

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
(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 pre-determined full annual recertification and state licensure survey.</p> <p>Dates of Survey: March 18, 19, 20, 21 and 22, 2013.</p> <p>Facility Number: 001065 Provider Number: 15G551 AIMS Number: 100239840</p> <p>Surveyor: Kathy J. Wanner, Medical Surveyor III.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 27, 2013 by Dotty Walton, Medical Surveyor III.</p>			W000000			

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: 15G551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
--	---

(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
W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, for 3 of 14 Bureau of Developmental Disabilities Services (BDDS) reports involving allegations of abuse and an injury of unknown origin reviewed, the facility failed to complete their investigation within 5 working days and to report the results to the administrator and/or to state officials regarding 1 of 3 sampled clients (client #1) and 1 additional client (client #6).</p> <p>Findings include:</p> <p>Facility records were reviewed on 3/18/13 at 3:13 P.M. including the BDDS reports from 4/2/12 through 3/18/13. The BDDS reports indicated the results of facility internal investigations were not submitted to state officials within five working days in accordance with state law:</p> <p>1. A BDDS report dated 10/4/12 for an injury of unknown origin involving client #1 having a 1-1/2 inch (one and one-half inch) scratch on the lower left side of her face which was discovered on 10/3/12 at 8:30 A.M. The results of the internal</p>	W000156	<p>CORRECTION: <i>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Specifically, the results of the investigations into an injury of unknown origin discovered on 10/3/12 and allegations of verbal abuse reported on 10/12/12 and 10/22/12 have been reported to the administrator.</i></p> <p>PREVENTION: New professional staff are in place at the facility and will be trained regarding the complete investigations within five working days and report the results to the administrator. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion and reporting.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Quality Assurance Team, Operations Team</p>	04/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
(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>investigation were reported to BDDS on 2/12/13. The investigation had determined client #1 had scratched herself.</p> <p>2. A BDDS report dated 10/14/12 for an allegation of staff verbal abuse (yelling) to client #6 on 10/12/12 at 3:00 P.M. There was no corresponding report of the investigation.</p> <p>3. A BDDS report dated 10/22/12 at 4:37 P.M. for an allegation of staff speaking to client #1 "in a disrespectful and authoritative manner...telling [client #1] to sit down whenever she would get up to walk around the house..." The results of the internal investigation were reported to BDDS on 2/12/13. The investigation determined the allegation had been substantiated and the staff had been terminated.</p> <p>An interview with the facility Quality Assurance Manager (QAM) was conducted on 3/20/13 at 4:30 P.M. The QAM indicated they have had some difficulty getting them (reports) submitted timely in the past. The QAM stated, "Yes, they (investigations) should have been submitted within five working days, and we now have a system in place to correct it."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256		
(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	
	9-3-2(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
--	---

(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
W000209	<p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p>Based on record review and interview, the facility failed to assure participation by the client, parent, legal guardian in the developmental process of the Individual Support Program (ISP)/Behavior Support Program (BSP) for 3 of 3 sampled clients (clients #1, #2 and #3).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/19/13 at 3:38 P.M. Client #1's record indicated she had an ISP/BSP, both dated 3/23/12. Client #1's record indicated she had a guardian to assist her with decisions. Client #1's ISP and BSP were not signed by her guardian. There was no evidence client #1's guardian had been involved in the ISP/BSP process or evidence indicating the guardian's participation would have been unobtainable or inappropriate.</p> <p>Client #2's record was reviewed on 3/19/13 at 4:00 P.M. Client #2's record indicated he had an ISP and a BSP, both dated 10/10/12. Client #2's record indicated he had a guardian to assist him with decisions. Client #2's ISP/BSP were</p>	W000209	<p>CORRECTION: <i>Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Specifically, The QDDPD will assure that both of Client #1 and Client #2's guardians receive written invitations to attend all interdisciplinary meetings and that they receive the opportunity for input toward the ongoing development and modification of their Individual Support Plans and Behavior Support Plans, when they are unable to attend in person. Additionally the team will assure that Client #3 participates in the ongoing development and modification of her Individuals Support Plan and Behavior Support Pan.</i></p> <p>PREVENTION: New professional staff are in place at the facility and will be trained regarding the need to assure complete interdisciplinary team involvement, including co-guardians and clients, in decision making. Members of the Operations and Quality Assurance Teams will review interdisciplinary team notes as</p>	04/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
--	---

(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>not signed by him or by his guardian. There was no evidence client #2 or his guardian had been involved in the ISP/BSP process or evidence indicating the client's and guardian's participation would have been unobtainable or inappropriate.</p> <p>Client #3's record was reviewed on 3/19/13 at 4:30 P.M. Client #3's record indicated she had an ISP dated 8/17/12. Client #3's ISP was not signed by client #3. There was no evidence client #3 was involved in the ISP process or evidence indicating the client's participation would have been unobtainable or inappropriate.</p> <p>An interview was conducted with the Qualified Developmental Disabilities Professional Designee (QDDPD) on 3/21/13 at 4:40 P.M. When asked about client/guardian participation in the ISP/BSP process the QDDP stated, "I was unable to locate them." The QDDPD stated, "[Client #1's] guardian is in the military and I was unable to reach her."</p> <p>An interview was conducted with the Program Manager (PM) on 3/21/13 at 4:36 P.M. When asked about client/guardian/HCR participation in the ISP/BSP process the PM stated, "They (staff) are not available to locate them at this time."</p>		<p>meetings occur to assure guardian representation occurs. Additionally, the governing body is assisting the facility with the development of a standardized approach to ensuring guardian and client involvement in the IDT process.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Quality Assurance Team, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
--	---

