

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 02/18/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN 46260
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 2/11/14, 2/12/14, 2/13/14, 2/17/14 and 2/18/14.</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 2/24/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 12 allegations of abuse, neglect, mistreatment and exploitation reviewed, the facility failed to implement its policy and procedures to immediately notify the BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of neglect for clients #1 and #6.</p>	W000149	CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically facility direct support staff have been retrained on the need to submit incident reports to the Program Manager and Clinical Supervisor via electronic fax upon completion in order to facilitate proper reporting to the Bureau of	03/20/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Findings include:</p> <p>The facility's BDDS reports and investigations were reviewed on 2/11/14 at 4:32 PM. The review indicated the following:</p> <p>-BDDS reports for clients #1 and #6 dated 10/17/13 indicated on 10/15/13, "[Client #1] and [client #6] were sitting in the group home unattended when the RM (Residential Manager) returned to the group home. [Staff #1], the staff who was working the morning shift, had clocked out a minute before the residential manager entered the group home. [Client #1] and [client #6] are under twenty four hour supervision."</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/13/14 at 10:44 AM. CS #1 indicated all allegations of abuse, neglect, mistreatment and exploitation should be reported to BDDS within 24 hours of the facility's knowledge of the incident. CS #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>The facility's policy and procedures were reviewed on 2/17/14 at 8:32 AM. The facility's 2/26/11 policy and procedure entitled, "Abuse, Neglect, Exploitation...</p>		<p>Developmental Disability Services per state law. There have been no additional late reports since the incident on 10/15/13. PREVENTION:Supervisory staff will review all facility documentation to assure incidents are reported as required. 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. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Operations Team</p>		

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W000153	<p>Mistreatment" indicated, "(5.) Following Adept protocol for the exact process to report incidents, once the suspicion has been reported to the supervisor and/or PD (Program Director), the PD will report, within 24 hours, the suspected abuse, neglect or exploitation as follows: ... (g.)To the BDDS...."</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 2 of 12 allegations of abuse, neglect, mistreatment and exploitation reviewed, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of neglect for clients #1 and #6.</p> <p>Findings include: The facility's BDDS reports and investigations were reviewed on 2/11/14 at 4:32 PM. The review indicated the following: -BDDS reports for clients #1 and #6</p>	W000153	<p>CORRECTION: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 facility direct support staff have been retrained on the need to submit incident reports to the Program Manager and Clinical Supervisor via electronic fax upon completion in order to facilitate proper reporting to the Bureau of Developmental Disability Services per state law. There have been no additional late reports since the incident on 10/15/13. PREVENTION:Supervi</p>	03/20/2014			

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W000322	<p>dated 10/17/13 indicated on 10/15/13, "[Client #1] and [client #6] were sitting in the group home unattended when the RM (Residential Manager) returned to the group home. [Staff #1], the staff who was working the morning shift, had clocked out a minute before the residential manager entered the group home. [Client #1] and [client #6] are under twenty four hour supervision."</p> <p>CS (Clinical Supervisor) #1 was interviewed on 2/13/14 at 10:44 AM. CS #1 indicated all allegations of abuse, neglect, mistreatment and exploitation should be reported to BDDS within 24 hours of the facility's knowledge of the incident.</p> <p>9-3-1(b)(5) 9-3-2(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1 had an annual physical examination.</p> <p>Findings include: Client #1's record was reviewed on</p>	W000322	<p>sory staff will review all facility documentation to assure incidents are reported as required. 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. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Operations Team</p> <p>CORRECTION:The facility must provide or obtain preventive and general medical care. Specifically, Client #1 will receive an annual physical examination. PREVENTION:The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not</p>	03/20/2014	

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W000327	<p>2/12/14 at 9:40 AM. Client #1's record indicated client #1's most recent Annual Physical (AP) was completed on 1/29/13.</p> <p>Nurse Manager (NM) #1 was interviewed on 2/13/14 at 10:40 AM. NM #1 indicated client #1 should have an annual physical assessment completed yearly. NM #1 indicated there was not additional documentation regarding client #1's annual physical examination.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4), the facility failed to ensure an annual/yearly TB (Tuberculosis) testing, x-ray or symptom screening checklist was completed for clients #1, #3 and #4.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on</p>	W000327	<p>limited to annual physical examinations, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure appropriate medical follow-up takes place as required. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION: The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics,</p>	03/20/2014			

