PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE C A. BUILDING B. WING	00		TE SURVEY MPLETED 23/2012		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZI SAN RICARDO DR	P CODE			
COMMU	INITY ALTERNATI\	/ES-ADEPT	INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
W0000	This visit was for complaint #INO Complaint #INO Federal/state de allegation are ci W189, W418 ar Dates of Survey 5/23/12 Facility Number Provider Number Aim Number: 1 Surveyors: Paula Chika, Mel	or the investigation of 0107741. 00107741-Substantiated, ficiencies related to the ted at W104, W149, ad W434. 1. 5/14, 5/15, 5/17 and 1. 001000 1. or: 15G486 1.00245010 1. dedical Surveyor III-Team 1. dedical Surveyor III	W0000	Director		DATE		
	findings in acco Quality Review	ies also reflect state rdance with 460 IAC 9. completed 6/1/12 by Ruth edical Surveyor III.						

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED	
		15G486	B. WIN			05/23/2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				AN RICARDO DR		
COMMUI	NITY ALTERNATIV	ES-ADEPT	INDIANAPOLIS, IN 46256				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	PLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	П	OATE
W0104	policy, budget, a	ODY ody must exercise general nd operating direction over					
	the facility.					0.516	
		ation, interview and	W0	104	CORRECTION: The Governing	g = 06/2	22/2012
	record review for	r 4 of 4 sampled clients			body must exercise general policy, budget and operating		
	(A, B, C and D)	and for 4 additional			direction over the facility.		
	clients (E, F, G a	nd H), the facility's			Specifically, the agency's		
	governing body f	failed to exercise general			contracted pest control provide	er	
		tion direction over the			has returned to and retreated to	he	
	facility to ensure				residence to assure the		
	1	in a sanitary condition			elimination of bedbugs. facility		
	and to ensure the	•			professional and direct suppor will be retrained regarding pro		
		nented its policy and			implementation of the agency's		
	•	gard to bed bugs to			Bedbug infestation policy and		
					need to maintain a sanitary		
	1	restations which could			environment. PREVENTION:		
	cause harm to the	e clients.			The facility will conduct physic		
					environment safety inspections the home as needed but no les		
	Findings include	:			than monthly to assure a sanit	· -	
					and vermin-free training		
	1. During the 5/	14/12 observation period			environment is maintained. Th		
	between 5:45 PM	I and 7:10 PM, at the			Governing Body has establish	ed	
	group home, clie	nt B had a dead bed bug			a separate Quality Assurance		
	in his bed on his	sheet near the foot of the			Department to assist with audi facility systems and developing	~	
	bed. Client B ha	d a captain bed and one			sound risk management	1	
		s seen in the drawer			practices. Members of the		
	1	th client B's bed. Client			Operations and Quality		
		nmate, had two dead bed			Assurance Teams will periodic	-	
					perform inspections of the faci	-	
	bugs around a bed post located at the foot of client G's bed. Dead bed bugs were also seen at the entrance way in the hallway of the group home (near the base				on an ongoing basis to assure sanitary environment is	a	
					maintained. RESPONSIBLE		
					PARTIES: QDDPD, Home		
					Manager, Support Associates,		
		od floors) where client			Quality Assurance Team,		
	A, B, C and G's l	pedrooms were located.			Operations Team		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G486	B. WIN			05/23/	ZU 1Z
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY ALTERNATIV	ES-ADEPT			AN RICARDO DR APOLIS, IN 46256		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	DROWIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	In the bathroom	located in the hallway,					
	there was a throv	v rug located in the					
	middle of the flo	or. The throw rug was					
	1 -	had several (three plus)					
	dead bed bug car	casses on the throw rug					
	located in front of	of the toilet and the tub.					
	During the above	e mentioned observation					
	period, clients A	, B, C and E did not have					
	plastic coverings	on their mattresses					
	which zipped. C	lients A, B, C and E had					
	mesh like mattre	ss covers on their bed					
	which were made	e out of cloth not plastic.					
	There were dead	termites scattered on the					
	floor of the kitch	en by a kitchen window					
	and on the windo	ow sill. There were dead					
	flies on client B	and G's bedroom window					
	sill. In client D a	and E's bath room located					
	in their bedroom	, there were 4 light bulbs					
	which did not wo	ork in the light fixtures					
	over the bathroon	n sink. The floor in the					
	bathroom also ha	d not been swept as dead					
	roly poly worms	were on the floor with					
	other debris. The	e group home's kitchen					
	floor had food pa	articles on it near the					
	cracks/baseboard	ls of the floor which had					
	not been swept u	p and/or mopped. The					
	cabinets where th	ne pots and pans were					
	kept, had food dr	oppings and dirt at the					
	bottom of the cal	oinet. The 2 leather type					
	couches in the liv	ving room were worn and					
	discolored. The brown couch had turned						
	to yellow in different spots on the couch.						
	At 6:25 PM in cl	ient A and C's bedroom,					
	a urine smell/odo	or was detected upon					
	l						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	TE SURVEY MPLETED 23/2012	
NAME OF PROVIDER				7919 SA	ADDRESS, CITY, STATE, ZI AN RICARDO DR APOLIS, IN 46256	P CODE	
` `	ACH DEFICIEN	FATEMENT OF DEFICIE CY MUST BE PERCEDEI LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
floor	•	n. The clients' becand smelled of uring the floor.					
PM in bedro stated time a Interv PM in recent week Interv PM in and m	ndicated the som on a replace of the had cle ago. I do not with a cle ago. I do not with a cle and mopped with a cle and mopped dail to home had	ient D on 5/14/12 client did not clear gular basis. Client aned his room "a lot clean that often. ient E on 5/14/12 group home had a vacuum cleaner. eaned his bedroomd the floor. ient A on 5/14/12 ckitchen was to be y. Client A indicate a working vacuum	an his t D tong " at 6:06 Client n every at 6:25 e swept ated the				
indica smelle indica floor a indica mopp kitche swept indica	ed of urine ated client (and in his cated the floor was and mopport and mopport and clients)	aff #3 at 6:50 PM and C's bedroom due to client C. So would urinate or loset on clothes. So was to swept an taff #3 indicated to also supposed to ed daily. Staff #3 did chores and the id cleaning at night	taff #3 taff #3 the Staff #3 d he be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Interview with st PM indicated the bed bugs on 5/12 the kitchen floor When asked where last cleaned sure cleaned where last cleaned Des 5/15/12 at 3:26 F home had an inference had been treated by an exterminat QDDP-D indicate completed on 5/1 indicated facility cleaned up the dowere in the house indicated the rug have been remove and washed. The client C would us his bedroom. The client's bedroom cleaned/mopped indicated the light replaced in client Administrative staff should be clone a daily basis.	aff #2 on 5/14/12 at 7:00 facility was sprayed for full was mopped every night. In the kitchen cabinets fl. staff #2 stated "Not en I worked." dministrative staff #3 and welopmental ignee (QDDP-D) on full indicated the group estation of bed bugs and with 3 rounds of spray ing company. The ed the last spray was full full fl. fl. fl. fl. fl. fl. fl. fl. ed the last spray was full fl. fl. fl. fl. fl. fl. fl. fl. fl. f						

