

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 12/16/2011
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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W0000	<p>This visit was for an extended annual recertification and state licensure survey which resulted in an immediate jeopardy.</p> <p>Survey dates: 12/5/11, 12/6/11, 12/7/11, 12/8/11, 12/9/11 and 12/16/11.</p> <p>Facility Number: 000973 Provider Number: 15G459 AIM Number: 100244810</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/21/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0122	<p>The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 3 of 4 sampled clients (#2, #3 and #5) plus 4 additional clients (#4, #6, #7 and #8). The facility failed to implement its policy and procedure to prevent neglect of clients in</p>	W0122	<p>CORRECTION: <i>The facility must ensure that specific client protections requirements are met. Specifically, Client #1 has moved to a facility better suited to Client #1's behavioral, social and developmental needs and there have been no further incidents of client to client abuse. Additionally,</i></p>	01/15/2012

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>regards to monitoring/supervising client #1 to prevent physical aggression and/or intimidation towards clients #2, #3, #4, #5, #6, #7 and #8. The facility failed to implement its written policy and procedures regarding abuse/neglect to conduct a thorough investigation in regards to client #1's aggression toward clients #3, #6 and #7. The facility failed to put in place corrective actions/asures to prevent client #1's aggression toward clients #3, #6 and #7.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The immediate jeopardy was identified on 12/6/11 at 2:45 PM. The Immediate Jeopardy began on 11/4/11 when the facility failed to implement its policy and procedure to prevent neglect of clients in regards to monitoring/supervising client #1 to prevent physical aggression and/or intimidation towards clients #2, #3, #4, #5, #6, #7 and #8. The Group Home Director, the facility Executive Director, both facility Licensure and Quality Coordinators, and the Program Director were notified of the Immediate Jeopardy on 12/6/11 at 2:45 PM regarding the failure of the facility to implement its policy and procedure to prevent neglect of clients in regards to monitoring/supervising client #1 to prevent physical aggression and/or</p>		<p>the facility has completed investigations into the circumstances of incidents of client to client abuse on 11/4/11,11/6/11 and 11/8/11. PREVENTION: The Program Coordinator/QDDPD will be retrained regarding agency investigation procedures, with emphasis on timely completion. The Operations Team will monitor compliance with investigation timelines and coordinate corrective measures as needed. RESPONSIBLE PARTIES: QDDPD, Support Associates, Operations Team</p>				

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	<p>intimidation towards clients #2, #3, #4, #5, #6, #7 and #8. On 12/9/11, the facility submitted the following plan of action to remove the jeopardy: "[Client #1] has moved to a facility better suited to her current behavioral needs, with the following additional supports:</p> <ol style="list-style-type: none"> [Client #1's] Behavior Support Plan has been modified to include arms-length one to one observation between the hours of 7:00 AM and 11:00 PM. [Client #1] will have her own bedroom to eliminate the possibility of night time aggression toward a roommate. Shawnee Road staff will assist with [client #1's] one to one observation to provide her with continuity of care during her transition. Direct support staff at [client #1's] new supervised group living residence have been trained on her current training, behavioral and healthcare needs. Shawnee Road staff who will be assisting with [client #1's] transition have been trained on the revisions to her Behavior Support Plan. [Client #1's] team has identified additional potential physiological triggers for her behavior and has obtained a referral for a GI (Gastrointestinal) specialist to treat her recently diagnosed Hiatal Hernia as well as scheduled an additional dental evaluation." 			

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	<p>The facility implemented the plan of action. Through monitoring observations held on 12/9/11 at 1:30 PM, client #1 had moved to the alternate facility. Client #1 was laying in her bedroom with a one to one staff on duty. Client #1's one to one protocol was reviewed on 12/9/11 at 1:45 PM. Client #1's modified observation procedure prevented intimidation and/or physical aggression toward her peers. The immediate jeopardy was removed and the condition corrected on 12/9/11. The remaining deficiencies are cited at the standard level only.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to implement its policy and procedure to prevent neglect of clients in regards to monitoring/supervising client #1 to prevent physical aggression and/or intimidation towards clients #2, #3, #4, #5, #6, #7 and #8. The facility failed to implement its written policy and procedures regarding abuse/neglect to conduct a thorough investigation and put in place sufficient corrective action. Please see W149. 2. The facility failed to conduct an investigation and/or thorough investigation in regards to client #1's aggression toward clients #3, #6 and #7. 			

