

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  12/12/2014
--	---	--	---

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 the investigation of complaint #IN00160953.</p> <p>Complaint #IN00160953: Substantiated, federal and state deficiencies related to the allegations are cited at: W149, W159 and W210.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 12/11/14 and 12/12/14.</p> <p>Facility Number: 001065 Provider Number: 15G551 AIMS Number: 100239840</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/23/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to implement its policy and</p>	W000149	<p><b>CORRECTION:</b>  <i>The facility must develop and</i></p>	01/11/2015

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  12/12/2014	
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>procedures to prevent neglect of client A regarding elopement.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/11/14 at 3:08 PM. The review indicated the following:</p> <p>-BDDS report dated 12/11/14 indicated, "When evening shift staff reported to work, [DSP (Direct Support Professional) #1] checked on [client A] in his bedroom at 4:30 PM. At 4:45 PM [DSP #1] went to [client A's] room to prompt him to take his evening medication. [Client A] was not present and appeared to have exited the house through the fire exit door in his bedroom. ResCare supervisors and administrative staff immediately began searching the area around the home without success. [DSP #1] called 911 and a missing person report was filed. [Client A's] mother told the [RM (Residential Manager) #1] that [client A] had called her and was riding in a car with friends. [Client A's] mother said that he told her he did not want to return to his group home. [Police] located [client A] at approximately 2:00 PM on 12/11/14 at [intersection] in [city]. [Client A] lives with insulin dependent diabetes and a</p>		<p><i>implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</i> Specifically for Client A, the interdisciplinary team met immediately in response to the elopement incident and put protective measures in place. Client A was moved to a bedroom that did not have an outside exit door and alarms were placed on windows and doors. Additionally, Client A receives line of sight observation when he is in common areas of the home and 15 minute checks when he is in his bedroom. Consent from guardians and the Human rights committee was obtained prior to the initiation of these restrictive practices. No additional elopement attempts have occurred since the incident on 12/17/14. <b>Addendum 1/14/15: All staff have been retrained on appropriate implementation of Client A's enhanced supervision. The team has incorporated checking the functionality of window and door alarms into daily sift duties and direct support staff will be responsible for checking the alarms on each shift and documenting observations on a checklist. The Residential Manager and/or Team Leader will monitor documentation daily and perform spot check to assure the functionality of the</b></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 12/12/2014	
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>liver transplant. [Client A] is followed by a medical team at [hospital] for treatment of both conditions. [Client A] did not appear to be in distress but as a precaution ResCare requested that the police transport [client A] directly to the [hospital] ER (Emergency Room) for evaluation. ResCare staff will meet [client A] and the police at the ER and resume providing residential supports. [Client A] has been assessed as requiring 24 hour staff supervision and is considered to be at risk in the community without supervision due to his medical conditions. At the time of the incident, one staff was on duty supporting four individuals."</p> <p>CS (Clinical Supervisor) #1 was interviewed on 12/12/14 at 7:45 AM. CS #1 indicated the facility's abuse and neglect policy should be implemented. CS #1 indicated client A required 24 hour supervision and was considered to be at risk while in the community without supervision. CS #1 indicated failure to provide adequate staff support to prevent client A from potential physical harm was considered neglect.</p> <p>The facility's policy and procedures were reviewed on 12/12/14 at 3:45 PM. The facility's Abuse, Neglect, Exploitation and Mistreatment policy dated 2/26/11</p>		<p><b>alarms. Staff have been trained on this protocol.</b></p> <p><b>PERVENTION:</b></p> <p>Client A has indicated to the interdisciplinary team that he is unsatisfied with his current residential placement. The team is working with Client A, Client A's guardian and the Bureau of Developmental Disability Services to secure a supervised group living setting that more closely meets Client A's developmental, social and behavioral needs. Client A and his guardian have selected an alternate facility and Client A has initiated visits to the home to help him acclimate to the new setting. Arrangements are being made to assure all staff at the new facility are properly trained on implementation of Client A's complicated medical supports. Additionally the QIDP is working with staff to identify precursor behaviors that could indicate a potential elopement and these will be incorporated into Client A's Behavior Support Plan. <b>ADDENDUM 1/14/15: Staff will monitor Client A and observe for attempts to disarm the door and window alarms and will report observations immediately to the Residential Manager or supervisor-on-call and the QIDP will convene an emergency interdisciplinary</b></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  12/12/2014
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>indicated, "Program intervention neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm."</p> <p>This federal tag relates to complaint #IN00160953.</p> <p>9-3-2(a)</p>		<p><b>team meeting to implement additional protective measures. Staff have been trained to keep Client A engaged in preferred skills training activities and help him focus on his impending move to a more suitable facility. To date, Client A has made no attempts to disable the alarms. The Operations Team has reviewed current staffing levels and assessed that adequate staff are in place to provide the level of supervision necessary to keep Client A and his housemates safe. The team conducts monthly meetings with all individuals in the home to assess their satisfaction with their living arrangements. Additionally, management staff maintain contact with guardians and family members no less than twice monthly to assure ongoing satisfaction with service delivery.</b></p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p><b>CORRECTIONS COMPLETED BY:1/11/15</b></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  12/12/2014
--	---	--	---

