between bites and did not drink between bites.</p> <p>On 4/17/14 at 12:44pm, client G's 9/8/13 ISP was reviewed. Client G's ISP indicated he had "Chewing Difficulties, Swallowing Difficulties, and Dining Difficulties." Client G's ISP indicated a goal "...whenever [client G] eats...[Client G] will rest his silverware on his plate between bites of food...[Client G] will consume no more than 1 teaspoon of food." Client G's 9/8/13 "Comprehensive High Risk Plan" indicated "Diagnosis of Severe Pharyngeal Dysphagia Aspiration...[client G] must have supervision during all food/drink intake including snacks...." Client G's 10/2013 "Nutrition Assessment" indicated client G needed "assistance eating</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
W000268	<p>supervision" by the group home staff. Client G's 3/31/14 "Physician Order" indicated "Supervise client at all meals and offer verbal prompts as needed to get the client to slow down, take small bites, and chew foods thoroughly before swallowing."</p> <p>On 4/15/14 at 9:00am, an interview with Clinical Director (CD) #1 was conducted. CD #1 indicated client G should have been supervised during dining and redirected to slow his eating rate and take small bites.</p> <p>On 4/16/14 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the group home staff should have supervised and redirected client G at each opportunity.</p> <p>9-3-4(a) 483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients (B and C) and 1 additional client (client G), the facility failed to promote clients C and G's dignity in regard to having facial whiskers and failed to ensure clients B and C did not wear the same soiled clothing.</p> <p>Findings include:</p> <p>1. On 4/14/14 from 3:52pm until 6:30pm, on 4/15/14 from 5:25am until 7:55am, and on 4/15/14 from 9:50am until 10:35am, observations and interviews were completed</p>	W000268	<p>CORRECTION: These policies and procedures must promote the growth, development and independence of the client. Specifically, staff have been retrained on the need to assist clients with shaving and other hygiene needs and to prompt clients to wear appropriate and clean clothing when they leave the house.</p> <p>PREVENTION: The QIDP will be expected to observe no less than one morning and one evening active treatment</p>	05/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>for clients C and G. During the three observation periods clients C and G had facial whiskers. During the observation periods clients C and G were not encouraged and/or taught to shave their facial whiskers.</p> <p>On 4/15/15 at 9:55am, client C stated he "forgot" to shave his face on 4/14/14 and on 4/15/14. Client C indicated he had whiskers and preferred a clean shaven face.</p> <p>On 4/15/14 at 10:15am, client G stated he had "hair" on his "neck and face." Client G stated he "forgot" to shave his face on 4/14/14 and on 4/15/14. Client G indicated he preferred a clean shaven face.</p> <p>On 4/15/14 at 12:24pm, client C's record was reviewed. Client C's 6/3/13 ISP indicated a goal/objective to "initiate basic hygiene" for shaving.</p> <p>On 4/17/14 at 12:44pm, client G's 9/8/13 ISP did not indicate a goal/objective to shave his face.</p> <p>On 4/16/14 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated clients C and G should have been assisted by the group home staff to shave daily or "at least" three times a week. The QIDP indicated client G did not have a goal/objective to teach him to shave. The QIDP indicated clients C and G should have been taught to shave during formal and informal opportunities.</p> <p>2. On 4/14/14 from 3:52pm until 6:30pm, on 4/15/14 from 5:25am until 7:55am, and on 4/15/14 from 9:50am until 10:35am, observations and interviews were completed</p>		<p>sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff assist clients with personal hygiene and encourage clients to wear clean clothing. Similarly the Residential Manager will be expected to monitor no less than five active treatment sessions per week –assuring that oversight, training and coaching occurs on all shifts. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure that clients are groomed and dressed appropriately.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>for client B. During the three observation periods client B wore the same orange tee shirt and a pair of faded blue jeans. During the observation periods client C wore the same blue sweat shirt with a white colts insignia on the front and a dark brown spot below the chest area and above the waist line of the sweat shirt. During the observation periods client C was not prompted to change into a clean sweat shirt.</p> <p>On 4/14/14 at 4:06pm, client C showed his closet at the group home which held three (3) additional clean identical blue colts sweat shirts and client C continued to wear his soiled colts sweat shirt. At 4:06pm, client C indicated his sweat shirt was soiled.</p> <p>On 4/15/14 at 9:55am, client C indicated he was wearing the same soiled blue colts sweat shirt which he had worn on 4/14/14 and the morning of 4/15/14.</p> <p>On 4/15/14 at 10:15am, client B stated she wore the "same" orange tee shirt and the "same" faded blue jeans she had worn on 4/14/14 and the morning of 4/14/14. Client B stated "our washer was broke."</p> <p>On 4/15/14 at 10:50am, client B's record was reviewed. Client B's 1/14/2014 ISP (Individual Support Plan) indicated a goal/objective to complete her personal hygiene.</p> <p>On 4/15/14 at 12:24pm, client C's record was reviewed. Client C's 6/3/13 ISP indicated a goal/objective to complete all steps to laundry independently. Client C's record did not indicate a goal/objective for dressing.</p> <p>On 4/16/14 at 11:30am, an interview with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