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W0140	<p>Please see W154.</p> <p>3. The facility failed to put in place corrective actions/measures to prevent client #1's aggression toward clients #3, #6 and #7. Please see W157.</p> <p>9-3-2(a)</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 4 sampled clients (#5), the facility failed to assure a full and complete accounting of client's expenditures/purchases.</p> <p>Findings include:</p> <p>Client #5's record was reviewed on 12/7/11 at 3:15 PM. Client #5's Individual Financial Assessment (IFA) dated 10/11/11 indicated, "[Client #5] requires total assistance and will require staff assistance with all purchases...." Client #5's Internal Checking Account (ICA) ledger dated from 9/1/11 through 12/2/11</p>	W0140	<p>CORRECTION: <i>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Specifically Client #5's personal financial record is complete and up to date. PREVENTION: The Program Coordinator/QDDPD will maintain an up to date spending ledger for all clients, with corresponding receipts as appropriate. The Program Coordinator/QDDPD will turn in copies of client financial records to be maintained and tracked by the agency's business department Additionally the Operations Team will conduct</i></p>	01/15/2012	

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W0149	<p>indicated the following withdrawals:</p> <ul style="list-style-type: none"> -9/8/11, \$10.00 spending money -9/16/11, \$10.00 spending money -9/22/11, \$10.00 spending money -9/28/11, \$10.00 spending money -10/6/11, \$10.00 spending money -10/12/11, \$10.00 spending money -10/19/11, \$10.00 spending money -10/27/11, \$10.00 spending money -11/2/11, \$10.00 spending money -11/9/11, \$10.00 spending money -11/17/11, \$10.00 spending money -12/1/11, \$10.00 spending money <p>Client #5's financial record was reviewed on 12/8/11 at 2:45 PM. Client #5's financial record did not contain a petty/spending cash ledger for November 2011 and/or December 2011. The review did not indicate accounting of the client's transactions.</p> <p>Interview with Program Coordinator (PC) #1 on 12/8/11 at 3:30 PM indicated client #5's petty cash should be reconciled on the ledger on a weekly to bi-weekly basis with monthly oversight from the PC.</p> <p>Interview with Administrative Staff #1 on 12/8/11 at 3:45 PM indicated the client's petty cash should be accounted for.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p>		<p>formal and informal audits of client financial records on an ongoing basis RESPONSIBLE PARTIES: QDDPD, Support Associates, Operations Team</p>	

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	<p>Based on interview and record review for 3 of 4 sampled clients (#2, #3 and #5) plus 4 additional clients (#4, #6, #7 and #8), the facility failed to implement its policy and procedure to prevent neglect of clients in regards to monitoring/supervising client #1 to prevent physical aggression and/or intimidation towards clients #2, #3, #4, #5, #6, #7 and #8. The facility failed to implement its written policy and procedures regarding abuse/neglect to conduct a thorough investigation. The facility failed to put in place corrective actions/measures to prevent client #1's aggression toward clients #3, #6 and #7.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 12/5/11 at 12:00 PM. The facility's reportable incident reports indicated the following:</p> <p>- BDDS (Bureau of Developmental Disabilities Services) report dated 11/5/11 indicated on 11/4/11, "[Client #1] and [client #3] were returning from going out to dinner with their housemates in the facility van. Without apparent antecedent, [client #1] hit [client #3] in the back of the head with a closed hand and pulled her hair."</p>	W0149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, abuse or neglect of the client.</i> Specifically, Client#1 has moved to a facility better suited to Client #1's behavioral, social and developmental needs and there have been no further incidents of client to client abuse. Additionally, the facility has completed investigations into the circumstances of incidents of client to client abuse on 11/4/11, 11/6/11 and 11/8/11.</p> <p>PREVENTION: The Program Coordinator/QDDPD will be retrained regarding agency investigation procedures, with emphasis on timely completion. (Addendum, 1/13/12: Retraining will focus on the need to develop and maintain sound time management skills and to request assistance from the Operations Team as needed. Additionally, training will stress the importance of prioritizing facility support tasks to assure that alleged violations are investigated without delay.) The Operations Team will monitor compliance with investigation timelines and coordinate corrective measures as needed.</p> <p>RESPONSIBLE PARTIES: QDDPD, Support Associates, Operations Team</p>	01/15/2012	

