

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
--	--

(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
W 0000 Bldg. 00	<p>This visit was for the fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 4/29/15, 4/30/15, 5/1/15, 5/6/15 and 5/12/15.</p> <p>Facility Number: 0012633 Provider Number: 15G805 AIMS Number: 201072030</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 2 of 2 sampled clients (#1 and #2), the facility failed to ensure clients #1 and #2 had privacy in their personal bedrooms.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/30/15 from 12:00 PM</p>	W 0130	<p>CORRECTION:</p> <p><i>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Specifically, Client # 1 and #2's windows have been frosted top provide for privacy. A review of the facility's</i></p>	06/11/2015

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: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
--	--

(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
W 0137 Bldg. 00	<p>through 6:00 PM. Clients #1 and #2's personal bedroom areas were observed. Clients #1 and #2's bedrooms each had one window in their bedrooms and neither window had curtains. Both windows had privacy frosting/covering on the lower portion of the windows but had no frosting/covering on the top portion of the windows. The height of the windows in relation to the surrounding outside grade of the lawn created a clear unobstructed view into the bedroom from outside.</p> <p>QIDP (Qualified Intellectual Disability Professional) #1 was interviewed on 4/30/15 at 1:15 PM. QIDP #1 indicated clients #1 and #2's bedroom windows had previously had curtains that attached with Velcro strips due to both clients' targeted behaviors of property destruction and prior attempts to utilize metal curtain rods as weapons. QIDP #1 indicated clients #1 and #2's windows did not provide privacy in their personal bedroom areas.</p> <p>9-3-2(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use</p>		<p>physical environment demonstrated that this deficient practice did not affect any additional clients.</p> <p>PERVENTION:</p> <p>The QIDP has been retrained regarding the need to develop supports that provide for privacy for all clients. Members of the Operations Team, including Clinical Supervisors, Nurse Manager, Program Manager and Executive Director will conduct assessments of the facility physical environment no less than monthly to assure privacy is maintained.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/12/2015	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330			
(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>appropriate personal possessions and clothing.</p> <p>Based on observation, record review and interview for 1 of 2 sampled clients (#2), the facility failed to allow client #2 access to his own personal property (radio).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/30/15 from 12:00 PM through 6:00 PM. At 5:30 PM, client #2 was walking around the group home singing a rap song. Client #2 approached QIDP (Qualified Intellectual Disabilities Professional) #1 and began singing/rapping to him. QIDP #1 stated, "[Client #2] likes music. We can't keep his radio in his room though because he keeps destroying them when he has behaviors." Client #2 did not have access to his personal radio.</p> <p>Client #2's record was reviewed on 4/30/15 at 2:40 PM. Client #2's BSP (Behavior Support Plan) dated 12/1/14 indicate client #2 should be restricted from his personal radio for specified times when he was having property destruction behaviors.</p> <p>QIDP #1 was interviewed on 5/1/15 at 7:00 AM. QIDP #1 stated, "I did some</p>	W 0137	<p>CORRECTION:</p> <p><i>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Specifically for Client #2's radio is no longer secured in a locked cabinet and staff do not restrict Client #2's access to his radio except when Client #2 is displaying his targeted behavior of property destruction as directed in the Behavior Support Plan. Through observation, it has been determined that this deficient practice did not affect any additional clients.</i></p> <p>PREVENTION:</p> <p>All facility staff have been retrained regarding proper implementation of Client #2's behavior supports.</p> <p>The QIDP will be expected to observe no less than five active treatment sessions per week to assure that behavior supports are implemented as written. Additionally the facility's behaviorist will spend no less</p>	06/11/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
--	--

(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>checking into [client #2's] radio restriction and talked to the behaviorist who wrote [client #2's] BSP (Behavior Support Plan). We have been implementing his plan wrong. When he gets upset and starts to have a behavior we are supposed to implement a radio restriction while he's having the behavior. Otherwise, when he's not having a behavior he should have access to his radio. It's just a temporary restriction to keep him from tearing it up during behaviors."</p> <p>9-3-2(a)</p>		<p>than 10 hours weekly at the facility providing hands-on coaching of direct support staff to improve the effectiveness of behavior support implementation. Members of the Operations Team including the Clinical Supervisors, Nurse Manager, Program Manager and Executive Director will observe active treatment on an ongoing basis, but no less than monthly to assure appropriate program implementation occurs and that restrictive programs are not implemented without appropriate due process. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330
--	--

(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
W 0263 Bldg. 00	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 2 sampled clients (#1), with restrictive programs, the facility failed to ensure the client's legally appointed guardian gave written consent for client</p>	W 0263	<p>hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Behaviorist, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The committee should insure that these programs are conducted only with the written informed</i></p>	06/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/12/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330		
(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's use of psychotropic medications for behavior management and restrictive programs.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 4/30/15 at 12:38 PM. Client #1's BSP (Behavior Support Plan) dated 8/15/14 indicated, "[Client #1] is a 19 year old male who is an emancipated adult. [Client #1] was admitted to the [group home] on 8/15/14." Client #1's record indicated client #1 was not assessed as being able to give written informed consent. Client #1's record indicated the facility initiated securing a guardian for client #1 and obtained a legal guardian on 4/22/15. Client #1's BSP dated 8/15/14 indicated client #1 received Atarax 10 milligrams (mood disorder), Geodon 40 milligrams (affective disorder), Clonazepam 0.5 milligrams (mood disorder) and Remeron 7.5 milligrams (mood disorder) for behavior management. Client #1's 8/15/14 BSP indicated client #1 was restricted from full access to the group home's kitchen area, from access to sharp objects (knives) and from chemicals. Client #1's Modification of Rights form dated 11/15/14 indicated client #1's personal bedroom area would be subjected to periodic routine checks/sweeps for sharp</p>		<p><i>consent of the client, parents (if the client is a minor) or legal guardian. Specifically, written informed consent for restrictive programs, including the use of psychotropic medication has been obtained from Client 1's guardian and will be obtained from Client C's healthcare representative. A review of facility support documents and Human Rights Committee records indicated that this deficient practice did not affect any additional clients.</i></p> <p>PREVENTION:</p> <p>When guardians and healthcare representatives are unable to attend team meetings face to face, consent forms will be sent via postal mail for review and signature, along with a stamped envelope addressed to the facility. If consents are not returned to the facility in a timely manner via standard postal mail, the QIDP will send the forms to the appropriate legal representative via registered mail to assure the documents have been delivered and received. Members of the Operations Team including the Clinical Supervisors, Nurse Manager, Program Manager and Executive Director will review restrictive programs on an ongoing basis, but no less</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/12/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KELLAM RD CENTERVILLE, IN 47330		
(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>objects to prevent self injurious behavior. Client #1's record did not indicate written informed consent from client #1's guardian regarding the use of psychotropic medications for behavior management or restrictive programs.</p> <p>QIDP (Qualified Intellectual Disability Professional) #1 was interviewed on 4/30/15 at 1:15 PM. QIDP #1 indicated client #1 had been appointed a legal guardian on 4/22/15. QIDP #1 indicated client #1's guardian's written informed consent should be obtained regarding client #1's use of psychotropic medication for behavior management and his restrictive programs.</p> <p>9-3-4(a)</p>		<p>than monthly to assure prior written informed consent has been obtained.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Direct Support Staff, Operations Team</p>		