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W000331	<p>2/12/14 at 9:40 AM. Client #1's record indicated client #1's most recent annual TB testing/screening was completed on 11/13/12.</p> <p>2. Client #3's record was reviewed on 2/12/14 at 12:00 PM. Client #3's record indicated client #3's most recent annual TB testing/screening was completed on 11/13/12.</p> <p>3. Client #4's record was reviewed on 2/13/14 at 12:30 PM. Client #4's record indicated client #4's most recent annual TB testing/screening was completed on 11/13/12.</p> <p>Nurse Manager (NM) #1 was interviewed on 2/13/14 at 10:40 AM. NM #1 indicated clients #1, #3 and #4 should have an annual TB testing or screening completed yearly. NM #1 indicated there was not additional documentation regarding clients #1, #3 and #4's annual TB testing/screening.</p> <p>9-3-6(a) 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 4 of 4 sampled clients (#1, #2, #3 and #4), the facility nursing services</p>	W000331	<p>or both. Specifically, current tuberculosis screen tests will be conducted with Clients #1, #3 and #4. PREVENTION: The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to tuberculosis testing, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure appropriate medical follow-up takes place as required. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> <p>CORRECTION: The facility must provide clients with nursing services in accordance with their needs. Specifically, a new nurse</p>	03/20/2014			

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	<p>failed to ensure client #1's laboratory orders were followed, clients #2 and #4's dental recommendations were addressed and client #3's visual care recommendations were addressed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client #1's record was reviewed on 2/12/14 at 9:40 AM. Client #1's Physician's Orders Form (POF) dated 2/3/14 indicated, "Laboratory Orders: CMP (Comprehensive Metabolic Panel) every 3 months and Trileptal level every 3 months." Client #1's record indicated client #1's CMP and Trileptal levels had been tested on 5/29/13. Client #1's record did not indicate documentation of additional CMP and/or Trileptal levels for client #1 since 5/29/13. Client #2's record was reviewed on 2/12/13 at 11:14 AM. Client #2's Dental Summary Progress note dated 10/2/13 indicated, "[Client #2] needs scaling and root plan (unknown). We need to speak to someone (to schedule follow up). Please phone our office." Client #2's record did not indicate documentation of additional dental follow up services or communication with the dental office regarding the 10/2/13 recommendations. Client #3's record was reviewed on 		<p>has been assigned to the facility. The nurse has been trained to assure that: Client #1 receives a current Trileptal level and that moving forward, all labs will be obtained as ordered. Client #2 will receive currently recommended dental scaling and cleaning and Client #4 will receive a current dental evaluation. Additionally, future required dental follow-up will occur as directed. Client #3 will receive a recommended visual evaluation and the nurse will assure that future visual care occurs as directed. PREVENTION: The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments and testing, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure appropriate medical follow-up takes place as required. Additionally, the Nurse Manager has developed a data base to track facility medical appointments and lab testing and will provide nursing and facility staff with coaching and follow-up to assure that appointments and lab work occur as directed. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p>	

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	<p>2/12/14 at 12:00 PM. Client #3's Visual Care progress report dated 9/20/11 indicated client #3 return for a one year/annual follow up. Client #3's record did not indicate documentation of additional visual care follow up services.</p> <p>4. Client #4's record was reviewed on 2/13/14 at 12:30 PM. Client #4's Dental Summary Progress note dated 9/26/11 indicated the recommendation for client #4 to return every 6 months for follow up services. Client #4's record did not indicate additional documentation of dental services since 9/26/11.</p> <p>Nurse Manager (NM) #1 was interviewed on 2/13/14 at 10:40 AM. NM #1 indicated client #1's CMP and Trileptal levels should be tested every 3 months as ordered. NM #1 indicated there was no additional documentation regarding client #1's CMP and Trileptal testing. NM #1 indicated client #2's dental recommendations had not been addressed. NM #1 indicated there was not additional documenting of client #3 receiving visual care services since 9/20/11. NM #1 indicated client #4's dental recommendations for 6 month cleanings and examinations had not been implemented since the 9/26/11 dental visit.</p>				