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	<p>-BDDS report dated 11/5/11 indicated on 11/5/11, "[Client #1] was sitting on the couch and without apparent antecedent got up (sic) approached [client #3] and hit her in the chest."</p> <p>-BDDS report dated 11/6/11 indicated on 11/6/11, "All consumers and staff were sitting in the living room. [Client #1] got up and walked past [client #7] and slapped her forcefully on the left thigh before staff could intervene. Staff separated the two individuals with [client #1] threatening to hit staff...Later in the day [client #6] walked past [client #1] and [client #1] slapped her in the leg without much force. The team will investigate the circumstances of [client #1's] aggression toward her housemates and the team will meet to re-evaluate [client #1's] current behavior supports...."</p> <p>-BDDS report dated 11/8/11 indicated on 11/8/11, "[Client #3] was sitting in the living room by the medication room door and [client #1] was sitting on the living room couch. Without apparent antecedent, [client #1] walked over to [client #3] and grabbed her face. Staff came out of the medication room immediately and separated the two individuals. As a result of the incident [client #3] sustained a two inch scratch on the left side of her face... The team has initiated an investigation</p>				

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	<p>into the circumstances of the altercation and will meet to discuss [client #1's] ongoing cycle of aggression."</p> <p>-BDDS report dated 11/12/11 indicated on 11/12/11, "[Client #3] was sitting in her wheelchair watching television. [Client #1] was standing in the middle of the living room floor. Staff was on the couch doing paper work, [client #1] quickly walked over to [client #3] and scratched her on the nose."</p> <p>-BDDS report dated 12/1/11 indicated on 12/1/11, "...[client #1] went to her room, laid down in her bed and appeared to be calm. Fifteen minutes later staff heard [client #1] and her roommate [client #6] screaming. Staff went other room and observed [client #1] hitting [client #6]...."</p> <p>Client #1's record was reviewed on 12/6/11 at 12:00 PM. Client #1's IDT (Interdisciplinary Team Meeting) notes indicated the following:</p> <p>-6/7/11 IDT agenda indicated PT (Physical Therapy) assessment scheduled and transfer difficulties.</p> <p>-9/8/11 IDT agenda indicated the team discussed possibility of a wheelchair alarm and bedrails.</p>				

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	<p>-9/30/11 IDT agenda indicated discussion of neurologist for multiple falls and eye doctor visit, recent PT (Physical Therapy) recommendations and the use of a gait belt.</p> <p>Client #1's BSP (Behavior Support Plan) indicated a date of 4/26/11.</p> <p>Interview with AS (Administrative Staff) #1 on 12/6/11 at 3:00 PM indicated there were additional IDT notes available for review regarding client #1's physical aggression. AS #1 provided the following IDT notes on 12/6/11 at 4:28 PM. The IDT notes regarding client #1 that were provided by AS #1 included the following:</p> <p>-9/7/11 IDT indicated, "[Client #1] was supposed to start day program at [day services] today. But was unable because having an incident at home. I explained to [DSA (Day Service Administrator) #1] that until we were able to find a solution or med's to help relax [client #1] she would not be able to attend program. [DSA #1] agreed and give her a call when she is ready to start program." The IDT attendance roster indicated the meeting was attended by PD (Program Director) #1 and DSA #1.</p> <p>-10/11/11 IDT indicated, "[Guardian #1]</p>				