W000323	<p>QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated clients B and C did not have a goal/objective to teach them to wear clean clothing daily. The QIDP indicated group home staff should have taught and encouraged clients B and C to wear clean clothing for their dignity during formal and informal opportunities.</p> <p>On 4/17/14 at 12:40pm, an interview with the Clinical Director (CD) #1 was conducted. CD #1 indicated clients B, C, and G should have been prompted and encouraged by the group home staff to complete each client's personal hygiene during formal and informal opportunities. CD #1 indicated personal hygiene of shaving and clean clothing was a dignity issue.</p> <p>9-3-5(a) 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.</p> <p>Based on record review and interview, for 3 of 4 sampled clients (clients A, B, and D), the facility failed to ensure client A, B, and D's hearing was assessed annually.</p> <p>Findings include:</p> <p>On 4/15/14 at 12:55pm and on 4/16/14 at 11:45am, client A's record was reviewed. Client A's record indicated he was admitted on 5/25/12 and did not indicate a hearing evaluation. Client A's 7/31/13 Physician's History and Physical examination did not</p>	W000323	<p>CORRECTION: <i>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Specifically, the facility will obtain hearing evaluations that include tone assessments for Client's A, B and D. A review of client medical records indicated this deficient practice did affect other clients.</i></p> <p>PREVENTION: The facility nurse will maintain a</p>	05/17/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
W000367	<p>include a hearing assessment.</p> <p>On 4/15/14 at 10:50am, client B's record was reviewed. Client B's record indicated she was admitted on 11/30/2007 and did not indicate a hearing assessment. Client B's record indicated an appointment with her ENT (Ears, Nose, and Throat Doctor) on 8/22/13 for "ear wax removed."</p> <p>On 4/15/14 at 11:45am, client D's record was reviewed. Client D's record indicated she was admitted on 6/24/2006 and did not indicate a hearing assessment. Client D's record indicated a 1/17/2013 audiology appointment which indicated she was "hearing impaired" and did not include documentation that her audio hearing tones were assessed. Client D's 11/21/13 Physician's History and Physical indicated a diagnosis of "Hearing Impaired" and did not include an assessment of client D's hearing.</p> <p>On 4/16/14 at 11:00am, an interview with the agency RN (Registered Nurse), Clinical Director (CD) #1, and CD #2 was conducted. The three administrative staff indicated client A, B, and D's had not had a hearing examination completed within the past year as of this date.</p> <p>9-3-6(a) 483.460(k) DRUG ADMINISTRATION The facility must have an organized system for drug administration that identifies each drug up to the point of administration.</p> <p>Based on observation, record review, and interview, the facility failed to follow Core A/Core B medication training guidelines to</p>	W000367	<p>tracking grid for all clients to assure that routine medical assessments, including but not limited to annual audiological assessments, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure appropriate medical follow-up takes place as required. The nurse Manager had developed a database to track medical appointment compliance and assist the team with enhanced monitoring of medical appointment compliance.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION: The facility must have an organized system for drug administration that identifies each drug up to the point of</p>	05/17/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>administer medications for 1 of 4 sampled clients (client B) and 2 additional clients (clients F and H).</p> <p>Findings include:</p> <p>On 4/15/14 from 5:25am until 7:55am, observations and interviews were completed for clients B, F, and H. From 5:25am until 5:40am, the medication room door was unlocked, open to the hallway, and Group Home Staff (GHS) #2 walked in and out of eye sight of the open medication door. At 5:25am, GHS #2 stated client B's "Levothyroxine 50mcg (microgram) 1 tab (tablet) once daily" for hypothyroidism, client F's "Levothyroxine 100mcg 1 tab once daily" for hypothyroidism, and client H's "Levothyroxine 75mcg 1 tab once daily" for hypothyroidism were pre set in three individual medication cups and each cup sat on the counter inside the medication room. From 5:25am until 5:50am, GHS #2 indicated clients B, F, and H's pre set medication cups of oral medications were on the counter inside the open medication room. From 5:25am until 5:50am, GHS #2 left the medication room, went individually to client B, F, and H's bedrooms, woke up each client and prompted