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		DENTIFICATION NUMBER: 15G486	A. BUILDING B. WING	00 	COMPLETED 05/23/2012			
	PROVIDER OR SUPPLIER	S-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	direction over the facility implemen procedures to prevegard to bed bug. E, F, G and H. Pl	vent neglect of clients in s for clients A, B, C, D,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G486	B. WING		05/23/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		AN RICARDO DR	
COMMU	NITY ALTERNATIV	/ES-ADEPT	INDIAN		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0149	The facility mus written policies	MENT OF CLIENTS t develop and implement and procedures that prohibit eglect or abuse of the client.			
	Based on observ	vation, interview and	W0149	CORRECTION: The facility me	ust 06/22/2012
		or 4 of 4 sampled clients		develop and implement writter	1
		and for 4 additional		policies and procedures that	
		and H), the facility failed		prohibit mistreatment, neglect abuse of the client. Specificall	
	` ' '	s policy and procedures to		the agency's contracted pest	у,
	_	of clients in regard to a		control provider has completed	d
	1 .	· ·		additional bedbug eradication	
	bed bug infestat	IOII.		treatments. The team has bee	
	Findings include:			retrained on cleaning and ove sanitation expectations and preventative measures to prev	vent
	The facility's rep	portable incident reports		re-infestation will be implemen	nted
	and/or investiga	tions were reviewed on		per pest control provider recommendations	
	_	oon. The facility's		PREVENTION: The facility will	,
		ent reports indicated the		conduct physical environment	
	following:	ent reports marcated the		safety inspections of the home	• • • • • • • • • • • • • • • • • • •
	Tollowing.			needed but no less than mont	hly
	1/11/12 "A form	nily member told the		to assure a sanitary and	
		•		vermin-free training environments is maintained. The Governing	ent
	_	hey suspected the		Body has established a separa	ate
	1 -	bugs (sic) in the house.		Quality Assurance Departmen	
	_	ninating company] was		assist with auditing facility	
	_	ResCare facility and the		systems and developing soun	d
	administrative to	eam made arrangements		risk management practices.	
	for the extermin	ators to assess the home.		Members of the Operations ar	
	[Name of extern	ninating company]		Quality Assurance Teams will	
	_	firmed bedbugs (sic) had		periodically perform inspection of the facility on an ongoing be	
		A and C's] (individuals		to assure a sanitary environment	
supported by ResCare) bedroom. [Name			is maintained. RESPONSIBL		
	of exterminating company] performed the			PARTIES: QDDPD, Home	
	_	reduled treatments as soon		Manager, Support Associates,	
				Quality Assurance Team,	
	as they confirme	ed the infestation. Two		Operations Team	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
THINDTEMIN	or conduction	15G486		LDING		05/23/	
		.00.00	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/	
NAME OF P	PROVIDER OR SUPPLIER			1	AN RICARDO DR		
COMMUI	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION) uents will be administered		TAG	DEI ICIENCI)		DATE
		rvals. [Clients A and C] I [name of exterminating					
	company] eradic	-					
	successfully"	ates the bugs					
	successiuity						
	-4/27/12 "While	assisting [client B]					
		orted by ResCare) with					
		ine, staff noted what they					
	_	ed bugs in his room.					
		inating company] is					
	treating a bed bu	g infestation at [client					
	B's] residence an	d a second of three					
	treatments is sch	eduled for 4/28/12. As a					
	precaution, staff	transported [client B] to					
	the [name of hos	pital] Emergency					
	department to be	evaluated for bed bug					
	bites, ER person	nel evaluated [client B]					
	and noted no evi	dence of insect bites.					
	They released [c	=					
	(supported group	living) staff with a					
		cream to treat itching in					
	-	B] experiences any bites					
		aff will continue to					
	_	B] closely and assist					
	_	inating company] with					
		xtermination treatments."					
	_	7/12 reportable incident					
		to indicate any additional					
		place to protect client B					
		nate client E from bed					
	bugs.						
	During the 5/14/	12 observation period					
							l

