

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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 #IN00155415.</p> <p>Complaint #IN00155415: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W157, W159, W240 and W331.</p> <p>Dates of Survey: 10/21/14, 10/22/14, 10/23/14 and 10/24/14.</p> <p>Facility Number: 000973 Provider Number: 15G459 AIMS Number: 100244810</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/31/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p>			

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: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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, the facility failed to meet the Condition of Participation: Governing Body for 2 of 3 sampled clients (A and B) plus 3 additional clients (F, DC (Discharged Client) G and DC H). The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client F regarding the implementation of his mobility CHRHP (Comprehensive High Risk Health Plan), to prevent fractures regarding clients C, DC G and DC H, to identify and report an allegation of neglect regarding client F's mobility CHRHP and an injury of unknown origin regarding client A to BDDS (Bureau of Developmental Disabilities Services), to ensure the facility completed thorough investigations regarding client F's injuries as possible neglect, clients A, B, DC G and DC H's injuries of unknown origin and to develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility</p>	W000102	<p>CORRECTION:</p> <p><i>The facility must ensure that specific governing body and management requirements are met. Specifically:</i></p> <p>The QIDP will bring the interdisciplinary team together to review assessment data and develop supports to address Client A's skin picking self-injurious behavior. Additionally, the QIDP will coordinate with the facility Nurse and Nurse Manager to review Client F's Comprehensive High Risk Plan for mobility and make revisions as appropriate. All staff will be retrained toward proper implementation of Client F's supports to ensure Client F's safety.</p> <p>The staff responsible for failing to report Client A's skin abscess, in order to assure the provision of appropriate medical treatment received written corrective action and all facility staff were retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required.</p>	11/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>implemented its policy and procedures to prevent neglect of client F regarding the implementation of his mobility CHRHP, to prevent fractures regarding clients C, DC G and DC H, to identify and report an allegation of neglect regarding client F's mobility CHRHP and an injury of unknown origin regarding client A to BDDS, to ensure the facility completed thorough investigations regarding client F's injuries as possible neglect, clients A, B, DC G and DC H's injuries of unknown origin and to develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility. Please see W104.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 2 of 3 sampled clients (A and B) plus 3 additional clients (F, DC G and DC H), the facility failed to implement its policy and procedures to prevent neglect of client F regarding the implementation of his mobility CHRHP, to prevent fractures regarding clients C, DC G and DC H, to identify and report an allegation of neglect regarding client F's mobility CHRHP and an injury of unknown origin regarding client A to BDDS, to ensure the facility completed thorough investigations regarding client</p>		<p>The Residential Manager and members of the administrative investigation team have been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed, including employees of non-agency day service providers as appropriate. Additionally, the manager and investigative team have been retrained regarding the need to review all relevant documents including but not limited to progress notes and behavior tracking as part of the investigation process. Additionally, the Governing Body will revise current criteria for incidents requiring investigation to include events where staff could potentially have failed to implement safety protocols including but not limited to Comprehensive High Risk Plans. All supervisory staff will receive training toward implementation of the revised policy.</p> <p>PREVENTION:</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to falls and discovered injuries to review current supports and to make adjustments and revisions</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>F's injuries as possible neglect, clients A, B, DC G, DC H's injuries of unknown origin and to develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility. Please see W122.</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-1(a)</p>		<p>as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will 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 safety protocols. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 60 days, providing hands-on coaching and training as needed. After two months, The Operations team and QIDP will observe active treatment sessions no less than every two weeks for an additional 30 days. After 90 days, the Operations Team will review incident data and observational assessments to determine the need for ongoing oversight, with</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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 goal of scaling back the administrative presence in the home to no less than monthly.</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. The governing body has added an additional layer of supervision at the facility which will enhance oversight of the incident reporting process. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment.</p> <p>Investigations of allegations of abuse, neglect and mistreatment will undergo a formal peer review process to ensure the investigations are thorough. The Peer Review Team will be composed of administrative level staff including the Executive</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260		
(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	
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 2 of 3 sampled clients (A and B) plus 3</p>	W000104	<p>Director, Program Manager, Clinical Supervisors and a representative from the Human Resources Department. Additionally, the Residential Manager will turn in copies of completed internal facility investigations to the Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Completed abuse, neglect and mistreatment investigations will be reviewed as part of a formal quarterly audit process. When deficiencies are noted, the Executive Director will amend the agency's Quality Improvement Plan to correct and prevent future occurrences.</p> <p>RESPONSIBLE PARTIES: Operations Team, QIDP, Residential Manager, Team Leader, Direct Support Staff</p> <p>CORRECTION:</p>	11/23/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>additional clients (F, DC (Discharged Client) G and DC H), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client F regarding the implementation of his mobility CHRHP (Comprehensive High Risk Health Plan), to prevent fractures regarding clients C, DC G and DC H, to identify and report an allegation of neglect regarding client F's mobility CHRHP and an injury of unknown origin regarding client A to BDDS (Bureau of Developmental Disabilities Services), to ensure the facility completed thorough investigations regarding client F's injuries as possible neglect, clients A, B, DC G and DC H's injuries of unknown origin and to develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client F regarding the implementation of his mobility CHRHP, to prevent fractures regarding clients C, DC G and DC H, to identify and report</p>		<p><i>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Specifically,</i></p> <p>The QIDP will bring the interdisciplinary team together to review assessment data and develop supports to address Client A's skin picking self-injurious behavior. Additionally, the QIDP will coordinate with the facility Nurse and Nurse Manager to review Client F's Comprehensive High Risk Plan for mobility and make revisions as appropriate. All staff will be retrained toward proper implementation of Client F's supports to ensure Client F's safety.</p> <p>The staff responsible for failing to report Client A's skin abscess, in order to assure the provision of appropriate medical treatment received written corrective action and all facility staff were retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>an allegation of neglect regarding client F's mobility CHRHP and an injury of unknown origin regarding client A to BDDS, to ensure the facility completed thorough investigations regarding client F's injuries as possible neglect, clients A, B, DC G and DC H's injuries of unknown origin and to develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility identified and reported an allegation of neglect regarding client F's mobility CHRHP and to report an injury of unknown origin regarding client A to BDDS within 24 hours. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility completed thorough investigations regarding client F's injuries as possible neglect and clients A, B, DC G and DC H's injuries of unknown origin. Please see W154.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed and implemented corrective</p>		<p>state agencies as required.</p> <p>The Residential Manager and members of the administrative investigation team have been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed, including employees of non-agency day service providers as appropriate. Additionally, the manager and investigative team have been retrained regarding the need to review all relevant documents including but not limited to progress notes and behavior tracking as part of the investigation process. Additionally, the Governing Body will revise current criteria for incidents requiring investigation to include events where staff could potentially have failed to implement safety protocols including but not limited to Comprehensive High Risk Plans. All supervisory staff will receive training toward implementation of the revised policy.</p> <p>PREVENTION:</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to falls and discovered injuries to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility. Please see W157.</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-1(a)</p>		<p>review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will 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 safety protocols. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 60 days, providing hands-on coaching and training as needed. After two months, The Operations team and QIDP will observe active treatment sessions no less than every two weeks for an additional 30 days. After 90 days, the Operations Team will review incident data and observational</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>assessments to determine the need for ongoing oversight, with the goal of scaling back the administrative presence in the home to no less than monthly.</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. The governing body has added an additional layer of supervision at the facility which will enhance oversight of the incident reporting process. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment.</p> <p>Investigations of allegations of abuse, neglect and mistreatment will undergo a formal peer review process to ensure the investigations are thorough. The Peer Review Team will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260		