(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
	9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
(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			
W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview, the facility failed to ensure the Human Rights Committee reviewed, approved and monitored the Behavior Support Programs for 2 of 3 sampled clients (client #1 and #3) prior to implementation of the programs.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/19/13 at 3:38 P.M. Client #1's record indicated she had a Behavior Support Program (BSP) date 3/23/12. Client #1's BSP incorporated the use of restrictive interventions including the use of psychotropic medications for behavior management: Risperdal (anti-psychotic) and blocking and escorting (physical intervention) her away during physically aggressive behaviors. Client #1's record did not indicate her BSP had been reviewed, approved or monitored by the Human Rights Committee (HRC) prior to the program's implementation date of 3/23/12.</p>	W000262	<p>CORRECTION: <i>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Specifically, Client #1 and Client #3's restrictive programs will be reviewed and approved consensually by the Human Rights Committee.</i></p> <p>PREVENTION: New professional staff are in place at the facility and will be trained regarding the need to assure that the Human Rights Committee engages in a dialog to reach decisions regarding restrictive programs. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to, due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential</p>	04/21/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
(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>Client #3's record was reviewed on 3/19/13 at 4:30 P.M. Client #3's record indicated she had a BSP dated 8/17/12. Client #3's BSP incorporated the use of restrictive interventions including the use of psychotropic medications for behavior management: Buspar (anti-anxiety) and Paxil (anti-depressant). Client #3's record did not indicate her BSP had been reviewed, approved or monitored by the HRC prior to the program's implementation date of 8/17/12.</p> <p>An interview was conducted with the facility Quality Assurance Manager (QAM) on 3/21/13 at 4:30 P.M. The QAM stated, "The (HRC) signatures should have been there, we can look in the minutes, but I doubt we will find them. One of the functions of the HRC is to assure the plans have been approved by the guardians."</p> <p>An interview was conducted with the Program Manager (PM) on 3/21/13 at 4:36 P.M. The PM stated, "They (HRC signatures) were not able to be located at this time."</p> <p>9-3-4(a)</p>		<p>Manager, Quality Assurance Team, Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
--	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256		
(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	
W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body</p> <p>Sec. 1. b. The Residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: (4) Illness of any resident which requires hospitalization or which renders the resident bedfast for more than seven (7) days.</p> <p>This rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to timely report and complete written summaries as requested for a hospitalization involving 1 of 3 additional clients (client #6) to BDDS (Bureau of Developmental Disabilities Services) and to other officials in accordance with State law through established procedures.</p> <p>Findings include:</p>	W009999	<p>CORRECTION: <i>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division (15. A fall resulting in injury, regardless of the severity of the injury). Specifically, the facility has submitted a follow-up summary to BDDS for the incident involving client #6 on 12/17/12. The report has satisfied BDDS requirements and the incident has been closed.</i></p> <p>PREVENTION: New professional staff are in place at the facility and will be trained regarding the complete investigations within five working days and report the results to the administrator. Additionally, the facility's Clinical Supervisor will meet with the Quality Assurance Manager weekly to review incidents that require follow-up and investigation to assure timely completion and reporting.</p> <p>RESPONSIBLE PARTIES: Clinical Supervisor, Residential Manager, Quality Assurance Team, Operations Team</p>	04/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
(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>The BQIS/DDRS (Bureau of Quality Improvement Services/Division of Disability and Rehabilitative Services) Policy: Incident Reporting and Management DDRS Policy Manual Effective Date: March. 1, 2011 was reviewed on 3/22/13 at 5:00 P.M. The Policy indicated the following:</p> <p>"Incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to:</p> <p>...11. An emergency intervention for the individual resulting from:</p> <p>a. a physical symptom; b. a medical or psychiatric condition...."</p> <p>Facility records were reviewed on 3/18/13 at 3:13 P.M. including the BDDS reports from 4/2/12 through 3/18/13. The BDDS reports indicated the results of facility internal investigations were not submitted to state officials in a timely manner:</p> <p>-A BDDS report dated 12/20/12 at 11:30 A.M. indicated client #6 was sent to the ER (emergency room) by her primary care physician on 12/17/12 with a "diagnosis of dehydration, hypolitemia (sic) (electrolyte imbalance) and weight loss of 30 (thirty) pounds over 2-3 (two-three)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
--	---

(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>months...refusing her meals, food supplements, and medications through-out the month...[Client #6] was admitted to [hospital] for treatment and putting in a g-tube...." The corresponding follow-up BDDS report dated 1/8/13 indicated "[Client #6] has remained at [Hospital] over 15 (fifteen) days and has been discharged from ResCare. Also per physician's order in 10/2012, referred placement at a long term care facility."</p> <p>An interview with the facility Quality Assurance Manager (QAM) was conducted on 3/20/13 at 4:30 P.M. The QAM indicated they have had some difficulty getting them (reports) submitted timely in the past. The QAM stated, "Yes, they (investigations) should have been submitted... and we now have a system in place to correct it."</p> <p>9-3-1(b)(4)</p>			