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G486	B. WIN	G		05/23/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	NITV ALTEDNIATIV	EQ ADEDT			AN RICARDO DR APOLIS, IN 46256		
	NITY ALTERNATIV			<u> </u>	APOLIS, IN 40230		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		1 and 7:10 PM, at the		1710			DATE
		nt B had a dead bed bug					
		sheet near the foot of the					
		d a captain bed and one					
		s seen in the drawer					
		th client B's bed. Client					
		nmate, had two dead bed					
	· ·	ed post located at the foot					
	_	Dead bed bugs were					
		entrance way in the					
		oup home (near the base					
	1	od floors) where client					
		bedrooms were located.					
		located in the hallway,					
		v rug located in the					
		or. The throw rug was					
		had several (three plus)					
	*	casses on the throw rug					
		of the toilet and the tub.					
		e mentioned observation					
	_	, B, C and E did not have					
	_	on their mattresses					
	1 -	lients A, B, C and E had					
		ss covers on their bed					
		e out of cloth not plastic.					
		he garage off the kitchen,					
		ses and 2 boxes which					
		oards were seen in the					
		s attached to the group					
		mattresses were covered					
		y came in and standing					
	up/touching the	,					
		J					
	Client B's record	was reviewed on					
	I .						l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G486	B. WIN			05/23/	2012
NAME OF F	PROVIDER OR SUPPLIER	\ \			DDRESS, CITY, STATE, ZIP CODE		
CONANALII	NUTY ALTERNATIV	EC ADEDT			AN RICARDO DR		
	NITY ALTERNATIV			<u> </u>	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ГЕ	COMPLETION DATE
TAG		PM. Client B's Record		TAG	BHICKET		DATE
	of Visits indicated the following:						
	-4/27/12 "1. Reason for Visit: Bed Bugs						
		ngs of Examination: itch					
	3. Diagnosis: be	•					
	Recommendation	•					
	Benadryl Steroid						
		1/27/12 form indicated an					
		actions sheet for bed					
		care sheet indicated					
	~						
		ougs are most active at					
		le are bitten while					
		attress or bedding that has					
	been infected wi	th bed bugs"					
	5/2/12 Client D	saw his primary care					
		's 5/3/12 form indicated					
	"Bed bug bites so	ouse x (times) 2 exam					
		rea on (L) (left) neck &					
		JE (left upper extremity)					
	` ′	ted." The 5/3/12 form					
		Diagnosis: "resolving bed					
		ecommendations for					
		inue prn treatment for					
	symptomatic red	11055.					
	Client R'a Murair	ng Monthly Summerice					
	Client B's Nursing Monthly Summaries indicated the following:						
	muicated the 1011	iowing.					
	_4/16/12 "late er	ntry. No bed bug bites					
	noted. 0 noted it	-					
		at B] went to [name of					
	-r/2//12 [CIICII	it b) went to maine or					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G486	B. WIN			05/23/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
TWINE OF T	NO VIDER OR SOIT EIEF				AN RICARDO DR		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
		nergency room) for bed					
	bugs. New orders for Triamcinolone						
		ffected area 3 x day and					
		(milligrams) (one tablet)					
		rs) prn (as needed) for					
	symptoms. No b	-					
		scratching was noted."					
	-5/2/12 "Request	*					
		ream from [name of					
	doctor]."						
	-5/3/12 "[Client]	B] saw [name of doctor]					
	` .	p) bed bugs. 'Con't					
	(continue) PRN	treatment for					
	symptomatic red	ness.' Also received					
	faxed order to (c	hange) Triamcinolone					
	0.1% cream fron	n tid (three times a day)					
	to prn. 'Some re	ddened area on (L) neck					
	& ankle & LUE-	no infection noted.' "					
	-5/4/12 "Noted	red bumps on back of					
	left side of neck,	on (R) (right) arm above					
	elbow and on (L) wrist red bumps. NO					
		. Instructed staff to give					
	_	when scratching was					
	noted."						
		ed red bump areas					
		complaint of) itching					
		ing noted per staff."					
	-5/14/12 "O Red bumps noted on [client						
	B]. 0 itching noted."						
]						
	Client C's record	l was reviewed on					
	5/15/12 at 1:15 PM. Client C's April						
		onthly Summary					
	indicated the following in						
ı							

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PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486			LDING	NSTRUCTION 00	(X3) DATE COMPL 05/23	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
TAG	-4/14/12 "reported c/o of itching per [name of another Home directly af -4/30/12 [Client Ricardo Group From of other group has considered to the following of t	ed bug bites, red marks or staff. [Client C] went to group home] Group fter work." C] returned to San Iome after visiting [name ome] for 2 weeks." was reviewed on PM. Client A's April onthly Summary owing: A] moved (visited) to nome] Group Home. 0 es, red marks or c/o A] returned from [name visit. 0 reported bug		TAG	DEFICIENCY)		DATE	
		at H had any bed bug						