each client to go to the medication room to administer the pre set medication to each client. At 5:40am, GHS #2 prompted client F to come to the medication room, client F sat down on the sofa inside the medication room, and GHS #2 left the room with clients B, F, and H's oral medications sitting out on the counter unsecured. At 5:42am, GHS #2 prompted client H to come to the medication room; GHS #2 left the room with clients B and H's medications sitting out on the unsecured counter. At 5:50am, GHS #2 indicated</p>		<p>administration. Specifically the nurse will retrain all staff regarding the operation's medication administration procedures which are consistent with Core A and Core B (Living in the Community), including but not limited to prohibition from pre-setting medications for multiple clients. The governing body has determined that this deficient practice most likely affected clients A – H.</p> <p>PREVENTION: The QIDP will be expected to observe no less than one morning and one evening active treatment sessions per week to assure staff follow the agency's medication administration procedures. Similarly the Residential Manager will be expected to monitor no less than five active treatment sessions per week –assuring that oversight, training and coaching occurs on all shifts. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure that medications are administered per agency protocols. The Clinical Supervisor will also conduct periodic reviews of the facility Visitor's Log to monitor QIDP and Residential Manager compliance with supervisory expectations.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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, record review, and interview, for 1 of 8 clients (client H), the facility staff failed to administer medications without error and as prescribed by the client's physician for client H.</p> <p>Findings include:</p> <p>On 4/15/14 from 5:25am until 7:55am, observations and interviews were completed for client H. At 5:25am, Group Home Staff (GHS) #2 stated client H's "Levothyroxine 75mcg (microgram) 1 tablet once daily for hypothyroidism. Give one half hour before meds/meals" was pre set in an individual medication cup and the cup sat on the counter inside the medication room. At 5:42am, GHS #2 prompted client H to come to the medication room and administered her Levothyroxine medication. At 5:50am, GHS #2 requested client H to come to the medication room for morning medications. At 6:02am, GHS #2 administered and client H took her oral tablet medications. At 6:11am, client H's 4/2014 MAR (Medication Administration Record) and 3/31/2014 "Physician's Order" both indicated "Levothyroxine 75mcg 1 tablet once daily for hypothyroidism. Give one half hour before meds/meals." At 7:18am, client H consumed her first bite of food.</p> <p>On 4/16/14 at 11:00am, an interview with the agency RN (Registered Nurse), Clinical Director (CD) #1, and CD #2 was conducted. The three administrative staff indicated medications should be administered according to physician's orders. The RN indicated client H should have no effects from the staff administering client H's medication before a half an hour lapsed. The RN indicated the facility followed "Living in</p>		<p><i>administration must assure that all drugs are administered in compliance with the physician's orders. Specifically the nurse will retrain all staff regarding the operation's medication administration procedures which are consistent with Core A and Core B (Living in the Community), including but not limited to following physician instructions as transcribed in the Medication and Treatment Administration Record. A review of medical records indicated that in addition to Client H, this deficient practice most likely affected Client B and Client F</i></p> <p>PREVENTION: The QIDP will be expected to observe no less than one morning and one evening active treatment sessions per week to assure that medications are administered per physician's orders. Similarly the Residential Manager will be expected to monitor no less than five active treatment sessions per week –assuring that oversight, training and coaching occurs on all shifts. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure that medications are administered per physician's orders. The Clinical Supervisor will also conduct periodic reviews of the facility Visitor's Log to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
W000371	<p>the Community" for medication administration.</p> <p>On 4/16/14 at 11:00am, a record review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication should be administered according to physician's orders.</p> <p>On 4/17/14 at 12:40pm, an interview with the Clinical Director (CD) #1 was conducted. CD #1 indicated staff should follow "Living in the Community" for medication administration.</p> <p>9-3-6(a) 483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients (clients A and C), the facility failed to develop medication goals/objectives to provide medical training for clients A and C.</p> <p>Findings include:</p> <p>1. On 4/15/14 at 12:55pm, and on 4/16/14 at 11:45am, client A's record was reviewed. Client A's 3/31/14 Physician Orders were reviewed and indicated he did not require routine medications administered at the group home. Client A's record indicated he had his vital signs monitored weekly and</p>	W000371	<p>monitor QIDP and Residential Manager compliance with supervisory expectations.