(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	
W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition	W000122	composed of administrative level staff including the Executive Director, Program Manager, Clinical Supervisors and a representative from the Human Resources Department. Additionally, the Residential Manager will turn in copies of completed internal facility investigations to the Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Completed abuse, neglect and mistreatment investigations will be reviewed as part of a formal quarterly audit process. When deficiencies are noted, the Executive Director will amend the agency's Quality Improvement Plan to correct and prevent future occurrences. RESPONSIBLE PARTIES: Operations Team, QIDP, Residential Manager, Team Leader, Direct Support Staff CORRECTION:	11/23/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>of Participation: Client Protections for 2 of 3 sampled clients (A and B) plus 3 additional clients (F, DC (Discharged Client) G and DC H), the facility failed to implement its policy and procedures to prevent neglect of client F regarding the implementation of his mobility CHRHP (Comprehensive High Risk Health Plan), to prevent fractures regarding clients C, DC G and DC H, to identify and report an allegation of neglect regarding client F's mobility CHRHP and an injury of unknown origin regarding client A to BDDS (Bureau of Developmental Disabilities Services), to ensure the facility completed thorough investigations regarding client F's injuries as possible neglect, clients A, B, DC G and DC H's injuries of unknown origin and to develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect of client F regarding the implementation of his mobility CHRHP, to prevent fractures regarding clients C, DC G and DC H, to identify and report an allegation of neglect regarding client F's mobility CHRHP and an injury of unknown origin</p>		<p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i></p> <p>The QIDP will bring the interdisciplinary team together to review assessment data and develop supports to address Client A's skin picking self-injurious behavior. Additionally, the QIDP will coordinate with the facility Nurse and Nurse Manager to review Client F's Comprehensive High Risk Plan for mobility and make revisions as appropriate. All staff will be retrained toward proper implementation of Client F's supports to ensure Client F's safety.</p> <p>The staff responsible for failing to report Client A's skin abscess, in order to assure the provision of appropriate medical treatment received written corrective action and all facility staff were retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required.</p>	
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>regarding client A to BDDS, to ensure the facility completed thorough investigations regarding client F's injuries as possible neglect and clients A, B, DC G and DC H's injuries of unknown origin and to develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility. Please see W149.</p> <p>2. The facility failed to ensure staff immediately reported an injury of unknown origin regarding client A to the facility administrator and to report an incident as an allegation of neglect regarding client F's mobility to BDDS within 24 hours. Please see W153.</p> <p>3. The facility failed to complete a thorough investigations regarding client F's injuries as possible neglect and clients A, B, DC G and DC H's injuries of unknown origin. Please see W154.</p> <p>4. The facility failed to develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility. Please see W157.</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-2(a)</p>		<p>The Residential Manager and members of the administrative investigation team have been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed, including employees of non-agency day service providers as appropriate. Additionally, the manager and investigative team have been retrained regarding the need to review all relevant documents including but not limited to progress notes and behavior tracking as part of the investigation process. Additionally, the Governing Body will revise current criteria for incidents requiring investigation to include events where staff could potentially have failed to implement safety protocols including but not limited to Comprehensive High Risk Plans. All supervisory staff will receive training toward implementation of the revised policy.</p> <p>PREVENTION:</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to falls and discovered injuries to review current supports and to make adjustments and revisions as needed. The QIDP will turn in</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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
			copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will 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 safety protocols. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 60 days, providing hands-on coaching and training as needed. After two months, The Operations team and QIDP will observe active treatment sessions no less than every two weeks for an additional 30 days. After 90 days, the Operations Team will review incident data and observational assessments to determine the need for ongoing oversight, with the goal of scaling back the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>administrative presence in the home to no less than monthly.</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. The governing body has added an additional layer of supervision at the facility which will enhance oversight of the incident reporting process. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment.</p> <p>Investigations of allegations of abuse, neglect and mistreatment will undergo a formal peer review process to ensure the investigations are thorough. The Peer Review Team will be composed of administrative level staff including the Executive Director, Program Manager,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260		
(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	
W000149	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 2 of 3 sampled clients (A and B) plus 3	W000149	Clinical Supervisors and a representative from the Human Resources Department. Additionally, the Residential Manager will turn in copies of completed internal facility investigations to the Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Completed abuse, neglect and mistreatment investigations will be reviewed as part of a formal quarterly audit process. When deficiencies are noted, the Executive Director will amend the agency's Quality Improvement Plan to correct and prevent future occurrences. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team CORRECTION:	11/23/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>additional clients (F, DC (Discharged Client) G and DC H), the facility failed to implement its policy and procedures to prevent neglect of client F regarding the implementation of his mobility CHRHP (Comprehensive High Risk Health Plan), to prevent fractures regarding clients C, DC G and DC H, to identify and report an allegation of neglect regarding client F's mobility CHRHP and an injury of unknown origin regarding client A to BDDS (Bureau of Developmental Disabilities Services), to ensure the facility completed thorough investigations regarding client F's injuries as possible neglect, clients A, B, DC G, DC H's injuries of unknown origin and to develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility.</p> <p>Findings include:</p> <p>The facility's BDDS reports, IRs (Incident Reports) and Investigations were reviewed on 10/23/14 at 11:00 AM. The review indicated the following:</p> <p>1. IR dated 5/9/14 indicated, "[Client F] was getting on the van and slipped and hit his head on the door. [Client F] has a small tear by his right eye. [Client F] went to the ER (Emergency Room) and</p>		<p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i></p> <p>The QIDP will bring the interdisciplinary team together to review assessment data and develop supports to address Client A's skin picking self-injurious behavior. Additionally, the QIDP will coordinate with the facility Nurse and Nurse Manager to review Client F's Comprehensive High Risk Plan for mobility and make revisions as appropriate. All staff will be retrained toward proper implementation of Client F's supports to ensure Client F's safety.</p> <p>The staff responsible for failing to report Client A's skin abscess, in order to assure the provision of appropriate medical treatment received written corrective action and all facility staff were retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>got 2 stitches."</p> <p>-BDDS report dated 5/10/14 indicated on 5/9/14 "While boarding the van [client F] hit his head on the door of the vehicle and sustained a 1/2 inch laceration beside his right eye. [Staff #1] provided first aid, reported the incident and transported (sic) to the [hospital] ER for evaluation and treatment. ER personnel closed the wound with 2 sutures and released [client F] to ResCare staff with instructions to follow up in seven days to have the stitches removed."</p> <p>The 5/10/14 BDDS report indicated, "Staff will monitor [client F] closely and follow the ER wound care instructions. [Client F] has a high risk plan on (sic) place for limited mobility. The IDT (Interdisciplinary Team) will review the incident to determine if modifications to the plan are indicated. ResCare nursing will monitor the healing process of [client F's] wound."</p> <p>Client F's record was reviewed on 10/22/14 at 10:45 AM. Client F's PCPP (Person Centered Planning Profile) form dated 10/1/14 indicated, "[Client F] uses a wheelchair at all times." Client F's mobility CHRHP dated 7/23/13 indicated, "4. Staff to provide hands-on assistance when entering and exiting the</p>		<p>The Residential Manager and members of the administrative investigation team have been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed, including employees of non-agency day service providers as appropriate. Additionally, the manager and investigative team have been retrained regarding the need to review all relevant documents including but not limited to progress notes and behavior tracking as part of the investigation process. Additionally, the Governing Body will revise current criteria for incidents requiring investigation to include events where staff could potentially have failed to implement safety protocols including but not limited to Comprehensive High Risk Plans. All supervisory staff will receive training toward implementation of the revised policy.</p> <p>PREVENTION:</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to falls and discovered injuries to review current supports and to make adjustments and revisions as needed. The QIDP will turn in</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>van. 5. Staff to provide standby assistance during in home ambulation exercises. 6. Staff to provide at least standby assistance during showering/bathing." Client F's record did not indicate documentation of IDT review of client F's 5/9/14 injury.</p> <p>The BDDS and investigation review did not indicate documentation of an investigation regarding client F's 5/9/14 injury. The facility did not provide documentation of investigation of the 5/9/14 incident to determine if staff #1 implemented hands on assistance as described in client F's CHRHP.