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Event ID: G64J11

Facility ID: 001000

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	LDING	NSTRUCTION 00	(X3) DATE COMPL 05/23	ETED
	PROVIDER OR SUPPLIER		 7919 SA	AN RICARDO DR APOLIS, IN 46256	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	9:42 AM indicate exterminating co Successful Bed I (undated) recommunity. Remove all subedding material bag until they call infestation from remove outlet an Hot water/Dry houndated from individual written by hand of form: "Must 'gone coup Saturday 4/14/12 final treatment." The 5/17/12 e-m attachment of Insidated 4/11/12. The cord indicated home, were train on 4/11/12. The "Detailed Descrimade aware that The staff also is proper procedures that a The 5/17/12 e-m.	mpany's "Steps for Bug Elimination" form mended the following: sheets, pillows and s. Seal them in plastic in be cleaned to prevent spreading. Also please d switch plate covers. In put in bags" The licated the following was on the bottom of the ple of hours' (sic) Coming 2. Also 4/28/12, May 12 ail indicated an service Sign In sheet the 4/11/12 inservice facility staff, in the group ed in regard to bed bugs 4/11/12 form indicated ption: Staff is being the site has Bed Bugs. Being trained on the es of protecting the proper precaution				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	E SURVEY PLETED 3/2012
	PROVIDER OR SUPPLIER		7919 SA	ADDRESS, CITY, STATE, ZIP CO AN RICARDO DR APOLIS, IN 46256	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	receipt indicated with zippers wer	enter. The 4/14/12 8 twin mattress covers re purchased for \$6.97 A, B, C, D, E, F, G and H.				
	PM indicated the area on his head his right arm. W received the red indicated he did areas. Client H s	lient H on 5/14/12 at 5:35 e client had a small red and some red bumps on When asked how client H areas/bumps, client H not know how he got the stated the group home ent H stated the mattress old."				
	PM indicated he may have bed buthe group home Saturday (5/12/1	lient E on 5/14/12 at 6:06 thought the group home ags. Client E indicated was sprayed this past 2) for bugs. When asked a new mattress, client E				
	AM indicated the group home while being sprayed.	lient A on 5/15/12 at 6:25 e clients had to leave the le the group home was Client A indicated bed in his bedroom and other up home.				
	PM indicated the	lient E on 5/14/12 at 6:32 e client had been bitten the couch in the living had a light red				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G486	B. WIN			05/23/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NUTY ALTERNATIV	EC ADEDT			AN RICARDO DR		
	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG		,	+	IAG			DATE
	rash/bumps on h	is right arm.					
	Intonvious suith at	aff #3 on 5/14/12 at 6:50					
		d bugs were found during					
	_	the group home 2 to 3					
	_	en asked if staff #3 had					
	_	in regard to bed bugs,					
	staff #3 stated "N	No, I naven't."					
	To 4 con 1 con 141 co	- CC 2 5/14/12 -4 7:00					
		aff #2 on 5/14/12 at 7:00					
		e facility had been treated					
		aff #2 indicated she was					
		ad the bed bugs in the					
	1	aff #2 indicated clients A,					
		and H were all to be					
	~ ~	resses. Staff #2 indicated					
	1 *	complained of bed bugs					
		ch of the group home					
		dicated the facility knew					
		s after a family member					
	_	ained about possible bed					
	~	ed if staff #2 had					
		ning in regard to bed					
		ted "No." Staff #2 also					
		s not aware of the					
		in regard to bed bugs.					
		clients' clothes were to					
		ff #2 indicated she was					
		special temperatures that					
	needed to be use	d. Staff #2 indicated					
	clients' clothes h	ad been					
	washed/laundere	d. Staff #2 indicated she					
	did not know wh	at bed bugs looked like					
	and she had not s	seen any bed bugs in the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		15G486	A. BUII B. WIN	LDING		05/23/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				AN RICARDO DR		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	group home.						
	Interview with c	lient C on 5/14/12 at 7:10					
		had not seen any bed					
	bugs in his bedro						
	indicated he wou	ald be getting a new					
	mattress.						
		dministrative staff #3 and					
	the Qualified De	-					
		signee (QDDP-D) on					
		PM indicated the group					
		estation of bed bugs and					
		with 3 rounds of spray					
	*	ing company. The					
	1	ted the last spray was					
	•	12/12. The QDDP-D					
		A and B were moved to					
		ome while their bedroom					
		ne bed bugs. The					
	-	administrative staff #3					
		to the bed bugs found in The QDDP-D indicated					
		nd G had bed bugs found					
		s. The QDDP-D					
		bugs were first found on					
		DDP indicated facility					
		ained in regard to bed					
		not know why staff					
	_	ad not been trained. The					
	I	ted she was told to					
	`	esses for clients B and C,					
	1 ^	been placed on the					
		*					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		15G486	B. WIN	G		05/23/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
COMMUN	NITY ALTERNATIV	ES-ADEPT			AN RICARDO DR APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		f 5/15/12. The QDDP-D					
		sses had not been					
	•	ents C and G. The					
	QDDP-D also in						
	•	overs and placed them on					
		, E, F, G and H's beds.					
	,	dicated the mattress					
	•	tic and zipped. When					
		d been bed bugs in the					
		in the group home, the					
		ed one facility staff had					
	•	it being bitten while					
	_	ich. Administrative staff					
	-	P-D stated client A, B, C,					
		's clothes were to be					
	washed and dried	d on "high heat." The					
	QDDP-D indicat	ed she told a Group					
	Home Director o	on $5/5/12$, the group					
		ould need to be replaced.					
	The QDDP-D in	dicated only one client in					
	the group home ((client B) had bed bug					
	-	P-D indicated when					
	client B went to	the ER, the doctors did					
	not find bed bug	bites on the client at that					
	time, but the doc	tor went ahead and					
	ordered a cream	to be used three times a					
	day for the bed b	ug bites. When asked if					
	anyone was chec	king to see if the group					
	home still had an	active case of bed bugs,					
	the QDDP-D stat	ted "No." Administrative					
	staff #3 and the (QDDP-D indicated the					
	group home had	completed its treatment					
	of the bed bugs.	Administrative staff #3					
	indicated facility	staff should have been					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486		A. BUII		00 	COMPLETED 05/23/2012		
		13G466	B. WIN			05/23/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY ALTERNATIVE	ES-ADEPT			AN RICARDO DR APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
TAG	trained in regard facility's policy in Administrative st mattress covers s zippers. Interview with nu at 4:30 PM, by pl had bed bug bites indicated she did 4/27/12 when the for the bites. Nurse staff #1 indout to the ER as f bugs on client B's The facility's policy reviewed on 5/15 12:11 PM. The f and procedure en Disaster, Evacuatindicated the facility policy indicated the facility policy indicated the facility indicated the faci	to bed bugs and the regard to bed bugs. aff #3 indicated plastic hould be used with arse staff #1 on 5/15/12 hone, indicated client B son him. Nurse staff #1 not see the bites on client went to the ER rese staff #1 indicated the ren on 5/3/12 when the primary care doctor. dicated client B was sent facility staff saw bed so pillow on his bed. Accility's 1/4/12 policy titled Emergency tion Plans and Responses lity had an "Emergency festation (bed bugs)." atted the following (not all each and crevices that whide in during the day g a blood meal. or frames, floor cracks,		TAG	DEFICIENCY)		DATE
	carpet tack board	s, baseboards, electrical					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII		00	COMPL	ETED	
		15G486	B. WIN	G		05/23/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY ALTERNATIVE	ES-ADEPT			AN RICARDO DR APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
IAG		pictures, wall hangings,		IAG	,		DATE
		osened wallpaper, cracks					
		ling moldings. 2.					
	Frequently vacuu						
		edding and clothing in					
	•	on high heat for 30					
		ne mattress and box					
	· · · · · · · · · · · · · · · · · · ·	bed and vacuumed, put					
		d mattress encasement.					
		in place for a year8.					
		ve equipment will be					
	-	oyees/visitors to use if					
	-	luce possible occurrence					
	-	itors carrying the bugs					
		ome to their own home.					
		ncludes disposable					
	• •	nd head, painter overalls,					
	disposable gowns	•					
		ol spray" The facility's					
		icated "Practices for					
		l be shared with all staff					
	and individuals						
		•					
	The facility's 9/14	4/07 policy entitled					
	_	Exploitation indicated					
		ned as "failure to provide					
	_	vices necessary for the					
	individual to avo	•					
		nal and/or physical)"					
		r J - · · · · · · · · · · · · · · · · · ·					
	This federal tag r #IN00107741.	relates to complaint					
	9-3-2(a)						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 05/2	TE SURVEY PLETED 23/2012			
COMMUI	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE			