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	<p>stated that what ever it takes to help [client #1] she is willing to give her. Okay, (sic) she is also concerned about the past medical issue of a hernia. a (sic) was concerned if that could be contributing to [client #1's] behavior." The IDT attendance roster indicated the meeting was attended by PD #1 and Guardian #1 via phone.</p> <p>--11/12/11 IDT indicated, "I spoke with [guardian #1] over the phone to get approval for moving [client #1] to another bedroom because of aggression towards her roommate and [guardian #1] agreed to the move." The IDT attendance roster indicated the meeting was attended by PD #1 and guardian #1 via phone.</p> <p>PD #1 was interviewed on 12/7/11 at 1:30 PM. When asked if there were any additional IDT notes to review, PD #1 indicated there were no additional IDT notes. When asked who should attend an IDT, PD #1 indicated a formal IDT meeting should have herself, the Operations Director, the Licensure/Quality Coordinator, the Group Home Director, the client, the guardian, the nurse if applicable, staff that work with the client and outside agency staff as appropriate. PD #1 indicated no additional people were included in the 9/7/11, 10/11/11 and/or 11/12/11 IDT meetings.</p>			

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	When asked if the 9/7/11, 10/11/11 and /or 11/12/11 meetings were considered to be IDT meetings, PD #1 stated the meetings "were more emergent in nature and not actual IDT meetings." When asked if during the 9/7/11, 10/11/11, 11/12/11 and/or any other recent IDT, the team had discussed client #1's BSP, staffing protocols, monitoring or supervision supports, and/or other programming supports to address client #1's aggression towards her peers, PD #1 indicated the Group Home Director had initiated contact with a behavior consultant and an emergency one to one protocol but no IDT discussion had occurred. When asked if the one to one protocol that the Group Home Director had implemented on an emergency basis had been developed into a plan, a written protocol and/or if staff had received training regarding the specialized monitoring, PD #1 indicated the one to one written protocol had been developed on 12/6/11 and staff had not been trained regarding special supervision, additional supports or monitoring regarding client #1. When asked if any of the initiatives implemented by either the IDT or the Group Home Director had prevented further reoccurrences of client #1's aggression, PD #1 indicated no. PD #1 indicated she had completed an investigation into the 11/4/11 incident			

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	<p>regarding client #1 and client #3's incident on the group home van. When asked what the outcome of the investigation was, PD #1 indicated she had not completed that portion of the investigation. When asked if the investigation contained a summary of findings, PD #1 indicated she had not completed that portion of the investigation. When asked if the investigation was thorough, PD #1 indicated no. When asked if there were any additional investigations regarding client #1 and the 11/6/11 and/or 11/8/11 incidents of client to client aggression, PD #1 indicated no. When asked if incidents of client to client aggression should be investigated, PD #1 indicated yes.</p> <p>Interview with AS (Administrative Staff) #1 on 12/7/11 at 1:40 PM indicated there were no additional investigations available for review.</p> <p>AS #1 was interviewed on 12/6/11 at 3:30 PM. AS #1 indicated the behavior consultant had been conducting an assessment and was in the process of developing a new BSP for client #1. AS #1 indicated the BSP was completed but was not yet distributed and/or implemented. AS #1 provided client #1's new BSP on 12/6/11 at 5:38 PM. Client #1's revised BSP was dated 11/16/11.</p>						