</p> <p>-IR dated 6/4/14 indicated, "At about 5:10 PM, [Client F] was getting out from shower (sic) to sit in his wheelchair. [Client F] hits (sic) his arm against counter top (sic) in the bathroom. Causing (sic) two reddish spots and two light tears on his left lower arm."</p> <p>The review did not indicate documentation of client F's 6/4/14 incident was reported to BDDS as an allegation of staff failing to provide standby assistance during client F's shower/bathing activities. The review did not indicate documentation of the facility conducting an investigation to determine if staff implemented client F's Mobility</p>		<p>copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will 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 safety protocols. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 60 days, providing hands-on coaching and training as needed. After two months, The Operations team and QIDP will observe active treatment sessions no less than every two weeks for an additional 30 days. After 90 days, the Operations Team will review incident data and observational assessments to determine the need for ongoing oversight, with the goal of scaling back the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>CHRHP.</p> <p>2. BDDS report dated 8/25/14 indicated, "On 8/24/14, [staff #2] heard [DC G], cry out in her bedroom in pain. Staff noticed severe swelling in right leg and called 911 to have her transported to the [hospital] ER. While at the ER, [DC G] was diagnosed with a fracture of her right femur and admitted to the hospital. [DC G] has a high risk plans (sic) for falls and limited mobility. Upon notification of the incident to the administrative team, the staff that were on duty the evening of 8/24/14 were suspended pending an investigation into the circumstances of the fracture."</p> <p>The 8/25/14 BDDS report indicated, "An investigation into the circumstances of the fracture is currently ongoing. Staff on duty were suspended. ResCare nursing will follow [DC G's] care while at the hospital."</p> <p>-Investigative Summary dated 8/28/14 regarding DC G's 8/24/14 injury of unknown origin indicated a written summary of staff #2's interview. Staff #2's statement indicated, "I went to [DC G's] room and asked her if she could remember having got injured. [DC G] said she fell yesterday in the group home and she did not remember the time." The</p>		<p>administrative presence in the home to no less than monthly.</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. The governing body has added an additional layer of supervision at the facility which will enhance oversight of the incident reporting process. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment.</p> <p>Investigations of allegations of abuse, neglect and mistreatment will undergo a formal peer review process to ensure the investigations are thorough. The Peer Review Team will be composed of administrative level staff including the Executive Director, Program Manager,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>8/28/14 Investigative Summary indicated progress notes for DC G were reviewed for 8/24/14 and time and attendance records were reviewed for 8/24/14. The review did not indicate documentation of progress notes for 8/23/14, the date DC G indicated in staff #2's written interview, or identify and interview staff that had worked on 8/23/14. The review did not indicate documentation of DC G's day service provider being interviewed to determine if DC G had sustained her injury on 8/23/14 while at her day service provider.</p> <p>RM (Resident Manager) #1 was interviewed on 10/22/14 at 11:05 AM. RM #1 indicated she had assisted with DC G's 8/28/14 Investigative Summary. When asked if DC G had attended her day service provider on 8/23/14, RM #1 stated, "Yes." When asked if DC G's day service provider had been interviewed during the investigation, RM #1 stated, "I think I asked the staff but as far as the actual interview, no." RM #1 indicated DC G had been discharged to a rehabilitation facility since the 8/24/14 injury. RM #1 indicated DC G was currently residing in the rehabilitation facility and was scheduled to return to the group home upon her release.</p> <p>Day Service Manager (DSM) #1 was</p>		<p>Clinical Supervisors and a representative from the Human Resources Department. Additionally, the Residential Manager will turn in copies of completed internal facility investigations to the Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Completed abuse, neglect and mistreatment investigations will be reviewed as part of a formal quarterly audit process. When deficiencies are noted, the Executive Director will amend the agency's Quality Improvement Plan to correct and prevent future occurrences.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>interviewed on 10/22/14 at 2:00 PM. When asked if the facility had interviewed DSM #1 regarding DC G's 8/24/14 injury of unknown origin, DSM #1 stated "No, they didn't. Nobody said a word about it."</p> <p>3. BDDS report dated 8/26/14 indicated, "[DC H] was attempting to get into the purse of a staff member. Another individual in her team, [client F], told her to stop. [Client F] then wheeled his chair (wheelchair) to where she was and shoved [DC H], causing her to fall down on the left side of her body. Staff quickly assisted [DC H] up into a wheelchair. [DC H] began to complain that her left side was hurting. [Day Service Nurse (DSN) #1] was called to check [DC H]. No visible signs of injury were noted. However, [DC H] could not stand up out of the wheelchair with staff assistance. [DC H] complained that her leg was hurting, pointing to her left thigh. [DSN #1] made decision to contact 911 to have [DC H] taken for x-ray and assessment of additional injury."</p> <p>-Follow up BDDS report dated 9/17/14 indicated, "[DC H] is doing very well in recovering from a Femoral Neck Fracture. Surgery was completed with a Canulated Screw Fythnes (sic) put in place so [DC H] will not be in constant</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>pain with the consent of [DC H's] HCR (Health Care Representative). [DC H] is now in [rehabilitation facility] and is doing very well. [DC H] is expected to be discharged between 30-60 days per [rehabilitation facility] staff pending on (sic) [DC H] continuing to show progress with her treatment."</p> <p>-Investigation undated regarding DC H's 8/26/14 injury did not indicate documentation of other clients or staff in DC H's classroom who may have been potential witnesses or statements from these potential witnesses to the incident. The undated investigation did not indicate documentation of a statement/interview with DC H. The undated investigation did not address why the day services staff member's purse was out/accessible to DC H and why it remained out despite DC H's attempts to get into the purse and any policy or procedures regarding the staff leaving personal items unattended. The undated investigation did not indicate a date of completion or a summary, did not indicate documentation of a summary of information and findings, a description of the incident including where staff was in proximity of client F and DC H, an analysis of the evidence, findings of facts and determinations of if policy was implemented and if DC H's rights were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>violated.</p> <p>DC H's record was reviewed on 10/22/14 at 9:30 AM. DC H's ROV (Record of Visit) form dated 4/11/14 indicated, "[DC H] needs a gait belt and assist of one (staff) to walk." DC H's record did not indicate documentation of IDT review of the 4/11/14 recommendations. DC H's record did not indicate documentation of CHRHP being developed to address DC H's recommendations and mobility needs.</p> <p>DSS (Day Service Staff) #1 was interviewed on 10/22/14 at 2:40 PM. DSS #1 indicated she had been working in DC H's classroom during the 8/26/14 incident. DSS #1 indicated DC H was standing/walking near the staff member's purse. DSS #1 indicated DC H was not wearing a gait belt and was not being assisted while she stood/walked. DSS #1 stated, "[Client F] just reached out and pushed [DC H]. It wasn't even that hard. It looked like she just fell over. I was surprised she fell that way because he really didn't push her that hard. [DC H] is just so frail. [DC H] can barely stand up or walk on her own. We've been asking for an order for a wheelchair for awhile now for her. [DC H] could barely get from the van to the classroom." When asked if she had been instructed/trained by the facility regarding DC H's 4/11/14</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>recommended use of a gait belt and assistance while walking/standing, DSS #1 stated, "No, she's never had a gait belt here. I didn't know anything about it."</p> <p>DSM #2 was interviewed on 10/22/14 at 2:50 PM. DSM #2 indicated she had completed the 8/26/14 investigation regarding DC H's injury. DSM #2 indicated DSS #1 and DSS #2 were working in the classroom during the incident on 8/26/14. DSM #2 stated, "[DC H] was not stable. We had been asking for a wheelchair for her but they kept saying that they needed a doctor's order for a wheelchair. We couldn't watch her struggle to get from the van to her class so we started using our own wheelchair to get her in and out of the building safely. We were like, why are you bringing her in here like that? She needed a wheelchair or walker." When asked if she had been instructed/trained by the facility regarding DC H's 4/11/14 recommended use of a gait belt and assistance while walking/standing, DSM #2 stated, "No. If they had we would have done training with our staff. We would have needed a risk plan and trained our staff to use the gait belt and assist her."</p> <p>4. IR dated 9/4/14 indicated, "Staff smelled a foul odor coming off of [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>A]. Staff checked [client A] and saw a band-aid on her left bicept (sic). Staff removed the band-aid to discover a (sic) open sore that is dime sized, red on the outside and yellowish green on the inside. [Client A] did complain of pain. Staff washed area with hot soapy water then cleaned with peroxide."</p> <p>-BDDS report dated 9/5/14 indicated on 9/4/14 "[Client A] was still sitting up watching television when the overnight staff arrived on duty. [Staff #3] one of the overnight staff noticed that [client A] had a band-aid on her left bicept (sic). [Staff #3] asked [client A] why she had a band-aid on and [client A] said she had a sore. [Staff #3] removed the band-aid and noticed the sore was red and about half size (sic) in diameter and [client A] said it hurt. [Staff #3] cleaned the area with peroxide and notified the on-call nurse and supervisors of the incident. The nurse instructed the staff to inform the day staff to take [client A] to see (sic) primary care physician or to a med check to have have (sic) the sore checked out."</p> <p>The 9/5/14 BDDS report indicated, "Staff assisted [client A] to med check and [client A] was examined and the findings were [client A] has a skin abscess. Staff were sent home with the instructions for antibiotics and ointments and to follow</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>up with primary care physician in two weeks. An investigation is being conducted into why the incident was not reported and a corrective action will be given according to company policy and procedure for failure to report an injury."