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Event ID: G64J11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G486	B. WING		05/23/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				SAN RICARDO DR	
COMMUI	NITY ALTERNATIV	ES-ADEPT	INDIAN	NAPOLIS, IN 46256	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG W0189		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
VV0109	483.430(e)(1) STAFF TRAININ	IG PROGRAM			
		provide each employee with			
		uing training that enables the			
		form his or her duties			
	-	ently, and competently.	W0100		06/22/2012
		ation, interview and	W0189	correction: The facility many provide each employee with in	
		r 4 of 4 sampled clients		and continuing training that	nadi.
		nd for 4 additional clients		enables the employee to perfo	orm
		the facility failed to		his or her duties	
		eceived training in regard		effectively,efficiently, and	114.
	to bed bugs.			competently. Specifically, facily professional and direct support	-
				staff will be retrained on the	
	Findings include	:		agency's bedbug infestation a	
				prevention procedures, includ	ing
		ortable incident reports		but not limited to the need for	
	and/or investigat	ions were reviewed on		ongoing physical environment safety inspections of the	•
	5/15/12 at 12 noo	on. The facility's		residence, scheduled cleaning	g
	reportable incide	nt reports indicated the		routines. PREVENTION: The	
	following:			agency has established a	
				separate Quality Assurance Department to assist with aud	iting
	-4/14/12 "A fami	ily member told the		facility systems and developin	_
	supervisor that th	ney suspected the		and monitoring sound risk	
	presence of bedb	ougs (sic) in the house.		management practices. Memb	pers
	[Name of exterm	inating company] was		of the Operations and Quality	
	treating another l	ResCare facility and the		Assurance Teams will combin ongoing reviews of facility train	
	administrative te	am made arrangements		documentation with periodic v	
		ntors to assess the home.		to the facility to monitor the	
	[Name of exterm	inating company]		outcomes of the training.	
	technicians confi	rmed bedbugs (sic) had		RESPONSIBLE PARTIES: QDDPD, Home Manager,	
	infested [clients]	A and C's] (individuals		Support Associates, Quality	
	_	sCare) bedroom. [Name		Assurance Team, Operations	
		company] performed the		Team	
	_	eduled treatments as soon			
	as they confirmed	d the infestation"			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486		A. BUII B. WIN	LDING	00	COMPL 05/23/	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
	(individual supporhis morning routing believed to be be [Name of exterm treating a bed bug B's] residence and treatments is scheprecaution, staffethe [name of hospecaution, staffethe [name of hospec	assisting [client B] orted by ResCare) with ine, staff noted what they d bugs in his room. inating company] is g infestation at [client d a second of three eduled for 4/28/12. As a transported [client B] to pital] Emergency evaluated for bed bug 12 observation period I and 7:10 PM, at the nt B had a dead bed bug sheet near the foot of the d a captain bed and one is seen in the drawer th client B's bed. Client immate, had two dead bed d post located at the foot Dead bed bugs were intrance way in the oup home (near the base od floors) where client bedrooms were located. located in the hallway, we rug located in the or. The throw rug was had several (three plus) casses on the throw rug if the toilet and the tub.						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486		LDING	NSTRUCTION 00	(X3) DATE COMPL 05/23/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE		
	9:42 AM indicate exterminating co Successful Bed I (undated) recommunity. Remove all subedding material bags until they can infestation from remove outlet and Hot water/Dry has the state of the state	mpany's "Steps for Bug Elimination" form mended the following: sheets, pillows and s. Seal them in plastic an be cleaned to prevent spreading. Also please d switch plate covers. In put in bags" ail indicated an service Sign In sheet the 4/11/12 inservice facility staff, in the group ed in regard to bed bugs 4/11/12 form indicated ption: Staff is being the site has Bed Bugs. Being trained on the se of protecting he proper precaution are to be taken." Lient A on 5/15/12 at 6:25 to clients had to leave the set the group home was Client A indicated bed in his bedroom and other							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		15G486	B. WING			05/23/	2012
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					AN RICARDO DR		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		d bugs were found during					
	_	the group home 2 to 3					
		en asked if staff #3 had					
		g in regard to bed bugs,					
	staff #3 stated "N	No, I haven't."					
		taff #2 on 5/14/12 at 7:00					
	PM indicated the	e facility had been treated					
	for bed bugs. St	aff #2 indicated she was					
	not aware who h	ad the bed bugs in the					
	group home. Sta	aff #2 indicated clients A,					
	B, C, D, E, F, G	and H were all to be					
	getting new matt	tresses. Staff #2 indicated					
	facility staff had	complained of bed bugs					
	1	ch of the group home					
	_	dicated the facility knew					
		gs after a family member					
	'	lained about possible bed					
	_	ed if staff #2 had					
	_	ning in regard to bed					
	1	ated "No." Staff #2 also					
	• ,	s not aware of the					
		in regard to bed bugs.					
		v clients clothes were to					
	1	aff #2 indicated she was					
	· ·	special temperatures that					
		d. Staff #2 indicated					
	clients' clothes h						
		ed. Staff #2 indicated she					
		at bed bugs looked like					
		seen any bed bugs in the					
	group home.						
	Interview with a	dministrative staff #3 and					