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W000336	<p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility's nursing services failed to conduct quarterly nursing assessments of clients' health status and medical needs for clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client #1's record was reviewed on 2/12/14 at 9:40 AM. Client #1's POF (Physician's Orders Form) dated 2/3/14 indicated client #1's diagnoses included but were not limited to dementia, urinary incontinence, right side hemiparesis and gait abnormality. Client #1's QNA (Quarterly Nursing Assessment) form for the year 2013 did not indicate documentation of a quarterly or 3 month nursing physical assessment of client #1's health status and medical needs from 1/1/13 through 5/27/13. Client #2's record was reviewed on 2/12/14 at 11:14 AM. Client #2's POF 	W000336	<p>CORRECTION:Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Specifically, the facility has a new nurse that has been trained on expectations for quarterly nursing physicals and nursing physicals for the current quarter. PREVENTION:Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Additionally, Administrative Team members will review nursing documentation while conducting routine audits in the home, no less than monthly, to assure records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse manager to facilitate</p>	03/20/2014			

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	<p>dated 2/3/14 indicated client #2's diagnoses included but were not limited to moderate intellectual disability, hypertension, PTSD (Post Traumatic Stress Disorder), depression, endometriosis and anemia. Client #2's QNA form for the year 2013 did not indicate documentation of a quarterly or 3 month nursing physical assessment of client #2's health status and medical needs from 1/1/13 through 5/27/13.</p> <p>3. Client #3's record was reviewed on 2/12/14 at 12:00 PM. Client #3's POF dated 2/3/14 indicated client #3's diagnoses included but were not limited to moderate mental retardation, hypertension, seizure disorder, menopause, hypothyroidism, hiatal hernia, arthritis, chronic obstructive pulmonary disease, cardiac murmur, psychosis, ataxia, hearing loss, mood disorder, bipolar disorder, anemia and hypertension. Client #3's QNA form for the year 2013 did not indicate documentation of a quarterly or 3 month nursing physical assessment of client #3's health status and medical needs from 1/1/13 through 9/30/13.</p> <p>4. Client #4's record was reviewed on 2/13/14 at 12:30 PM. Client #4's POF dated 2/3/14 indicated client #4's diagnoses included but were not limited</p>		appropriate follow-up. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team				

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W000382	<p>to severe intellectual disabilities, deaf, mute, behavior disorder, overweight, polydipsia, severe gingivitis, constipation and depression. Client #4's QNA form for the year 2013 did not indicate documentation of a quarterly or 3 month nursing physical assessment of client #4's health status and medical needs from 1/1/13 through 4/1/13 and from 9/1/13 through 12/31/13.</p> <p>Nurse Manager (NM) #1 was interviewed on 2/13/14 at 10:40 AM. NM #1 indicated nursing physical assessments of clients' health status and medical needs should be conducted on a quarterly basis. NM #1 indicated there were no additional nursing physical assessments available for review regarding clients #1, #2, #3 and #4.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to maintain the clients' medication in a secure location.</p>	W000382	<p>CORRECTION: The facility must keep all drugs and biologicals locked except when being prepared for administration. All staff have been retrained regarding the need to keep medication secure at all times. PREVENTION: The QIDP will be expected to perform active</p>	03/20/2014

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	<p>Findings include:</p> <p>Observations were conducted at the group home on 2/11/14 from 6:00 PM through 7:15 PM. At 6:15 PM, staff #2 utilized a set of keys to unlock and open the group home's medication administration room, which contained clients #1, #2, #3, #4, #5, #6, #7 and #8's medications. At 6:15 PM, staff #2 exited the medication administration room and left the medication room door keys in the door lock. The medication room door had the keys left in the door lock. The group home's medication administration room door was located in the living room area. Staff #2 exited the medication administration room area/living room. Clients #2, #3 and #5 were seated in the living room area with the medication room door unsecured. At 6:31 PM, RM (Residential Manager) #1 approached the medication administration room and removed the medication room keys from the door.</p> <p>RM (Residential Manager) #1 was interviewed on 2/11/14 at 6:31 PM. When asked if the keys to the door were left in the door, RM #1 stated, "Yes, they are where they aren't supposed to be." RM #1 indicated the medication room door should be secured unless staff is administering medications.</p>		<p>treatment observations at the facility an needed but no less than one morning and one evening per week and the Residential Manager 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 monitor the medication administration room to assure medications and biologicals are secured properly, providing coaching and corrective action as needed. Members of the Operations Team will maintain an increased presence at the facility, performing unscheduled observation of active treatment no less weekly for the next 30 days, no less than three times weekly for an additional 30 days and no less than bi-monthly for an additional 30 days to assure that medications are secured properly. After two months the administrative team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
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	9-3-6(a)			