</p> <p>-Investigation dated 9/7/14 regarding client A's 9/4/14 injury of unknown origin indicated the following written statements:</p> <p>-Staff #4, "Was not aware that area was a sore at the time that [client A] came to me to receive her morning medications. [Client A] pointed out a red area with a pimple in the middle. I put peroxide on and Bacitracin ointment and covered with (sic) band-aid on 9/4/14 Thursday morning. I worked the evening shift on 9/4/14 and I showered [client A] and I could not figure out what the odor was I kept smelling on her. So, I checked her depend and found nothing throughout the shift. Night staff arrived on duty and [staff #3] asked what is that smell. I said, I'm trying to figure that out. [Staff #3] asked me have (sic) noticed the sore on [client A's] arm that's green (sic) spot in the middle. I asked her where and then I asked [client A] to take off her jacket and come into the medication room. I took the bandage off and that's when I saw the pimple. It had turned yellow and had a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>(sic) odor and I said we found the odor. I looked at [staff #3] and said, you knew about this and she said it didn't look like that (sic) way. So, I told her to call the nurse and write a (sic) incident (sic) because you might be at the hospital tonight. That's infected and the nurse has to be notified."</p> <p>-Staff #5, "I had showered [client A] Saturday morning (8/30/14) and the area was red 1/2 inch in size. Washed and cleaned area with peroxide and antibiotic and covered with a band-aid." Staff #5's written statement indicated, "Did not document anything. Other staff was going to do incident report."</p> <p>The investigation did not indicate documentation of a written statement or interview with staff #3. The investigation did not address staff #4's statement regarding the application of Bacitracin to client A's arm and potential allergy to Bacitracin. The investigation indicated, "Staff will immediately report any unusual or abnormal findings to the nurse and supervisors to prevent any future occurrences." The investigation did not indicate documentation of recommendations to address client A's picking behaviors to prevent reoccurrence.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>-BDDS report dated 9/12/14 indicated, "[Staff #4] was giving [client A] her morning medication when she noticed a half inch scratch in diameter (sic) going across a small bruise in the area of a previous wound which occurred a week ago. The nurse and supervisors were notified of this incident. Staff spoke with [client A] on how this scratch and bruise could have occurred and [client A] said she had scratched herself. [Client A] is known for picking sores and it is documented in her BSP (Behavior Support Plan). Staff will continue to follow [client A's] BSP and monitor [client A] more closely."</p> <p>-IR dated 9/14/14 indicated, "While changing [client A's] dressing, staff noticed additional bruising to her left arm on the inside where the tape from the abscess coverage lay (sic)."</p> <p>Client A's record was reviewed on 10/22/14 at 10:50 AM. Client A's HA (Healthcare Addendum) form dated 5/9/14 indicated, "[Client A] is allergic to... Bacitracin." Client A's BSP dated 5/9/14 indicated, "Updated 9/5/14." Client A's BSP indicated skin picking, picking scabs or sores was a targeted behavior. Client A's BSP indicated staff should "Observe [client A] for wounds and any unusual/abnormal findings,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>especially during bathing. Document any discovered wounds, abnormal findings, open sore or scabs. Complete an Accident/Incident report. Notify nurse, QIDP (Qualified Intellectual Disability Professional) and others in (sic) discovered injuries procedures. Return to training toward replacement behavior by teaching [client A] to inform staff when her skin itches or is bothering her." Client A's record did not indicate IDT assessment or recommendations regarding further supports to prevent client A's picking or SIB (Self- Injurious Behavior).</p> <p>RM #1 was interviewed on 10/22/14 at 11:05 AM. RM #1 indicated there was not additional documentation of IDTs regarding client A's picking or SIBs. RM #1 indicated client A's BSP had been updated to include reporting client A's injuries.</p> <p>5. BDDS report dated 10/15/14 indicated on 10/15/14 at 11:15 AM "[Client B] was seen by the primary care physician due to a knot along the right clavicle. The physician ordered an x-ray to assess for old displaced clavicle or old fracture. [Client B] has lost weight in the past year and this has made this area more noticeable. The results from the x-ray came back as a fracture. The nurse</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>instructed the staff to assist [client B] to the ER for further evaluation and to follow up with an orthopedic specialist per physician."</p> <p>-BDDS report dated 10/21/14 indicated, "Staff went and checked on [client B] during bed checked (sic) and noticed that she was crying from pain from her right shoulder that she had fractured. Staff called the nurse and the nurse stated to take her to the ER. Administrative team and doctor was (sic) notified. The hospital did x-rays and stated that the fracture that she went to the doctor for on 10/15/14 was not healing and stated that she needs to see the orthopedic doctor and put her in a sling. The doctor ordered pain medication and stated to keep the orthopedic appointment that [client B] already have (sic) on 10/28/14."</p> <p>-Investigative report dated 10/17/14 indicated RM #1 was the assigned investigator and had completed the investigation. The 10/17/14 investigative report indicated client B's injury of unknown origin was discovered by staff on 10/15/14 at 11:15 AM. The 10/17/14 investigative report indicated, "A. General Information. If applicable, dates and times investigator visited the site of the incident. Date 10/15/14. Time: Already on duty." The 10/17/14</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>investigative report indicated RM #1 was on duty working in the group home at the time of the discovery of client B's fractured clavicle. The investigation did not indicate documentation of RM #1 being interviewed as a potential witness to the origin of client B's injury. The 10/17/14 investigative report did not indicate documentation of interviews being conducted with client B's day service staff as potential witnesses to the origin of client B's fractured clavicle.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 10/22/14 at 9:00 AM. CS #1 indicated investigations of allegations of abuse, neglect, mistreatment and injuries of unknown origin should include all potential witnesses to the alleged event or injury. When asked if an investigation should include staff who had worked with a client within 24 hours of an alleged incident or injury, CS #1 stated, "Yes, we generally try to do 24 hours." CS #1 indicated the facility's abuse and neglect policy should be implemented. CS #1 indicated all allegations of abuse, neglect, mistreatment and injuries of unknown origin should be reported immediately to the administrator and within 24 hours to BDDS. CS #1 indicated all allegations of abuse, neglect, mistreatment and injuries of unknown origin should be thoroughly</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>investigated. CS #1 indicated corrective action to prevent reoccurrence of abuse, neglect or mistreatment should be developed from the IDT or from a peer review process.</p> <p>The facility's policy and procedures were reviewed on 10/23/14 at 8:00 AM. The facility's Abuse, Neglect, Exploitation and Mistreatment policy dated 2/26/11 indicated, "Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation or mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, ResCare and local state and federal guidelines." The 2/26/11 policy included the following definitions:</p> <p>- "Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being."</p> <p>- "Program intervention neglect: Failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan, inappropriate application of intervention</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>without a qualified person notification/review."</p> <p>The 2/26/11 Policy indicated, "A full investigation will be conducted by Adept personnel."</p> <p>The facility's Investigations policy dated 9/14/07 indicated, "In order to ensure the health, safety and welfare of the people we support, events or collections of circumstances that are outside of what is normally expected, cannot by (sic) explained and understood by the existence of the event and result in or have the potential to result in injury or abuse, neglect or exploitation to the consumer must be investigated. Investigations will be conducted per the protocols listing in the incident management best practices manual."</p> <p>The 9/14/07 policy indicated, "Witnesses: anyone who directly observed an incident or was affected by the incident, or who was directly or indirectly involved in the process i.e. injured parties, eyewitnesses, other participants. Types of witnesses: (1.) Principle (sic) witness; (2.) Eyewitnesses; (3.) Other potential witnesses."</p> <p>The 9/14/07 policy indicated, "A thorough investigation final report will be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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
W000153	<p>written at the completion of the investigation. The report shall include, but is not limited to the following: (1.) Description of the allegation or incident; (2.) Purpose of the investigation; (3.) Parties providing information; (4.) Summary of information and findings (evidence collected, witnesses interviewed, date of the investigation, name(s) of investigator(s); (5.) Description and chronology of what happened; (6.) Analysis of the evidence; (7.) Finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive; (8.) Concerns and recommendations; (9.) Witness statements and supporting documentation...; (10.) Methods to prevent future incidents."</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for</p>	W000153		11/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>2 of 23 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to ensure staff immediately reported an injury of unknown origin regarding client A to the facility administrator and to report an incident as an allegation of neglect regarding client F's mobility to BDDS (Bureau of Developmental Disabilities Services) within 24 hours in accordance with state law.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IRs (Incident Reports) and Investigations were reviewed on 10/23/14 at 11:00 AM. The review indicated the following:</p> <p>1. IR dated 6/4/14 indicated, "At about 5:10 PM, [Client F] was getting out from shower (sic) to sit in his wheelchair. [Client F] hits (sic) his arm against counter top (sic) in the bathroom. Causing (sic) two reddish spots and two light tears on his left lower arm."</p> <p>The review did not indicate documentation of client F's 6/4/14 incident being reported to BDDS as an allegation of staff failing to provide standby assistance during client F's</p>		<p>CORRECTION:</p> <p><i>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, The staff responsible for failing to report Client A's skin abscess, in order to assure the provision of appropriate medical treatment received written corrective action and all facility staff were retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of weekly body assessments and incident documentation confirmed that this deficient practice did not affect other clients.