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	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	
		15G486	A. BUII B. WIN			05/23/	2012
NAME OF D	DOVIDED OD SLIDDI IED				ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER		7919 SAN RICARDO DR				
COMMUN	NITY ALTERNATIVE	ES-ADEPT		INDIAN	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710	the Qualified Dev	*		1710			DATE
	-	ignee (QDDP-D) on					
		M indicated the group					
		estation of bed bugs and					
		with 3 rounds of spray					
		ing company. The					
	_	ed the last spray was					
	-	2/12. The QDDP-D					
	clients A, B, C ar	nd G had bed bugs found					
	in their bedrooms	s. The QDDP-D					
	indicated the bed	bugs were first found on					
	4/18/12. The QD	DDP indicated facility					
	staff had been tra	ined in regard to bed					
	bugs and she did	not know why staff					
	indicated they ha	d not been trained. The					
	QDDP-D indicate	ed only one client in the					
		nt B) had bed bug bites.					
	The QDDP-D inc	dicated when client B					
		he doctors did not find					
	_	the client at that time,					
		ent ahead and ordered a					
		three times a day for the					
	_	dministrative staff #3					
	*	indicated the group					
	_	eted its treatment of the					
	bed bugs. Admir						
		staff should have been					
	_	to bed bugs and the					
		n regard to bed bugs.					
		aff #3 indicated plastic					
		hould be used with					
	zippers.						
	This federal tag r	relates to complaint					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G64J11

Facility ID: 001000

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PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CC A. BUILDING B. WING	00		
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			7919 S	ADDRESS, CITY, STATE, ZIP O AN RICARDO DR IAPOLIS, IN 46256	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	#IN00107741.					
	9-3-3(a)					

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Event ID: G64J11

Facility ID: 001000

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PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2012	
	PROVIDER OR SUPPLIER		7919 S	ADDRESS, CITY, STATE, ZIP CODE SAN RICARDO DR NAPOLIS, IN 46256	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
W0418	clean, comfortable Based on observative record review for (A, B, C and D) a clients (E, F, G at to ensure each cloof bed bugs. Findings include The facility's repland/or investigat 5/15/12 at 12 nor reportable incider following: -4/14/12 "A family supervisor that the presence of bedbed [Name of extermative teating another ladministrative teating another ladministrative teating the extermative for the extermination of extermative teating another ladministrative teating an	provide each client with a le mattress. ation, interview and r 4 of 4 sampled clients and for 4 additional and H), the facility failed ient had a mattress free	W0418	CORRECTION: The facility provide each client with a clicomfortable mattress. Specifically, the facility will purchase new mattresses for Client's A – H. The mattress and pillows will be will be equipped with insect resistal coverings. PREVENTION: facility completes a monthly preventative maintenance checklists which are reviewed the Operations and Quality Assurance Teams. The check include furnishings. Professistaff will be retrained to inclumattresses in their prevental maintenance checks. Membershall the Operations and Quality Assurance Teams will period inspect facility furnishings including but not limited to mattresses on an ongoing be to assure they remain in good repair or are replaced. RESPONSIBLE PARTIES: QDDPD, Home Manager, Support Associates, Quality Assurance Team, Operation Team	or sees ant The ded by cklists ional aude ative pers of dically pasis od

