

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G622	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/02/2012
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 7520 KILMER 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	
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Date of Survey: March 27, 28, 29, 2012 April 2, 2012</p> <p>Provider Number: 15G622 Aims Number: 100245690 Facility Number: 001159</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 4/12/12 by Tim Shebel, Medical Surveyor III.</p>	W0000			

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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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (#2) to include interventions/methods in the clients' individual support plan (ISP) in regards to staff assistance needs with gait belt use.</p> <p>Findings include:</p> <p>An observation was done at the facility on 3/28/12 from 4:20p.m. to 6:12p.m. Client #2 walked independently and did not use a gait belt.</p> <p>Record review of client #2 was done on 3/29/12 at 11:08a.m. Client #2 had a 3/8/09 (most recent documented) physical therapy (PT) note. The PT recommended client #2 use a gait belt for stairs, distance and uneven surfaces.</p> <p>Staff #1 was interviewed on 3/29/12 at 11:55a.m. Staff #1 indicated client #2 did not have a gait belt. Staff #1 indicated client #2 did not need a gait belt and there was no interventions in place to indicate to staff how to assist client #2 with his ambulation needs in regards to client #2's PT recommendations.</p> <p>9-3-4(a)</p>	W0240	<p><b>CORRECTION:</b> <i>The individual program plan must describe relevant interventions to support the individual toward independence. Specifically Client #2's comprehensive high risk plan for falls has been updated to include the use of a gait belt and staff have been trained on implementation of the fall prevention plan. Additionally, the team has scheduled a physical therapy evaluation for Client #2 and the fall prevention plan will be revised to accommodate any additional recommendations.</i></p> <p><b>PREVENTION:</b> Professional staff will be retrained regarding the need to incorporate PT and OT recommendations into Individual Support Plans as well as the need to maintain current assessments from all relevant disciplines. Additionally, members of the Operations Team and Quality Assurance Team will periodically review medical records and support documents to assure that professional recommendations are incorporated into each client's individual support plan and that all assessments are current.</p> <p><b>Responsible Parties:</b> QDDPD, Support Associates, Health Services Team, Operations Team, Quality Assurance Team</p>	05/02/2012			

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview, the facility's Human Rights Committee (HRC) failed for 4 of 4 clients (#1, #2, #3, #4) to review restrictive interventions: the facility practice of the use of door alarms on the facility entrance/exit doors.</p> <p>Findings include:</p> <p>An observation was done on 3/28/12 at the group home from 4:20p.m. to 6:12p.m. At 4:20p.m., while entering the group home a door sounded. At 4:37p.m. the door alarm sounded when client #4 went out to the back deck. Staff #1 was interviewed on 3/28/12 at 4:44p.m. Staff #1 indicated there were door alarms on all entrance/exit doors due to clients #3 and #4's behavior.</p> <p>Record review of the facility's HRC reviews from 3/1/11 to 3/29/12 was done on 3/29/12 at 11:55a.m. There was no documentation the HRC had reviewed the</p>	W0264	<p><b>CORRECTION:</b> <i>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Specifically the QDDP has located Human Rights Committee meeting minutes from 12/16/11, when approval was discussed for door alarms and Behavior Support Plans for Client #1 and Client #2. <b>PREVENTION:</b> The Human rights Committee Chairperson will forward copies of HRC meeting minutes to the Operations Team and the Quality Assurance Team to assure that they may be reproduced for the Indiana State Department of Health review upon request. <b>Responsible Parties:</b>QDDPD, Operations Team, Quality Assurance Team, Human Rights Committee Chair</i></p>	05/02/2012			

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	<p>facility's restrictive practice of activated entrance/exit door alarms for clients #1, #2, #3 and #4.</p> <p>Interview of professional staff #1 on 3/29/12 at 12:52p.m. indicated they could not find documentation the facility restriction of the use of entry/exit door alarms had been presented to and reviewed by the facility's HRC. 9-3-4(a)</p>			