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION: <i>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Specifically, the interdisciplinary Team will develop learning objectives to train Clients A and C toward self-medication. A review of facility support documents indicated this deficient practice does not currently affect other</i></p>	05/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>used as needed medications for allergy relief, itching, and constipation. Client A's 6/25/13 ISP (Individual Support Plan) did not indicate an objective to teach client A about his medications and/or his medical well being. Client A's 3/2014, 2/2014, and 1/2014 QIDP (Qualified Intellectual Disabilities Professional) reviews did not include teaching client A about his as needed medication and treatments. Client A's 3/31/14 "Physician's Order" for "Mineral Oil" drops in each ear twice a week to soften ear wax.</p> <p>2. On 4/14/14 at 5:40pm, client C was observed at the group home with Group Home Staff (GHS) #1 to complete medication administration. Client C opened the medication cabinet to obtain his glucose testing supplies in a black cloth pouch. At 5:40pm, client C selected a lancet, an alcohol pad to wipe his finger, poked his finger to obtain blood, placed blood on the test strip in the glucometer machine (a machine to test blood glucose), and obtained a reading of 136. GHS #1 administered client C's "Metformin 100mg (milligrams)" for Diabetes Mellitus. At 6:00pm, Client C's 4/2014, Medication Administration Record (MAR) was reviewed and indicated an order for "Accu-Checks (Blood Glucose Checks) twice daily at 6am & 5pm Blood Sugar <70 or >240 call RN (Registered Nurse)...." Client C took the oral medication with water and left the medication room. No teaching was observed completed about client C's specific medications.</p> <p>Client C's record was reviewed on 4/15/14 at 12:24pm. Client C's 3/31/14 "Physician Orders" indicated "Metformin 100mg 1 tab (tablet) twice daily (for Non Insulin Dependent</p>		<p>clients.</p> <p>PREVENTION: The QIDP will be retrained regarding the need to assure that all individuals have prioritized training objectives targeting self-administration of medication. Members of the and Operations Team will periodically compare current support documents to assessment data to assure medication education training needs are addressed in each client's individual support plan. These audits will occur as needed but no less than quarterly.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
W000382	<p>Diabetes Mellitus)...Accu-Checks (Blood Glucose Checks) twice daily at 6am & 5pm Blood Sugar <70 or >240 call RN (Registered Nurse)...." Client C's 6/3/13 ISP did not indicate a goal/objective to teach client C about his medications.</p> <p>On 4/16/14 at 11:00am, an interview with the Agency RN (Registered Nurse), Clinical Director (CD) #1, and CD #2 was conducted. Both the RN and CD #2 indicated clients A and C did not have documented objectives to teach clients A and C about their medications and/or medical well being. CD #1 and CD #2 both indicated no goals/objectives for clients A and C were available for review for teaching each client about their specific medications.</p> <p>9-3-6(a) 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation, record review, and interview, the facility failed to keep medications locked/secured when not administered for 4 of 4 sampled clients (A, B, C, and D) and four additional clients (clients E, F, G, and H) who resided in the home.</p> <p>Findings include:</p> <p>On 4/15/14 from 5:25am until 7:55am, observations and interviews were completed for clients A, B, C, D, E, F, G, and H. From 5:25am until 5:40am, the medication room door was unlocked, open to the hallway, and Group Home Staff (GHS) #2 walked in and</p>	W000382	<p>CORRECTION: <i>The facility must keep all drugs and biologicals locked except when being prepared for administration. Specifically, the nurse will retrain all staff regarding the operation's medication administration procedures which are consistent with Core A and Core B (Living in the Community), including but not limited to keeping the medication room locked and/or the medications secured in a locked cabinet when the medications are not being prepared or administered.</i></p>	05/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>out of eye sight of the open medication door. At 5:25am, GHS #2 stated client B's "Levothyroxine 50mcg (microgram) 1 tab (tablet) once daily" for hypothyroidism, client F's "Levothyroxine 100mcg 1 tab once daily" for hypothyroidism, and client H's "Levothyroxine 75mcg 1 tab once daily" for hypothyroidism were pre set in three individual medication cups and each cup sat on the counter inside the medication room. From 5:25am until 5:50am, GHS #2 indicated clients B, F, and H's pre set medication cups of oral medications were each on the counter inside the unsecured medication room. From 5:25am until 5:50am, GHS #2 left the medication room, went individually to client B, F, and H's bedrooms, woke up each client and prompted each client to the medication room to administer the pre set medication to each client. At 5:40am, GHS #2 prompted client F to come to the medication room, client F sat down on the sofa inside the medication room, and GHS #2 left the room with clients B, F, and H's oral medications sitting out on the counter unsecured. At 5:42am, GHS #2 prompted client H to come to the medication room, GHS #2 left the room with clients B and H's medications sitting out on the unsecured counter. At 5:50am, GHS #2 indicated clients B, F, and H's pre set medication cups of oral medications were each on the counter inside the unsecured medication room.