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Event ID: G64J11

Facility ID: 001000

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PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	A. BUILDING		00	(X3) DATE S COMPL 05/23/	ETED
	PROVIDER OR SUPPLIER		79	19 SA	DDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY ALTERNATIV	ES-ADEPT	IN	DIANA	APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	-4/27/12 "While	assisting [client B]					
	(individual suppo	orted by ResCare) with					
	his morning rout	ine, staff noted what they					
	believed to be be	ed bugs in his room.					
	[Name of exterm	inating company] is					
		g infestation at [client					
	B's] residence an	d a second of three					
	treatments is sch	eduled for 4/28/12"					
	Danius - 41 5/14/	12 -1					
	_	12 observation period					
		I and 7:10 PM, at the					
		ant B had a dead bed bug sheet near the foot of the					
	_	above mentioned od, clients A, B, C and E					
	•	etic coverings on their					
	•	zipped. Clients A, B, C					
		like mattress covers on					
		were made out of cloth					
		located in the garage off					
	•	new mattresses and 2					
	· · · · · · · · · · · · · · · · · · ·	tained head boards were					
		e which was attached to					
		The new mattresses					
		the plastic they came in					
		touching the garage floor.					
	8 up						
	Client B's record	was reviewed on					
	5/15/12 at 12:45	PM. Client B's Record					
	of Visits indicate	ed the following:					
	-4/27/12 "1. Rea	ason for Visit: Bed Bugs					
		ngs of Examination: itch					
	3. Diagnosis: B						

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f '			(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G486	B. WIN			05/23/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
COMMUNITY ALTERNATIVES-ADEPT					AN RICARDO DR		
			_	<u> </u>	APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	Recommendation		+	IAG	,		DATE
	Benadryl Steroid						
		1/27/12 form indicated an					
		actions sheet for bed					
		care sheet indicated					
	~	ougs are most active at					
		le are bitten while					
		ttress or bedding that has					
	been infected wi	_					
	been infected wi	in oca oags					
	-5/3/12 Client B	saw his primary care					
		's 5/3/12 form indicated					
	"Bed bug bites so						
	_	ouse x (times) 2 exam					
		rea on (L) (left) neck &					
		JE (left upper extremity)					
	` ′	ted." The 5/3/12 form					
		Diagnosis: "resolving bed					
		commendations for					
	_	inue prn treatment for					
	symptomatic red	•					
	symptomatic red	ness.					
	Client R's Nursir	ng Monthly Summaries					
	indicated the foll						
	marcated the foll						
	 -4/16/12: "late er	ntry. No bed bug bites					
	noted. 0 noted it	-					
		it B] went to [name of					
		nergency room) for bed					
		rs for Triamcinolone					
	~	ffected area 3 x day and					
		(milligrams) (one tablet)					
	1	rs) prn (as needed) for					
	symptoms. No b						
	57 mp to 110 t	Tours apon					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G486	B. WIN			05/23/2012
NAME OF F	PROVIDER OR SUPPLIER	\ \			DDRESS, CITY, STATE, ZIP CODE	
CONANALII	NUTY ALTERNATIV	EC ADEDT			AN RICARDO DR	
	NITY ALTERNATIV				APOLIS, IN 46256	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	COMPLETION DATE
TAG		, , , , , , , , , , , , , , , , , , ,		TAG	Birtelinery	DATE
		scratching was noted."				
	-5/2/12 "Request	-				
	doctor]."	ream from [name of				
		B] saw [name of doctor]				
	_	b) bed bugs. 'Con't				
	` `	, ,				
	(continue) PRN					
	1	ness.' Also received				
	,	hange) Triamcinolone 1 tid (three times a day)				
		ddened area on (L) neck				
		no infection noted.'				
		red bumps on back of				
		on (R) (right) arm above				
) wrist red bumps. NO				
	_	. Instructed staff to give				
		when scratching was				
	noted."	d mad by man amang				
		ed red bump areas complaint of) itching				
	`	, ,				
		ing noted per staff."				
		bumps noted on [client				
	B]. 0 itching not	tea."				
	Pavious of an a m	nail sent on 5/17/12 at				
	9:42 AM indicat					
		ompany's "Steps for				
	_	Bug Elimination" form				
		mended the following:				
		sheets, pillows and				
		ls. Seal them in plastic				
		n be cleaned to prevent				
		•				
		spreading. Also please				
	remove outlet an	d switch plate covers.				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	COMPL	
11.15 12.11	or condition,	15G486		LDING		05/23/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				AN RICARDO DR		
COMMU	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46256		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG				TAG	DLI TELLACT)		DATE
	Hot water/Dry he	ot put in bags					
	The 5/17/12 a m	ail also indicated an					
		4/14/12 receipt from a					
		enter. The 4/14/12					
		8 twin mattress covers					
		e purchased for \$6.97					
		A, B, C, D, E, F, G and H.					
		1, D, C, D, D, 1, O and 11.					
	Interview with a	dministrative staff #3 and					
	the Qualified De						
	-	signee (QDDP-D) on					
		PM indicated the group					
		estation of bed bugs and					
		with 3 rounds of spray					
		ing company. The					
	*	ed the last spray was					
	*	12/12. The QDDP-D					
	•	nd G had bed bugs found					
	in their bedroom	s. The QDDP-D					
	indicated the bed	bugs were first found on					
	4/18/12. The QI	DDP-D indicated she was					
	told to purchase	2 mattresses for clients B					
	and C, but they h	and not been placed on					
		as of $5/15/12$. The					
	QDDP-D indicat	ed mattresses had not					
		For clients C and G. The					
	QDDP-D also in						
	_	overs and placed them on					
		, E, F, G and H's bed.					
	-	dicated the mattress					
	covers were plas	* *					
		taff #3 indicated plastic					
	mattress covers s	should be used with					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G486			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/23/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE AN RICARDO DR	
COMMU	NITY ALTERNATIV	'ES-ADEPT		APOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	zippers.				
	This federal tag #IN00107741.	relates to complaint			
	9-3-7(a)				