</i></p> <p>PREVENTION:</p> <p>Supervisory staff will review all facility documentation to assure incidents are reported as required. The governing body has added an additional layer of supervision at the facility which will enhance oversight of the incident reporting process. Additionally, internal and day service incident reports will be</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>shower/bathing activities.</p> <p>Client F's record was reviewed on 10/22/14 at 10:45 AM. Client F's PCPP (Person Centered Planning Profile) form dated 10/1/14 indicated, "[Client F] uses a wheelchair at all times." Client F's mobility CHRHP dated 7/23/13 indicated, "6. Staff to provide at least standby assistance during showering/bathing."</p> <p>2. IR dated 9/4/14 indicated, "Staff smelled a foul odor coming off of [client A]. Staff checked [client A] and saw a band-aid on her left bicept (sic). Staff removed the band-aid to discover a (sic) open sore that is dime sized, red on the outside and yellowish green on the inside. [Client A] did complain of pain. Staff washed area with hot soapy water then cleaned with peroxide."</p> <p>-BDDS report dated 9/5/14 indicated on 9/4/14 "[Client A] was still sitting up watching television when the overnight staff arrived on duty. [Staff #3] one of the overnight staff noticed that [client A] had a band-aid on her left bicept (sic). [Staff #3] asked [client A] why she had a band-aid on and [client A] said she had a sore. [Staff #3] removed the band-aid and noticed the sore was red and about half size (sic) in diameter and [client A] said</p>		<p>sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>it hurt. [Staff #3] cleaned the area with peroxide and notified the on-call nurse and supervisors of the incident. The nurse instructed the staff to inform the day staff to take [client A] to see (sic) primary care physician or to a med check to have have (sic) the sore checked out."</p> <p>The 9/5/14 BDDS report indicated, "Staff assisted [client A] to med check and [client A] was examined and the findings were [client A] has a skin abscess. Staff were sent home with the instructions for antibiotics and ointments and to follow up with primary care physician in two weeks. An investigation is being conducted into why the incident was not reported and a corrective action will be given according to company policy and procedure for failure to report an injury."</p> <p>-Investigation dated 9/7/14 regarding client A's 9/4/14 injury of unknown origin indicated the following written statements:</p> <p>-Staff #4, "Was not aware that area was a sore at the time that [client A] came to me to receive her morning medications. [Client A] pointed out a red area with a pimple in the middle. I put peroxide on and Bacitracin ointment and covered with (sic) band-aid on 9/4/14 Thursday morning. I worked the evening shift on</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>9/4/14 and I showered [client A] and I could not figure out what the odor was I kept smelling on her. So, I checked her depend and found nothing throughout the shift. Night staff arrived on duty and [staff #3] asked what is that smell. I said, I'm trying to figure that out. [Staff #3] asked me have (sic) noticed the sore on [client A's] arm that's green (sic) spot in the middle. I asked her where and then I asked [client A] to take off her jacket and come into the medication room. I took the bandage off and that's when I saw the pimple. It had turned yellow and had a (sic) odor and I said we found the odor. I looked at [staff #3] and said, you knew about this and she said it didn't look like that (sic) way. So, I told her to call the nurse and write a (sic) incident (sic) because you might be at the hospital tonight. That's infected and the nurse has to be notified."</p> <p>-Staff #5, "I had showered [client A] Saturday morning (8/30/14) and the area was red 1/2 inch in size. Washed and cleaned area with peroxide and antibiotic and covered with a band-aid." Staff #5's written statement indicated, "Did not document anything. Other staff was going to do incident report."</p> <p>CS #1 (Clinical Supervisor) was interviewed on 10/22/14 at 9:00 AM. CS</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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
W000154	<p>#1 indicated all allegations of abuse, neglect, mistreatment and injuries of unknown origin should be reported immediately to the administrator and within 24 hours to BDDS.</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-1(b)(5) 9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 4 of 23 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to ensure the facility completed thorough investigations regarding client F's injuries as possible neglect and clients A, B, DC (Discharged Client) G and DC H's injuries of unknown origin.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IRs (Incident Reports) and Investigations were reviewed on 10/23/14</p>	W000154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, the Residential Manager and members of the administrative investigation team have been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed, including employees of non-agency day service providers as appropriate. Additionally, the manager and investigative team have been retrained regarding the need to review all relevant documents including but not limited to progress notes and behavior tracking as part of the</i></p>	11/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>at 11:00 AM. The review indicated the following:</p> <p>1. IR dated 5/9/14 indicated, "[Client F] was getting on the van and slipped and hit his head on the door. [Client F] has a small tear by his right eye. [Client F] went to the ER (Emergency Room) and got 2 stitches."</p> <p>-BDDS report dated 5/10/14 indicated on 5/9/14 "While boarding the van [client F] hit his head on the door of the vehicle and sustained a 1/2 inch laceration beside his right eye. [Staff #1] provided first aid, reported the incident and transported (sic) to the [hospital] ER for evaluation and treatment. ER personnel closed the wound with 2 sutures and released [client F] to ResCare staff with instructions to follow up in seven days to have the stitches removed."</p> <p>Client F's record was reviewed on 10/22/14 at 10:45 AM. Client F's PCPP (Person Centered Planning Profile) form dated 10/1/14 indicated, "[Client F] uses a wheelchair at all times." Client F's mobility CHRHP dated 7/23/13 indicated, "4. Staff to provide hands-on assistance when entering and exiting the van. 5. Staff to provide standby assistance during in home ambulation exercises. 6. Staff to provide at least</p>		<p>investigation process. Additionally, the Governing Body will revise current criteria for incidents requiring investigation to include events where staff could potentially have failed to implement safety protocols including but not limited to Comprehensive High Risk Plans. All supervisory staff will receive training toward implementation of the revised policy.</p> <p>PREVENTION: Investigations of allegations of abuse, neglect and mistreatment will undergo a formal peer review process to ensure the investigations are thorough. The Peer Review Team will be composed of administrative level staff including the Executive Director, Program Manager, Clinical Supervisors and a representative from the Human Resources Department. Additionally, the Residential Manager will turn in copies of completed internal facility investigations to the Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. Completed abuse, neglect and mistreatment investigations will be reviewed as part of a formal quarterly audit process. When deficiencies are noted, the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>standby assistance during showering/bathing." Client F's record did not indicate documentation of IDT (Interdisciplinary Team) review of client F's 5/9/14 injury.</p> <p>The BDDS report and investigation review did not indicate documentation of an investigation regarding client F's 5/9/14 injury. The facility did not provide documentation of investigation of the 5/9/14 incident to determine if staff #1 implemented client F's CHRHP.</p> <p>-IR dated 6/4/14 indicated, "At about 5:10 PM, [Client F] was getting out from shower (sic) to sit in his wheelchair. [Client F] hits (sic) his arm against counter top (sic) in the bathroom. Causing (sic) two reddish spots and two light tears on his left lower arm."</p> <p>The review did not indicate documentation of the facility conducting an investigation to determine if staff implemented client F's Mobility CHRHP.</p> <p>2. BDDS report dated 8/25/14 indicated, "On 8/24/14, [staff #2] heard [DC G], cry out in her bedroom in pain. Staff noticed severe swelling in right leg and called 911 to have her transported to the [hospital] ER. While at the ER, [DC G] was diagnosed with a fracture of her right</p>		<p>Executive Director will amend the agency's Quality Improvement Plan to correct and prevent future occurrences. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>femur and admitted to the hospital. [DC G] has a high risk plans (sic) for falls and limited mobility. Upon notification of the incident to the administrative team, the staff that were on duty the evening of 8/24/14 were suspended pending an investigation into the circumstances of the fracture."</p> <p>The 8/25/14 BDDS report indicated, "An investigation into the circumstances of the fracture is currently ongoing. Staff on duty were suspended. ResCare nursing will follow [DC G's] care while at the hospital."</p> <p>-Investigative Summary dated 8/28/14 regarding DC G's 8/24/14 injury of unknown origin indicated a written summary of staff #2's interview. Staff #2's statement indicated, "I went to [DC G's] room and asked her if she could remember having got injured. [DC G] said she fell yesterday in the group home and she did not remember the time." The 8/28/14 Investigative Summary indicated progress notes for DC G were reviewed for 8/24/14 and time and attendance records were reviewed for 8/24/14. The review did not indicate documentation of progress notes for 8/23/14, the date DC G indicated in staff #2's written interview, or identify and interview staff that had worked on 8/23/14. The review did not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>indicate documentation of DC G's day service provider being interviewed to determine if DC G had sustained her injury on 8/23/14 while at her day service provider.</p> <p>RM (Resident Manager) #1 was interviewed on 10/22/14 at 11:05 AM. RM #1 indicated she had assisted with DC G's 8/28/14 Investigative Summary. When asked if DC G had attended her day service provider on 8/23/14, RM #1 stated, "Yes." When asked if DC G's day service provider had been interviewed during the investigation, RM #1 stated, "I think I asked the staff but as far as the actual interview, no." RM #1 indicated DC G had been discharged to a rehabilitation facility since the 8/24/14 injury. RM #1 indicated DC G was currently residing in the rehabilitation facility and was scheduled to return to the group home upon her release.</p> <p>Day Service Manager (DSM) #1 was interviewed on 10/22/14 at 2:00 PM. When asked if the facility had interviewed DSM #1 regarding DC G's 8/24/14 injury of unknown origin, DSM #1 stated "No, they didn't. Nobody said a word about it."