</p> <p>On 4/16/14 at 11:00am, an interview with the agency RN (Registered Nurse), Clinical Director (CD) #1, and CD #2 was conducted. The three administrative staff indicated medications should be kept locked/secured when medications were not administered. The RN indicated clients A, B, C, D, E, F, G, and H had access to the medication room</p>		<p>PREVENTION: The QIDP will be expected to observe no less than one morning and one evening active treatment sessions per week to assure that medications are locked as appropriate. Similarly the Residential Manager will be expected to monitor no less than five active treatment sessions per week –assuring that oversight, training and coaching occurs on all shifts. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure that medications locked as appropriate. The Clinical Supervisor will also conduct periodic reviews of the facility Visitor's Log to monitor QIDP and Residential Manager compliance with supervisory expectations.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Health Services Team, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
W000436	<p>when the room was not locked. The RN indicated the facility followed "Living in the Community" for medication administration.</p> <p>On 4/16/14 at 11:00am, a record review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication should be kept secure when not administered.</p> <p>On 4/17/14 at 12:40pm, an interview with the Clinical Director (CD) #1 was conducted. CD #1 indicated medications should be kept locked/secured when medications were not administered. The CD #1 indicated the facility followed "Living in the Community" for medication administration.</p> <p>9-3-6(a) 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 2 of 4 sampled clients (clients B and C) and 1 additional client (client G) with adaptive equipment, the facility failed to teach and encourage clients B and G to wear their prescribed eye glasses and for client C to wear his prescribed hearing aids when opportunities existed.</p> <p>Findings include:</p>	W000436	<p>CORRECTION: <i>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Specifically, the team has developed learning objectives to</i></p>	05/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>1. On 4/14/14 from 3:52pm until 6:30pm, on 4/15/14 from 5:25am until 7:55am, and on 4/15/14 from 9:50am until 10:35am, observations and interviews were completed for clients B and G. During the three observation periods clients B and G did not wear their prescribed eye glasses. During the three observation periods clients B and G completed medication administration, hand washing, read the newspaper/magazine, watched television, fed themselves meals, and completed assembly at the workshop. During the three observation periods clients B and G did not wear their prescribed eye glasses and were not prompted or encouraged to wear their prescribed eye glasses.</p> <p>On 4/15/14 at 10:50am, client B's record was reviewed. Client B's 1/14/2014 ISP (Individual Support Plan) did not indicate a goal/objective to wear her prescribed eye glasses. Client B's 1/17/14 "Nursing Assessment Mobility" indicated client B was "Visual Impairment" and wore "glasses." Client B's 4/14/14 "Nutrition Assessment" indicated she wore prescribed "glasses." Client B's 12/13/13 visual assessment indicated she had wore prescribed "eye glasses."</p> <p>On 4/17/14 at 12:44pm, client G's 9/8/13 ISP did not indicate he wore prescribed eye glasses and and did not indicate a goal for him to wear his eye glasses. Client G's 4/9/14 visual assessment indicated "pick up glasses." Client G's undated "Dr. [Name of Eye Doctor]" indicated a prescribed calibration order for his prescribed eye glasses.</p>		<p>support Clients B and G in learning to wear and care fore her eyeglasses and Client C to wear his hearing aids.</p> <p>PREVENTION: The QIDP will be expected to observe no less than one morning and one evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training toward proper implementation of learning objectives including but not limited to adaptive equipment goals. Similarly the Residential Manager will be expected to monitor no less than five active treatment sessions per week –assuring that oversight, training and coaching occurs on all shifts. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure that clients are utilizing adaptive equipment as recommended.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>On 4/16/14 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated clients B and G wore prescribed eye glasses to see. The QIDP indicated clients B and G did not have goals/objectives to teach the clients when to wear their prescribed eye glasses and staff should have taught and encouraged clients B and G to wear their eye glasses during formal and informal opportunities.