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	<p>Client #1's Interdisciplinary Diagnostic and Evaluation Center Form dated 6/22/10 was reviewed on 12/6/11 at 12:00 PM. The form indicated, "It was noted that her housemates often complain and generally tend to avoid [client #1]. [Client #1] often will keep them up all night and can be very aggressive and her constant screaming is very disconcerting to everyone. It was observed that a housemate who came home from some type of activity during the midmorning was almost wincing listening to [client #1] yell in another room and put her hands over her ears... [Client #1] can become aggressive and she will have very persistent screaming... [Client #1's] maladaptive behaviors are screaming and growling or even a high pitched scream that can go on for hours for up to 18 hours. [Client #1] is potentially dangerous to both herself and others... [Client #1] will grab staff and others around the neck. [Client #1] has been known to bite, kick and scratch staff. [Client #1] also has been noted to become physically aggressive towards more fragile individuals with whom she comes in contact with. [Client #1] is seen frequently by her psychiatrist and medications have been adjusted and changed with limited positive results. [Client #1's] behavior continues to be problematic in both group home and elsewhere. [Client #1's] constant</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260		
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	<p>screaming and periodic physical aggression are not only stressful for her and staff but also affecting the quality of life of her housemates. [Client #1] will ride with staff if her behavior is somewhat controlled but she is potentially dangerous to the driver if she is agitated.</p> <p>Recommendations:</p> <p>1. [Client #1] needs an alternative residential placement where [Client #1] can be supervised 24/7 that does not require participation in daily activities since [Client #1] resists these. Since [Client #1] can be aggressive towards others it would be best if [Client #1] were not around other individuals who are fragile and unable to protect themselves...</p> <p>3. Continued efforts need to be made to modify [Client #1's] behavior or treat it medically. Despite significant and ongoing efforts to address her behaviors [Client #1] is continuously disruptive to the group home and cannot be taken out into the community except perhaps going through a drive through at a restaurant. At times [Client #1] is not safe to be driven by another person to appointments because of her agitation...."</p> <p>Client #1's Daily Progress Notes were reviewed on 12/6/11 at 12:00 PM. The review indicated the following:</p> <p>-10/1/11, "[Client #1] was in bed shortly</p>				

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	<p>after the beginning of the shift. [Client #1] was trying to hit staff but was redirected by another back to bed. Staff continued to redirect [Client #1] almost the entire shift, she kept attempting to go after staff and individuals in the home."</p> <p>-10/3/11, "[Client #1] tried to attack [client #2] with a fork at the kitchen table. Staff intervened before [client #1] struck [client #2]. [Client #1] got out of the bed to punch and kick staff."</p> <p>-10/6/11, "[Client #1] was in bed when staff came in [Client #1] got up about 2 am screaming and fighting all night she was fighting staff it took both staff to get her washed and dressed (sic)."</p> <p>-10/8/11, "[Client #1] was very aggressive towards staff and the individuals in the home. [Client #1] threw two plates of food, try 9(sic) to throw med's but all med's were found and given. [Client #1] was given a prn (as needed) med for pain. [Client #1] still aggressive towards staff and individuals. [Client #1] threw lunch in trash and went back to the rm (sic). [Client #1] was aggressive again towards staff and individuals in the home.</p> <p>3p- 11p shift: at the beginning of the shift [client #1] was aggressive forward staff and roommate she was redirected to her room she repeated this behavior at which</p>				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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	<p>staff repeatedly redirected her at 9pm she went to bed and came right back out and 1030 pm and continued behaviors (sic)."</p> <p>-10/9/11, "[Client #1] hitting herself on the left side of her face, leg and thigh and pulling her hair. Yelling and screaming. [Client #1] was lying in bed sleep when arrived [client #1] soon after was targeting staff and individuals. [Client #1] was given prn med's for pain."</p> <p>-11/3/11, "[Client #1] was trying to hit [client #3] (sic) staff take [client #1] away from [client #3] and bring her in the living room."</p> <p>-11/4/11, "11p-7a [client #1] was up walking around when staff came in. [Client #1] was trying to hold staff hands. [Client #1] began screaming on and off. [Client #1] did hit at staff 3 times. 2p-10p At 7:25 pm [client #1] began to punch [client #3]. [Client #1] also pulled [client #3's] hair."</p> <p>-11/5/11, "[Client #1] was up hitting individuals and [client #1] was a little aggressive and passing hits as well (sic). [Client #1] ate lunch, was hitting herself and acting out."</p> <p>-11/6/11, "[Client #1] was hitting [client #7] on her leg five times and hit [client</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260		
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	<p>#5] also on her head."</p> <p>-11/12/11, "[Client #1] was in bed when staff came in. [Client #1] was up throughout the night walking in and out of the front room. [Client #1] got up this morning and attacked [client #3]."</p> <p>-11/18/11, "[Client #1] was up sitting on the couch when staff came. [Client #1] started yelling and hitting herself on the leg and head and face. [Client #1] was pulling her hair and was trying to fight staff all threw (sic) the night. [Client #1] was throwing stuff off the front room table and was bringing hard objects out of her room throwing them into the front room."</p> <p>-11/22/11, "This morning all the clients were in the living room and [client #1] was sitting on the couch slapping herself in the face and chest (sic) she finally stopped and all consumers were in dining area and [client #1] was sitting at the table slapping herself and yelling at the table."</p> <p>-11/24/11, "[Client #1] was sitting on the couch yelling then she went to her room lied (sic) down and started yelling and hitting herself. Came back into the living room yelling and stomping her foot...."</p> <p>-11/26/11, "[Client #1] was on the couch</p>				