</p> <p>3. BDDS report dated 8/26/14 indicated, "[DC H] was attempting to get into the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>purse of a staff member. Another individual in her team, [client F], told her to stop. [Client F] then wheeled his chair (wheelchair) to where she was and shoved [DC H], causing her to fall down on the left side of her body. Staff quickly assisted [DC H] up into a wheelchair. [DC H] began to complain that her left side was hurting. [Day Service Nurse (DSN) #1] was called to check [DC H]. No visible signs of injury were noted. However, [DC H] could not stand up out of the wheelchair with staff assistance. [DC H] complained that her leg was hurting, pointing to her left thigh. [DSN #1] made decision to contact 911 to have [DC H] taken for x-ray and assessment of additional injury."</p> <p>-Follow up BDDS report dated 9/17/14 indicated, "[DC H] is doing very well in recovering from a Femoral Neck Fracture. Surgery was completed with a Canulated Screw Fythnes (sic) put in place so [DC H] will not be in constant pain with the consent of [DC H's] HCR (Health Care Representative). [DC H] is now in [rehabilitation facility] and is doing very well. [DC H] is expected to be discharged between 30-60 days per [rehabilitation facility] staff pending on (sic) [DC H] continuing to show progress with her treatment."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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 undated regarding DC H's 8/26/14 injury did not indicate documentation of other clients or staff in DC H's classroom who may have been potential witnesses or statements from these potential witnesses to the incident. The undated investigation did not indicate documentation of a statement/interview with DC H. The undated investigation did not address why the day services staff member's purse was out/accessible to DC H, why it remained out despite DC H's attempts to get into the purse and any policy or procedures regarding the staff leaving personal items unattended. The undated investigation did not indicate a date of completion or a summary, did not indicate documentation of a summary of information and findings, a description of the incident including where staff was in proximity of client F and DC H, an analysis of the evidence, findings of facts and determinations of if policy was implemented and if DC H's rights were violated.</p> <p>DSS (Day Service Staff) #1 was interviewed on 10/22/14 at 2:40 PM. DSS #1 indicated she had been working in DC H's classroom during the 8/26/14 incident. DSS #1 indicated DC H was standing/walking near the staff member's purse. DSS #1 indicated DC H was not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>wearing a gait belt and was not being assisted while she stood/walked. DSS #1 stated, "[Client F] just reached out and pushed [DC H]. It wasn't even that hard. It looked like she just fell over. I was surprised she fell that way because he really didn't push her that hard. [DC H] is just so frail. [DC H] can barely stand up or walk on her own. We've been asking for an order for a wheelchair for awhile now for her. [DC H] could barely get from the van to the classroom." When asked if she had been instructed/trained by the facility regarding DC H's 4/11/14 recommended use of a gait belt and assistance while walking/standing, DSS #1 stated, "No, she's never had a gait belt here. I didn't know anything about it."</p> <p>DSM #2 was interviewed on 10/22/14 at 2:50 PM. DSM #2 indicated she had completed the 8/26/14 investigation regarding DC H's injury. DSM #2 indicated DSS #1 and DSS #2 were working in the classroom during the incident on 8/26/14. DSM #2 stated, "[DC H] was not stable. We had been asking for a wheelchair for her but they kept saying that they needed a doctor's order for a wheelchair. We couldn't watch her struggle to get from the van to her class so we started using our own wheelchair to get her in and out of the building safely. We were like, why are</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>you bringing her in here like that? She needed a wheelchair or walker." When asked if she had been instructed/trained by the facility regarding DC H's 4/11/14 recommended use of a gait belt and assistance while walking/standing, DSM #2 stated, "No. If they had we would have done training with our staff. We would have needed a risk plan and trained our staff to use the gait belt and assist her."</p> <p>4. IR dated 9/4/14 indicated, "Staff smelled a foul odor coming off of [client A]. Staff checked [client A] and saw a band-aid on her left bicept (sic). Staff removed the band-aid to discover a (sic) open sore that is dime sized, red on the outside and yellowish green on the inside. [Client A] did complaint of pain. Staff washed area with hot soapy water then cleaned with peroxide."</p> <p>-BDDS report dated 9/5/14 indicated on 9/4/14 "[Client A] was still sitting up watching television when the overnight staff arrived on duty. [Staff #3] one of the overnight staff noticed that [client A] had a band-aid on her left bicept (sic). [Staff #3] asked [client A] why she had a band-aid on and [client A] said she had a sore. [Staff #3] removed the band-aid and noticed the sore was red and about half size (sic) in diameter and [client A] said</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>it hurt. [Staff #3] cleaned the area with peroxide and notified the on-call nurse and supervisors of the incident. The nurse instructed the staff to inform the day staff to take [client A] to see (sic) primary care physician or to a med check to have have (sic) the sore checked out."</p> <p>The 9/5/14 BDDS report indicated, "Staff assisted [client A] to med check and [client A] was examined and the findings were [client A] has a skin abscess. Staff were sent home with the instructions for antibiotics and ointments and to follow up with primary care physician in two weeks. An investigation is being conducted into why the incident was not reported and a corrective action will be given according to company policy and procedure for failure to report an injury."</p> <p>-Investigation dated 9/7/14 regarding client A's 9/4/14 injury of unknown origin indicated the following written statements:</p> <p>-Staff #4, "Was not aware that area was a sore at the time that [client A] came to me to receive her morning medications. [Client A] pointed out a red area with a pimple in the middle. I put peroxide on and Bacitracin ointment and covered with (sic) band-aid on 9/4/14 Thursday morning. I worked the evening shift on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>9/4/14 and I showered [client A] and I could not figure out what the odor was I kept smelling on her. So, I checked her depend and found nothing throughout the shift. Night staff arrived on duty and [staff #3] asked what is that smell. I said, I'm trying to figure that out. [Staff #3] asked me have (sic) noticed the sore on [client A's] arm that's green (sic) spot in the middle. I asked her where and then I asked [client A] to take off her jacket and come into the medication room. I took the bandage off and that's when I saw the pimple. It had turned yellow and had a (sic) odor and I said we found the odor. I looked at [staff #3] and said, you knew about this and she said it didn't look like that (sic) way. So, I told her to call the nurse and write a (sic) incident (sic) because you might be at the hospital tonight. That's infected and the nurse has to be notified."</p> <p>-Staff #5, "I had showered [client A] Saturday morning (8/30/14) and the area was red 1/2 in size. Washed and cleaned area with peroxide and antibiotic and covered with a band-aid." Staff #5's written statement indicated, "Did not document anything. Other staff was going to do incident report."</p> <p>Client A's record was reviewed on 10/22/14 at 10:50 AM. Client A's HA</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>(Healthcare Addendum) form dated 5/9/14 indicated, "[Client A] is allergic to... Bacitracin."</p> <p>The investigation did not indicate documentation of a written statement or interview with staff #3. The investigation did not address staff #4's statement regarding the application of Bacitracin to client A's arm and potential allergy to Bacitracin. The investigation indicated, "Staff will immediately report any unusual or abnormal findings to the nurse and supervisors to prevent any future occurrences."</p> <p>5. BDDS report dated 10/15/14 indicated on 10/15/14 at 11:15 AM "[Client B] was seen by the primary care physician due to a knot along the right clavicle. The physician ordered an x-ray to assess for old displaced clavicle or old fracture. [Client B] has lost weight in the past year and this has made this area more noticeable. The results from the x-ray came back as a fracture. The nurse instructed the staff to assist [client B] to the ER for further evaluation and to follow up with an orthopedic specialist per physician."</p> <p>-BDDS report dated 10/21/14 indicated, "Staff went and checked on [client B] during bed checked (sic) and noticed that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>she was crying from pain from her right shoulder that she had fractured. Staff called the nurse and the nurse stated to take her to the ER. Administrative team and doctor were notified. The hospital did x-rays and stated that the fracture that she went to the doctor for on 10/15/14 was not healing and stated that she needs to see the orthopedic doctor and put her in a sling. The doctor ordered pain medication and stated to keep the orthopedic appointment that [client B] already have (sic) on 10/28/14."</p> <p>-Investigative report dated 10/17/14 indicated RM #1 was the assigned investigator and had completed the investigation. The 10/17/14 investigative report indicated client B's injury of unknown origin was discovered by staff on 10/15/14 at 11:15 AM. The 10/17/14 investigative report indicated, "A. General Information. If applicable, dates and times investigator visited the site of the incident. Date 10/15/14. Time: Already on duty." The 10/17/14 investigative report indicated RM #1 was on duty working in the group home at the time of the discovery of client B's fractured clavicle. The investigation did not indicate documentation of RM #1 being interviewed as a potential witness to the origin of client B's injury. The 10/17/14 investigative report did not</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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
W000157	<p>indicate documentation of interviews being conducted with client B's day service staff as potential witnesses to the origin of client B's fractured clavicle.</p> <p>CS #1 (Clinical Supervisor) was interviewed on 10/22/14 at 9:00 AM. CS #1 indicated investigations of allegations of abuse, neglect, mistreatment and injuries of unknown origin should include all potential witnesses to the alleged event or injury. When asked if an investigation should include staff who had worked with a client within 24 hours of an alleged incident or injury, CS #1 stated, "Yes, we generally try to do 24 hours." CS #1 indicated all allegations of abuse, neglect, mistreatment and injuries of unknown origin should be thoroughly investigated.</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 23 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to</p>	W000157	<p>CORRECTION:</p> <p><i>If the alleged violation is verified, appropriate corrective action must</i></p>	11/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>develop and implement corrective actions to prevent reoccurrence regarding client A's picking behavior and client F's mobility.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IRs (Incident Reports) and Investigations were reviewed on 10/23/14 at 11:00 AM. The review indicated the following:</p> <p>1. IR dated 5/9/14 indicated, "[Client F] was getting on the van and slipped and hit his head on the door. [Client F] has a small tear by his right eye. [Client F] went to the ER (Emergency Room) and got 2 stitches."</p> <p>-BDDS report dated 5/10/14 indicated on 5/9/14 "While boarding the van [client F] hit his head on the door of the vehicle and sustained a 1/2 inch laceration beside his right eye. [Staff #1] provided first aid, reported the incident and transported (sic) to the [hospital] ER for evaluation and treatment. ER personnel closed the wound with 2 sutures and released [client F] to ResCare staff with instructions to follow up in seven days to have the stitches removed."</p>		<p><i>be taken. Specifically:</i></p> <p>The QIDP will bring the interdisciplinary team together to review assessment data and develop supports to address Client A's skin picking self-injurious behavior.</p> <p>The QIDP will coordinate with the facility Nurse and Nurse Manager to review Client F's Comprehensive High Risk Plan for mobility and make revisions as appropriate. All staff will be retrained toward proper implementation of Client F's supports to ensure Client F's safety.</p> <p>PREVENTION:</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to falls and discovered injuries to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260		