</p> <p>2. On 4/14/14 from 3:52pm until 6:30pm, on 4/15/14 from 5:25am until 7:55am, and on 4/15/14 from 9:50am until 10:35am, observations and interviews were completed for client C. During the three observation periods client C did not wear his prescribed hearing aids. During the three observation periods client C completed medication administration, hand washing, listened to music with his headphones on, watched television, fed himself meals, and completed assembly at the workshop. During the three observation periods client C did not wear his prescribed hearing aids, client C talked in whispered tones of voice, and was not prompted or encouraged to wear his prescribed hearing aids.</p> <p>On 4/15/14 at 12:24pm, client C's record was reviewed. Client C's 6/3/13 ISP indicated a goal/objective to communicate his wants and needs and indicated he wore "a hearing aid." Client C's ISP did not include a goal/objective to teach client C to wear his prescribed hearing aids. Client C's 8/9/13 and 2/2/12 hearing assessments indicated he wore prescribed hearing aids. Client C's 2/2/12 "Audiologic Assessment" indicated "Hearing: moderately-severe...rec (recommend) re-eval in 1 yr. (year) (sic)." Client C's Audiologic</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
W000484	<p>assessment did not indicate which ear and/or the number of hearing aids recommended.</p> <p>On 4/16/14 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client C wore prescribed hearing aids to hear. The QIDP indicated client C did not have a goal/objective to teach him when to wear his prescribed hearing aids and staff should have taught and encouraged client C to wear his hearing aids during formal and informal opportunities.</p> <p>On 4/17/14 at 12:40pm, an interview with the Clinical Director (CD) #1 was conducted. CD #1 indicated clients B, C, and G should have been prompted and encouraged by the group home staff to wear their prescribed eye glasses and/or hearing aids during formal and informal opportunities. CD #1 indicated he was unsure if client C wore hearing aids in both ears or if client C wore one hearing aid.</p> <p>9-3-7(a) 483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and 4 additional clients (clients E, F, G, and H), the facility staff failed to teach and encourage clients to have a full set of silverware, napkins, and to use dining glasses/utensils.</p> <p>Findings include:</p>	W000484	<p>CORRECTION: <i>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Specifically, staff have been retrained to assure that a complete table setting is in place for each meal.</i></p> <p>PREVENTION:</p>	05/17/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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>On 4/14/14 at 6:17pm, clients A, B, C, D, E, F, G, and H served and fed themselves the evening meal of Chicken Fajitas, Rice, Cheese Bread, Salad, and cut Strawberries. Clients A, B, C, D, E, F, G, and H had a plate, a glass, a bowl, and a fork. Clients A, B, C, D, E, F, G, and H did not have a knife, a spoon, and a napkin for their use. During the meal clients A, B, C, D, E, F, G, and H wiped their hands on their clothing and/or licked their fingers while the clients were eating.</p> <p>On 4/15/14 from 7:25am until 7:45am, clients A, B, C, D, E, F, G, and H had a spoon, a bowl, and one glass at the breakfast meal. Clients C, D, F, G, and H were prompted to use a small plastic spoon by GHS (Group Home Staff) #2. Clients A, B, C, D, E, F, G, and H did not have a napkin available for their use. Milk, coffee, water, and juice were choices of drinks and one glass was available for clients A, B, C, D, E, F, G, and H. Clients used the same glass for water after drinking milk and other drink mixtures. Clients A, B, C, D, E, F, G, and H used their hands to wipe their mouths then wiped their hands on their clothing.</p> <p>On 4/15/14 at 9:00am, an interview with Clinical Director (CD) #1 was conducted. CD #1 indicated clients A, B, C, D, E, F, G, and H should have been provided a full set of silverware, a napkin, and more than one glass to drink from during dining.</p> <p>On 4/16/14 at 11:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the group home staff should have ensured clients A, B, C, D, E, F, G, and H had a full set of silverware, a napkin, and more than one glass to drink more than one</p>		<p>The QIDP will be expected to observe no less than one morning and one evening active treatment sessions per week to assess direct support staff meal time interaction with clients and to provide hands on coaching and training to assure that appropriate condiments, napkins and a complete table setting of silverware are present. Similarly the Residential Manager will be expected to monitor no less than five active treatment sessions per week –assuring that oversight, training and coaching occurs on all shifts. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than monthly to assure that appropriate table settings are provided at meals.</p> <p>RESPONSIBLE PARTIES: QIDP, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	kind of drink. 9-3-8(a)			