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
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 2 sampled clients (A and B), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure the facility's IDT (Interdisciplinary Team) completed client A's CFA (Comprehensive Functional Assessment) within 30 days of his admission to the group home and to ensure client B's CFA was reviewed/updated annually by the facility's IDT.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The QIDP failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure the facility's IDT completed client A's CFA within 30 days of his admission to the group home. Please see W210.</li> <li>2. The QIDP failed to integrate, coordinate and monitor client B's active treatment program by failing to ensure client B's CFA was reviewed/updated annually by the facility's IDT. Please see W259.</li> </ol>	W000159	<p><b>CORRECTION:</b></p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, the QIDP has completed a Comprehensive Functional Assessment for Client A and updated Client B's Comprehensive Functional Assessment. A review of facility support documents indicated this deficient practice did not affect any additional clients.</i></p> <p><b>PREVENTION:</b></p> <p>The QIDP has been retrained regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission and no less than annually thereafter. Members of the Operations Team will follow up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required.</p>	01/11/2015

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  12/12/2014
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	
W000210	<p>This federal tag relates to complaint #IN00160953.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 2 sampled clients (A), the facility's IDT (Interdisciplinary Team) failed to ensure client A's CFA (Comprehensive Functional Assessment) was completed</p>	W000210	<p>The Clinical Supervisor and other members of the Operations Team will review facility support documents no less than monthly to assure appropriate re-assessment occurs as required.</p> <p>A new QIDP has been assigned to the facility and has initiated a process up reviewing and updating all facility support documents including but not limited to assessments.</p> <p><b>RESPONSIBLE PARTIES:</b>  QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p><b>CORRECTION:</b>  <i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or</i></p>	01/11/2015	

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  12/12/2014	
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>within 30 days of his admission to the group home.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/11/14 at 3:08 PM. The review indicated the following:</p> <p>-BDDS report dated 12/11/14 indicated, "When evening shift staff reported to work, [DSP (Direct Support Professional) #1] checked on [client A] in his bedroom at 4:30 PM. At 4:45 PM [DSP #1] went to [client A's] room to prompt him to take his evening medication. [Client A] was not present and appeared to have exited the house through the fire exit door in his bedroom. ResCare supervisors and administrative staff immediately began searching the area around the home without success. [DSP #1] called 911 and a missing person report was filed. [Client A's] mother told the [RM (Residential Manager) #1] that [client A] had called her and was riding in a car with friends. [Client A's] mother said that he told her he did not want to return to his group home. [Police] located [client A] at approximately 2:00 PM on 12/11/14 at [intersection] in [city]. [Client A] lives with insulin dependent diabetes and a</p>		<p><i>reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</i> Specifically, the QIDP has completed a Comprehensive Functional Assessment for Client A.</p> <p>A review of facility support documents indicated this deficient practice did not affect any additional clients.</p> <p><b>PERVENTION:</b></p> <p>The QIDP has been retrained regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission. Members of the Operations Team will follow up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required. A new QIDP has been assigned to the facility and has initiated a process up reviewing and updating all facility support documents including but not limited to assessments.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Direct Support Staff, 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  12/12/2014
--	---	--	---

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>liver transplant. [Client A] is followed by a medical team at [hospital] for treatment of both conditions. [Client A] did not appear to be in distress but as a precaution ResCare requested that the police transport [client A] directly to the [hospital] ER (Emergency Room) for evaluation. ResCare staff will meet [client A] and the police at the ER and resume providing residential supports. [Client A] has been assessed as requiring 24 hour staff supervision and is considered to be at risk in the community without supervision due to his medical conditions. At the time of the incident, one staff was on duty supporting four individuals."</p> <p>Client A's record was reviewed on 12/11/14 at 5:01 PM. Client A's ISP (Individual Support Plan) dated 10/15/14 indicated client A's date of admission to the group home was 9/15/14. Client A's CFA dated 10/10/14 was not completed and sections of the assessment were left blank. Client A's CFA dated 10/10/14 indicated the following:</p> <p>"Item 12: Runs away/attempts to run away." Item 12 did not indicate documentation of assessment or assignment of or numerical scores regarding attempts to run away from home or from group activities.</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  12/12/2014
--	---	--	---

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
W000259	<p>CS (Clinical Supervisor) #1 was interviewed on 12/11/14 at 5:15 PM. CS #1 indicated client A's CFA had sections/items not completed. CS #1 indicated client A had been admitted to the group home on 9/15/14. CS #1 indicated client A's elopement assessment section of his CFA should have been completed within 30 days of his admission.</p> <p>This federal tag relates to complaint #IN00160953.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 2 sampled clients (B), the facility failed to ensure client B's CFA (Comprehensive Functional Assessment) was reviewed by the IDT (Interdisciplinary Team).</p> <p>Findings include:</p> <p>Client B's record was reviewed on 12/11/14 at 5:25 PM. Client B's CFA</p>	W000259	<p><b>CORRECTION:</b></p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Specifically, Client B's Comprehensive Functional Assessment has been updated. A review of facility support documents indicated this deficient</p>	01/11/2015

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  12/12/2014
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>dated 10/8/13 did not indicate documentation of annual review by the facility's IDT.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 12/11/14 at 5:30 PM. CS #1 indicated client B's CFA should be reviewed/updated annually by the IDT.</p> <p>9-3-4(a)</p>		<p>practice did not affect any additional clients.</p> <p><b>PREVENTION:</b></p> <p>The QIDP will be retrained regarding the need to assure that all relevant assessments are reviewed and updated as needed but no less than annually. The Clinical Supervisor and other members of the Operations Team will review facility support documents no less than monthly to assure appropriate re-assessment occurs as required. A new QIDP has been assigned to the facility and has initiated a process up reviewing and updating all facility support documents including but not limited to assessments.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>		