(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 5/10/14 BDDS report indicated, "Staff will monitor [client F] closely and follow the ER wound care instructions. [Client F] has a high risk plan on (sic) place for limited mobility. The IDT (Interdisciplinary Team) will review the incident to determine if modifications to the plan are indicated. ResCare nursing will monitor the healing process of [client F's] wound."</p> <p>-IR dated 6/4/14 indicated, "At about 5:10 PM, [Client F] was getting out from shower (sic) to sit in his wheelchair. [Client F] hits (sic) his arm against counter top (sic) in the bathroom. Causing (sic) two reddish spots and two light tears on his left lower arm."</p> <p>Client F's record was reviewed on 10/22/14 at 10:45 AM. Client F's PCPP (Person Centered Planning Profile) form dated 10/1/14 indicated, "[Client F] uses a wheelchair at all times." Client F's mobility CHRHP dated 7/23/13 indicated, "4. Staff to provide hands-on assistance when entering and exiting the van. 5. Staff to provide standby assistance during in home ambulation exercises. 6. Staff to provide at least standby assistance during showering/bathing." Client F's record did not indicate documentation of IDT review of client F's 5/9/14 or 6/4/14</p>		<p>will meet weekly with the QIDP to review incidents which require interdisciplinary team action.</p> <p>The Residential Manager will be expected to observe no less than one morning and one evening active treatment session per week and the Team Leader will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will 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 safety protocols. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 60 days, providing hands-on coaching and training as needed. After two months, The Operations team and QIDP will observe active treatment sessions no less than every two weeks for an additional 30 days. After 90 days, the Operations Team will review incident data and observational assessments to determine the need for ongoing oversight, with the goal of scaling back the administrative presence in the home to no less than monthly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>injury.</p> <p>2. IR dated 9/4/14 indicated, "Staff smelled a foul odor coming off of [client A]. Staff checked [client A] and saw a band-aid on her left bicept (sic). Staff removed the band-aid to discover a (sic) open sore that is dime sized, red on the outside and yellowish green on the inside. [Client A] did complain of pain. Staff washed area with hot soapy water then cleaned with peroxide."</p> <p>-BDDS report dated 9/5/14 indicated on 9/4/14 "[Client A] was still sitting up watching television when the overnight staff arrived on duty. [Staff #3] one of the overnight staff noticed that [client A] had a band-aid on her left bicept. [Staff #3] asked [client A] why she had a band-aid on and [client A] said she had a sore. [Staff #3] removed the band-aid and noticed the sore was red and about half size (sic) in diameter and [client A] said it hurt. [Staff #3] cleaned the area with peroxide and notified the on-call nurse and supervisors of the incident. The nurse instructed the staff to inform the day staff to take [client A] to see (sic) primary care physician or to a med check to have have (sic) the sore checked out."</p> <p>The 9/5/14 BDDS report indicated, "Staff assisted [client A] to med check and</p>		<p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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 A] was examined and the findings were [client A] has a skin abscess. Staff were sent home with the instructions for antibiotics and ointments and to follow up with primary care physician in two weeks. An investigation is being conducted into why the incident was not reported and a corrective action will be given according to company policy and procedure for failure to report an injury."</p> <p>-Investigation dated 9/7/14 regarding client A's 9/4/14 injury of unknown origin indicated the following written statements:</p> <p>-Staff #4, "Was not aware that area was a sore at the time that [client A] came to me to receive her morning medications. [Client A] pointed out a red area with a pimple in the middle. I put peroxide on and Bacitracin ointment and covered with (sic) band-aid on 9/4/14 Thursday morning. I worked the evening shift on 9/4/14 and I showered [client A] and I could not figure out what the odor was I kept smelling on her. So, I checked her depend and found nothing throughout the shift. Night staff arrived on duty and [staff #3] asked what is that smell. I said, I'm trying to figure that out. [Staff #3] asked me have (sic) noticed the sore on [client A's] arm that's green (sic) spot in the middle. I asked her where and then I</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>asked [client A] to take off her jacket and come into the medication room. I took the bandage off and that's when I saw the pimple. It had turned yellow and had a (sic) odor and I said we found the odor. I looked at [staff #3] and said, you knew about this and she said it didn't look like that (sic) way. So, I told her to call the nurse and write a (sic) incident (sic) because you might be at the hospital tonight. That's infected and the nurse has to be notified."</p> <p>-Staff #5, "I had showered [client A] Saturday morning (8/30/14) and the area was red 1/2 in size. Washed and cleaned area with peroxide and antibiotic and covered with a band-aid." Staff #5's written statement indicated, " Did not document anything. Other staff was going to do incident report."</p> <p>The investigation did not indicate documentation of recommendations to address client A's picking behaviors to prevent reoccurrence.</p> <p>-BDDS report dated 9/12/14 indicated, "[Staff #4] was giving [client A] her morning medication when she noticed a half inch scratch in diameter (sic) going across a small bruise in the are of a previous wound which occurred a week ago. The nurse and supervisors were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>notified of this incident. Staff spoke with [client A] on how this scratch and bruise could have occurred and [client A] said she had scratched herself. [Client A] is known for picking sores and it is documented in her BSP (Behavior Support Plan). Staff will continue to follow [client A's] BSP and monitor [client A] more closely."</p> <p>-IR dated 9/14/14 indicated, "While changing [client A's] dressing, staff noticed additional bruising to her left arm on the inside where the tape from the abscess coverage lay (sic)."</p> <p>Client A's record was reviewed on 10/22/14 at 10:50 AM. Client A's HA (Healthcare Addendum) form dated 5/9/14 indicated, "[Client A] is allergic to... Bacitracin." Client A's BSP dated 5/9/14 indicated, "Updated 9/5/14." Client A's BSP indicated skin picking, picking scabs or sores was a targeted behavior. Client A's BSP indicated staff should "Observe [client A] for wounds and any unusual/abnormal findings especially during bathing. Document any discovered wounds, abnormal findings open sore or scabs. Complete an Accident/Incident report. Notify nurse, QIDP (Qualified Intellectual Disability Professional) and others in (sic) discovered injuries procedures. Return to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>training toward replacement behavior by teaching [client A] to inform staff when he skin itches or is bothering her." Client A's record did not indicate IDT assessment or recommendations regarding further supports to prevent client A's picking or SIB (Self- Injurious Behavior).</p> <p>RM #1 (Resident Manager) was interviewed on 10/22/14 at 11:05 AM. RM #1 indicated there was not additional documentation of IDTs regarding client A's picking or SIBs. RM #1 indicated client A's BSP had been updated to include reporting client A's injuries.</p> <p>CS #1 (Clinical Supervisor) was interviewed on 10/22/14 at 9:00 AM. CS #1 indicated corrective action to prevent reoccurrence of abuse, neglect or mistreatment should be developed from the IDT or from a peer review process.</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260		
(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>a qualified mental retardation professional. Based on record review and interview for 1 of 3 sampled clients (A), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure client A's BSP (Behavior Support Plan) included specific measures to address client A's skin picking/SIB (Self-Injurious Behavior).</p> <p>Findings include:</p> <p>The QIDP failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure client A's BSP included specific measures to address client A's skin picking/SIB. Please see W240.</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-3(a)</p>	W000159	<p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, the QIDP will bring the interdisciplinary team together to review assessment data and develop supports to address Client A's skin picking self-injurious behavior.</i></p> <p>PREVENTION:</p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment and interdisciplinary input. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing developmental and behavioral needs. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 60 days, comparing observed behaviors and needs with current support documents and making recommendations for revisions as</p>	11/23/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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