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	<p>sitting when staff came in she started yelling and hitting herself on the side of her head."</p> <p>-12/1/11, "[Client #1] was up thrown (sic) out the night yelling and hitting her self. [Client #1] did hit another client."</p> <p>DSP (Direct Support Staff) #1 was interviewed on 12/5/11 at 6:10 PM. DSP #1 indicated client #1 targeted client #3 and now client #6. When asked if client #3 was vulnerable and/or able to defend herself, DSP #1 indicated client #3 was in a wheelchair, on portable oxygen, older and not able to defend herself from client #1. When asked if client #3 was afraid and/or intimidated by client #1, DSP #1 indicated yes. When asked if any other clients were fearful of client #1 due to aggression and/or her verbal outbursts, DSP #1 indicated yes. DSP #1 stated client #1's behaviors are "unpredictable" and do not always have clear antecedents. DSP #1 indicated client #1 would attack clients and staff at random.</p> <p>Client #6 was interviewed on 12/6/11 at 11:45 AM. When asked if she liked having client #1 as a new roommate, Client #6 began shaking her head no, crossed her arms and stated, "NO!" When asked if client #1 had hit her, client #6 stated, "yes." When asked if client #1</p>				

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	<p>made her feel afraid or scared, client #6 stated, "yes, uh-huh."</p> <p>DSP #2 was interviewed on 12/6/11 at 11:50 AM. DSP #2 was asked how client #1 was getting along with her peers in the home. DSP #2 stated client #1 was "disruptive" by yelling and "attacking" everyone. When asked which clients client #1 targeted, DSP #2 indicated client #1 targeted clients #3, #6 and #7 but has attacked all of her peers. DSP #2 indicated client #1's roommate was changed from client #3 to client #6. DSP #2 indicated client #6 had been fearful of client #1 and was showing increased self isolation behaviors and refusing to attend her day program since the change of roommates. DSP #1 stated all of the clients in the home are "uncomfortable and intimidated" by client #1. DSP #1 indicated the clients in the group home are elderly and have multiple health issues which makes them vulnerable for client #1's physical aggression. When asked if she had received any training on client #1's behavior, DSP #2 indicated she had not received any additional training on how to monitor/supervise client #1.</p> <p>Client #8 was interviewed on 12/7/11 at 3:10 PM. When asked how things were going in the group home, client #8 stated, "Well, that woman, she is mean." When</p>				

