STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	8211 CHRISTIANA LN INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: 5/13/14, 5/14/14, 5/15/14, 5/16/14 and 5/19/14. Facility Number: 001065 Provider Number: 15G551 AIMS Number: 100239840 Surveyor: Keith Briner, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/29/14 by Ruth Shackelford, QIDP.	W000000		
W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS 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. Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to secure a surrogate to assist client #1 with making informed choices and decisions.	W000125	**CORRECTION:** *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*	06/18/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement 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.

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	Findings include: Client #1's record was reviewed on 5/14/14 at 9:30 AM. Client #1's ISP (Individual Support Plan) dated 3/22/14 indicated client #1 had a HCR (Health Care Representative). Client #1's PCPP (Person Centered Planning Profile) form dated 3/22/14 indicated the following: -"[Client #1] has not had contact with her family members including her [sister/HCR], [brother in law], their two children, stepfather (sic) since November 2011. [Client #1's] current diagnosis is severe mental retardation, sleep apnea and also she had been diagnosed with intermittent explosive disorder due to expressing self injurious behaviors." -"[Client #1] has not been contacted by her [sister/HCR], or [brother in law] since November 2011 via telephone, and they did express concerns about visiting [client #1] on a routine basis." -"Decisions for [client #1] are made by her [sister/HCR] and [brother in law] due to her lack of ability to make any decisions except for basic desires and needs, but attempts to contact them via telephone and mail have failed. [Client #1] has not been assessed as being able to give informed consent on major life		*complaints, and the right to due process.* Specifically, the facility has reassessed Client 1's ability to give informed consent and has obtained a healthcare representative for Client #1. **PREVENTION:** Professional staff will be retrained regarding the need to assure that all individuals have appropriate assistance making major life decision, based on their assessed ability to give informed consent. As part of an ongoing quarterly audit process, the Operations Team will review informed consent assessments to assure clients have appropriate legal representation. **RESPONSIBLE PARTIES:** QIDP, Operations Team	

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	decisions." Client #1's Informed Consent Assessment form dated 10/8/13 indicated client #1 was not assessed as being able to give informed consent. CS (Clinical Supervisor) #1 and QIDP (Qualified Intellectual Disabilities Professional) #1 were interviewed on 5/14/14 at 10:50 AM. CS #1 indicated client #1's current HCR was her sister. CS #1 indicated the facility had attempted to contact client #1's HCR for approvals but had not been able to reach the HCR for over a year. QIDP #1 indicated she had attempted to call client #1's HCR and had mailed items with no response. CS #1 indicated client #1 was in need of a new HCR. 9-3-2(a)			
W000263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for	W000263	**CORRECTION:** *The committee should insure that*	06/18/2014

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	1 of 3 sampled clients (#1), facility's HRC (Human Rights Committee) failed to obtain the written informed consent of client #1's HCR (Health Care Representative) before the use of psychotropic medications and restrictive programs for the management of client #1's behavior. Findings include: Client #1's record was reviewed on 5/14/14 at 9:30 AM. Client #1's ISP (Individual Support Plan) dated 3/22/14 indicated client #1 had a HCR (Health Care Representative). Client #1's BSP (Behavior Support Plan) dated 3/20/14 indicated client #1 received Risperdal 1 milligram daily (Intermittent Explosive Disorder). Client #1's modification of rights form dated 3/20/14 indicated client #1 was restricted from free access to her personal funds, the community and food items in the home. Client #1's record did not indicate documentation of client #1's HCR's written informed consent for the use of psychotropic medications or restrictive programs. CS (Clinical Supervisor) #1 and QIDP (Qualified Intellectual Disabilities Professional) #1 were interviewed on 5/14/14 at 10:50 AM. CS #1 indicated client #1's current HCR was her sister.		*these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.* Specifically, the interdisciplinary team has obtained healthcare representative approval for all of Clients #1's behavior controlling medications and other restrictive programs. A record review indicated this deficient practice did not affect any additional clients. **PREVENTION:** The QIDP will be retrained regarding the need to confirm that members of the Human Rights committee have assured guardian approval is in place prior to approving rights restrictions. Members of the Operations Team will conduct periodic reviews to assure that all programs are incorporated into clients' plans and that due process occurs. These reviews will occur no less than quarterly. **RESPONSIBLE PARTIES:** QIDP, Human Rights Committee, Operations Team	

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	CS #1 indicated the facility had attempted to contact client #1's HCR for approvals but had not been able to reach the HCR for over a year. QIDP #1 indicated she had attempted to call client #1's HCR and had mailed items with no response. CS #1 indicated the facility had not been able to obtain written informed consent regarding client #1's psychotropic medications and restrictive programs. 9-3-4(a)			
W000331	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 of 3 sampled clients (#2), the facility's nursing services failed to ensure client #2's laboratory orders were implemented. Findings include: Client #2's record was reviewed on 5/14/14 at 10:31 AM. Client #2's POF (Physician's Orders Form) dated 4/29/14 included but was not limited to the following Laboratory Orders: -"Thyroid Panel every 6 months."	W000331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically, Client #2 has received the following lab tests: Thyroid Panel, CBC with Differential, CMP, Lipid Panel and Hepatic Panel. A record review indicated this deficient practice did not affect any other clients. **PREVENTION:** The Nurse Manager will assist the facility nurse and direct support medical coach with tracking routine appointments and lab tests to assure they occur as	06/18/2014

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	-"Comprehensive metabolic profile (CMP), lipid panel, hepatic panel, CBC (Complete Blood Count) with differential annually." Client #2's record did not indicate documentation of a Thyroid Panel being completed for client #2. Client #2's record did not indicate documentation of a CMP, lipid panel, hepatic panel and CBC being completed. LPN (Licensed Practical Nurse) #1 was interviewed on 5/14/14 at 11:15 AM. LPN #1 indicated client #2's laboratory orders as written on the 4/29/14 POF should be followed. LPN #1 indicated there was not additional documentation regarding client #2's laboratory testing available for review. 9-3-6(a)		recommended. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, twice monthly for the next 90 days to assure labs and appointments occur as recommended. After three 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, Quality Assurance Team, Operations Team	