W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's BSP (Behavior Support Plan) included specific measures to address client A's skin picking/SIB (Self-Injurious Behavior).</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services)</p>	W000240	<p>appropriate. After two months, The Operations team and QIDP will observe active treatment sessions no less than every two weeks for an additional 30 days. After 90 days, the Operations Team will review incident data and observational assessments to determine the need for ongoing oversight, with the goal of scaling back the administrative presence in the home to no less than monthly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The individual program plan must describe relevant interventions to support the individual toward independence. Specifically, the QIDP will bring the interdisciplinary team together to review assessment data and develop supports to address Client A's skin picking self-injurious behavior. A review of incident documentation and</i></p>	11/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>reports, IRs (Incident Reports) and Investigations were reviewed on 10/23/14 at 11:00 AM. The review indicated the following:</p> <p>IR dated 9/4/14 indicated, "Staff smelled a foul odor coming off of [client A]. Staff checked [client A] and saw a band-aid on her left bicept (sic). Staff removed the band-aid to discover a (sic) open sore that is dime sized, red on the outside and yellowish green on the inside. [Client A] did complain of pain. Staff washed area with hot soapy water then cleaned with peroxide."</p> <p>-BDDS report dated 9/5/14 indicated on 9/4/14 "[Client A] was still sitting up watching television when the overnight staff arrived on duty. [Staff #3] one of the overnight staff noticed that [client A] had a band-aid on her left bicept (sic). [Staff #3] asked [client A] why she had a band-aid on and [client A] said she had a sore. [Staff #3] removed the band-aid and noticed the sore was red and about half size (sic) in diameter and [client A] said it hurt. [Staff #3] cleaned the area with peroxide and notified the on-call nurse and supervisors of the incident. The nurse instructed the staff to inform the day staff to take [client A] to see (sic) primary care physician or to a med check to have have (sic) the sore checked out."</p>		<p>current behavior support plans indicated that this deficient practice did not affect additional clients.</p> <p>PREVENTION:</p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment and interdisciplinary input. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring, including but not limited to assessing developmental and behavioral needs. Additionally, members of the Operations Team and the QIDP will conduct active treatment observations on a weekly basis for the next 60 days, comparing observed behaviors and needs with current support documents and making recommendations for revisions as appropriate. After two months, The Operations team and QIDP will observe active treatment sessions no less than every two weeks for an additional 30 days. After 90 days, the Operations Team will review incident data and observational assessments to determine the need for ongoing oversight, with the goal of scaling back the administrative presence</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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 9/5/14 BDDS report indicated, "Staff assisted [client A] to med check and [client A] was examined and the findings were [client A] has a skin abscess. Staff were sent home with the instructions for antibiotics and ointments and to follow up with primary care physician in two weeks. An investigation is being conducted into why the incident was not reported and a corrective action will be given according to company policy and procedure for failure to report an injury."</p> <p>-Investigation dated 9/7/14 regarding client A's 9/4/14 injury of unknown origin did not indicate documentation of recommendations to address client A's picking behaviors to prevent reoccurrence.</p> <p>-BDDS report dated 9/12/14 indicated, "[Staff #4] was giving [client A] her morning medication when she noticed a half inch scratch in diameter (sic) going across a small bruise in the area of a previous wound which occurred a week ago. The nurse and supervisors were notified of this incident. Staff spoke with [client A] on how this scratch and bruise could have occurred and [client A] said she had scratched herself. [Client A] is known for picking sores and it is documented in her BSP (Behavior</p>		<p>in the home to no less than monthly.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>Support Plan). Staff will continue to follow [client A's] BSP and monitor [client A] more closely."</p> <p>-IR dated 9/14/14 indicated, "While changing [client A's] dressing, staff noticed additional bruising to her left arm on the inside where the tape from the abscess coverage lay (sic)."</p> <p>Client A's record was reviewed on 10/22/14 at 10:50 AM. Client A's HA (Healthcare Addendum) form dated 5/9/14 indicated, "[Client A] is allergic to... Bacitracin." Client A's BSP dated 5/9/14 indicated, "Updated 9/5/14." Client A's BSP indicated skin picking, picking scabs or sores was a targeted behavior. Client A's BSP indicated staff should "Observe [client A] for wounds and any unusual/abnormal findings especially during bathing. Document any discovered wounds, abnormal findings open sore or scabs. Complete an Accident/Incident report. Notify nurse, QIDP (Qualified Intellectual Disability Professional) and others in (sic) discovered injuries procedures. Return to training toward replacement behavior by teaching [client A] to inform staff when he skin itches or is bothering her." Client A's record did not indicate IDT assessment or recommendations regarding further supports to prevent</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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
W000331	<p>client A's picking or SIB (Self- Injurious Behavior). Client A's BSP did not indicate how staff were specifically to supervise or intervene to prevent client A's picking behaviors.</p> <p>RM #1 (Resident Manager) was interviewed on 10/22/14 at 11:05 AM. RM #1 indicated there was not additional documentation of IDTs regarding client A's picking or SIBs. RM #1 indicated client A's BSP had been updated to include reporting client A's injuries.</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 additional client (DC (Discharged Client H), the facility nursing services failed to meet the health needs of DC H.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IRs (Incident Reports) and</p>	W000331	<p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically: A new nurse was hired and assigned to the facility after the incident in which Discharged Client H sustained a femoral neck fracture. The nurse will be trained on the need to</i></p>	11/23/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>Investigations were reviewed on 10/23/14 at 11:00 AM. The review indicated the following:</p> <p>-BDDS report dated 8/26/14 indicated, "[DC H] was attempting to get into the purse of a staff member. Another individual in her team, [client F], told her to stop. [Client F] then wheeled his chair (wheelchair) to where she was and shoved [DC H], causing her to fall down on the left side of her body. Staff quickly assisted [DC H] up into a wheelchair. [DC H] began to complain that her left side was hurting. [Day Service Nurse (DSN) #1] was called to check [DC H]. No visible signs of injury were noted. However, [DC H] could not stand up out of the wheelchair with staff assistance. [DC H] complained that her leg was hurting, pointing to her left thigh. [DSN #1] made decision to contact 911 to have [DC H] taken for x-ray and assessment of additional injury."</p> <p>-Follow up BDDS report dated 9/17/14 indicated, "[DC H] is doing very well in recovering from a Femoral Neck Fracture. Surgery was completed with a Canulated Screw Fythnes (sic) put in place so [DC H] will not be in constant pain with the consent of [DC H's] HCR (Health Care Representative). [DC H] is now in [rehabilitation facility] and is</p>		<p>include all pertinent recommendations from applicable medical disciplines when developing Comprehensive High Risk Plans. A review of incident documentation and current risk plans indicated that this deficient practice did not affect additional clients.</p> <p>PREVENTION:</p> <p>The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. Additionally, Operations Team members will review physician and other specialist recommendations, comparing them to current risk plans to assure appropriate supports are in place no less than monthly. Once nursing care and high risk plans are developed and/or updated, the QIDP and nursing staff will assure that facility and outside service staff are trained on the components of the plan. Supervisory and administrative staff will review support documents and training documentation at day service facilities as part of a monthly review process.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260			
(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>doing very well. [DC H] is expected to be discharged between 30-60 days per [rehabilitation facility] staff pending on (sic) [DC H] continuing to show progress with her treatment."</p> <p>DC H's record was reviewed on 10/22/14 at 9:30 AM. DC H's ROV (Record of Visit) form dated 4/11/14 indicated, "[DC H] needs a gait belt and assist of one to walk." DC H's record did not indicate documentation of IDT review of the 4/11/14 recommendations. DC H's record did not indicate documentation of CHRHP (Comprehensive High Risk Health Plan) being developed to address DC H's recommendations and mobility needs.</p> <p>DSS (Day Service Staff) #1 was interviewed on 10/22/14 at 2:40 PM. DSS #1 indicated she had been working in DC H's classroom during the 8/26/14 incident. DSS #1 indicated DC H was standing/walking near the staff member's purse. DSS #1 indicated DC H was not wearing a gait belt and was not being assisted while she stood/walked. DSS #1 stated, "[Client F] just reached out and pushed [DC H]. It wasn't even that hard. It looked like she just fell over. I was surprised she fell that way because he really didn't push her that hard. [DC H] is just so frail. [DC H] can barely stand up</p>		<p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Health Services Team Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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 walk on her own. We've been asking for an order for a wheelchair for awhile now for her. [DC H] could barely get from the van to the classroom." When asked if she had been instructed/trained by the facility regarding DC H's 4/11/14 recommended use of a gait belt and assistance while walking/standing, DSS #1 stated, "No, she's never had a gait belt here. I didn't know anything about it."</p> <p>DSM #2 was interviewed on 10/22/14 at 2:50 PM. DSM #2 indicated she had completed the 8/26/14 investigation regarding DC H's injury. DSM #2 indicated DSS #1 and DSS #2 were working in the classroom during the incident on 8/26/14. DSM #2 stated, "[DC H] was not stable. We had been asking for a wheelchair for her but they kept saying that they needed a doctor's order for a wheelchair. We couldn't watch her struggle to get from the van to her class so we started using our own wheelchair to get her in and out of the building safely. We were like, why are you bringing her in here like that? She needed a wheelchair or walker." When asked if she had been instructed/trained by the facility regarding DC H's 4/11/14 recommended use of a gait belt and assistance while walking/standing, DSM #2 stated, "No. If they had we would have done training with our staff. We</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
--	---

(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>would have needed a risk plan and trained our staff to use the gait belt and assist her."</p> <p>DON (Director of Nursing) #1 was interviewed on 10/22/14 at 11:15 AM. DON #1 indicated DC H's 4/11/14 recommendation for a gait belt and staff assistance should be included in a CHRHP to address her mobility needs. DON #1 indicated she would research the issue and provide additional documentation of nursing supports regarding DC H.</p> <p>DON #1 did not provide additional documentation of nursing services regarding DC H's mobility.</p> <p>This federal tag relates to complaint #IN00155415.</p> <p>9-3-6(a)</p>			