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Event ID: G64J11

Facility ID: 001000

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		15G486	B. WING		05/23/2012
NAME OF F	AD OUTDED ON GUIDNI TEN		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		7919	SAN RICARDO DR	
	NITY ALTERNATIV			NAPOLIS, IN 46256	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0434	483.470(f)(3) FLOORS				
		have exposed floor surfaces			
	and floor coverin				
	maintenance of s	sanitary conditions.			
		ation, interview and	W0434	CORRECTION: The facility m	
	record review for	r 4 of 4 sampled clients		have exposed floor surfaces a floor coverings that promote	ana
	(A, B, C and D) a	and for 4 additional		maintenance of sanitary	
	clients (E, F, G a	nd H), the facility failed		conditions. Specifically, Facility	tv
	to ensure floors v	were cleaned.		professional and direct suppo	
				staff will be retrained on the n	
	Findings include	:		to maintain clean floor surface	es.
	Č			Training will include the re-incorporation of shift	
	During the 5/14/	12 observation period		responsibility checklists to	
	_	I and 7:10 PM, at the		facilitate a team effort in	
		ent G had two dead bed		maintaining sanitary condition	
		ed post located at the foot		PREVENTION: The facility wil	
	~	on the floor. Dead bed		conduct physical environment safety inspections of the home	
		een at the entrance way in		needed but no less than mont	
	_	e group home (near the		to assure a sanitary and	, l
	I	he wood floors) where		vermin-free training environme	
		*		is maintained. Members of the	
		d G's bedrooms were		Operations and Quality Assurance Teams will periodic	cally
		athroom located in the		perform inspections of the fac	-
	1	as a throw rug located in		on an ongoing basis to assure	
		floor. The throw rug		sanitary environment, includin	
		and had several (three		but not limited to clean floor	
	_	ug carcasses on the throw		surfaces, is maintained.	
	_	ont of the toilet and the		RESPONSIBLE PARTIES: QDDPD, Home Manager,	
	tub. In client D a	nd E's bath room located		Support Associates, Quality	
	in their bedroom,	, the floor had not been		Assurance Team, Operations	
	swept as dead rol	ly poly worms were on		Team	
	the floor with oth	ner debris. The group			
	home's kitchen fl	loor had food particles on			
		/baseboards of the floor			
		een swept up and/or			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 05/23	ETED
	PROVIDER OR SUPPLIER			7919 SA	DDRESS, CITY, STATE, ZIP CODE AN RICARDO DR APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
TAG	mopped. At 6:25 bedroom, a urine upon entering the bedroom floor was urine when stand. Interview with color PM indicated the recently bought at E indicated he color week and mopped. Interview with color PM indicated the and mopped dailing group home had color color and in his c	tient E on 5/14/12 at 6:06 group home had a vacuum cleaner. Client eaned his bedroom every		TAG	DEFICIENCY)	NATE.	DATE
	_	1/12. Staff #2 indicated was mopped every night.					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED			
	15G486	A. BUILDING B. WING		05/23/2012			
27.17.== -			ADDRESS, CITY, STATE, ZIP CODE	1			
	PROVIDER OR SUPPLIER	7919 SAN RICARDO DR					
COMMU	NITY ALTERNATIVES-ADEPT	INDIAN.	APOLIS, IN 46256				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				
TAG	REGULATOR FOR ESC IDENTIFICATION INFORMATION)	IAG	,	DATE			
	Interview with administrative staff #3 and						
	the Qualified Developmental						
	Professional-Designee (QDDP-D) on						
	5/15/12 at 3:26 PM indicated the group						
	home had an infestation of bed bugs and						
	had been treated with 3 rounds of spray						
	by an exterminating company. The						
	QDDP-D indicated the last spray was						
	completed on 5/12/12. The QDDP-D						
	indicated facility staff should have						
	cleaned up the dead bugs/insects that						
	were in the house. The QDDP-D						
	indicated the rug in the bathroom should						
	have been removed from the bathroom						
	and washed. The QDDP-D indicated						
	client C would urinate on the floor and in						
	his bedroom. The QDDP-D indicated the						
	client's bedroom floor should be						
	cleaned/mopped daily.						
	This federal tag relates to complaint						
	#IN00107741.						
	0.2.7(-)						
	9-3-7(a)						

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