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	<p>asked who he meant by saying that 'mean woman', client #8 indicated client #1. Client #8 indicated client #1 yells a lot and keeps him awake at night. Client #8 stated, "[Client #1] is always trying to fight everyone." When asked if he was afraid of client #1, client #8 stated, "Yes." When asked if he told his staff when he was feeling afraid of client #1, client #8 indicated his staff knew and that he tried to tell them.</p> <p>DSP #3 was interviewed on 12/7/11 at 3:20 PM. When asked how client #1 was doing in the group home, DSP #3 stated, "Not so good. [Client #1] is always up at night yelling and trying to attack her roommate. [Client #1] was hitting [client #6] like a windmill one night. I've never seen anything quite like it. [Client #1] was calm and went to bed and next thing you know she was attacking [client #6]." When asked if client #6 was able to defend herself from client #1's aggression, DSP #3 stated, "[Client #1] is smart, she goes for people she can get. [Client #6] was asleep and laying down in bed and was taken by surprise." When asked if the clients are fearful and/or intimidated by client #1, DSP #3 stated, "Well, I would be. If someone was screaming all the time and then trying to come at me with their fists and throwing things, I would be afraid. I think that they are."</p>				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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	<p>PD #1 was interviewed on 12/7/11 at 1:30 PM. When asked if the clients in the group home were afraid and/or intimidated by client #1, PD #1 indicated yes. When asked if actual harm had occurred from client #1's physically aggression, PD #1 indicated yes. When asked if there is likelihood of potential harm to occur, PD #1 indicated yes. When asked how frequently client #1's physical and verbal behaviors occur, PD #1 indicated client #1 has verbal outbursts daily and physical outbursts of aggression three to four times a week. When asked if she and/or the team were aware of the pattern of client #1's behaviors and the fearfulness of the other clients in the home, PD #1 indicated the facility was aware of the pattern of aggression and was aware the other clients were not comfortable around client #1. When asked if the incidents of client to client aggression in which client #1 had assaulted her housemates had been thoroughly investigated, PD #1 indicated no. When asked if the fear and intimidation of clients #2, #3, #4, #5, #6, #7 and/or #8 was likely to continue, PD #1 indicated yes. When asked if the clients living in fear and intimidation of client #1 was considered neglect/abuse, PD #1 indicated yes.</p>			

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	<p>The facility's policy and procedures were reviewed on 12/7/11 at 5:25 PM. The facility's 9/14/07 policy and procedure entitled Abuse, Neglect, Exploitation operating standard 1.26 indicated, "Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being...." Program intervention neglect is defined as, "failure to provide good and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan, inappropriate application of intervention without a qualified person notification/review.</p> <p>Intimidation/Emotional abuse: the act or failure to act that results or could result in emotional injury to an individual...</p> <p>Discouraging or inhibiting behavior by threatening both actual and implied.</p> <p>Attitude or actions that interfere with the psychological and social well being of an individual...."</p> <p>9-3-2(a)</p>				

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W0154	<p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 3 of 6 allegations of abuse/mistreatment reviewed, the facility failed to conduct an investigation and/or thorough investigation in regards to client #1's aggression toward clients #3, #6, and #7.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 12/5/11 at 12:00 PM. The facility's reportable incident reports indicated the following:</p> <ul style="list-style-type: none"> - BDDS (Bureau of Developmental Disabilities Services) report dated 11/5/11 indicated on 11/4/11, "[Client #1] and [client #3] were returning from going out to dinner with their housemates in the facility van. Without apparent antecedent, [client #1] hit [client #3] in the back of the head with a closed hand and pulled her hair." -BDDS report dated 11/6/11 indicated on 11/6/11, "All consumers and staff were sitting in the living room. [Client #1] got 	W0154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically the facility has completed investigations into the circumstances of incidents of client to client abuse on 11/4/11, 11/6/11 and 11/8/11.</p> <p>PREVENTION: The Program Coordinator/QDDPD will be retrained regarding agency investigation procedures, with emphasis on timely completion. The Operations Team will monitor compliance with investigation timelines and coordinate corrective measures as needed.</p> <p>RESPONSIBLE PARTIES:QDDPD, Support Associates, Operations Team</p>	01/15/2012

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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	<p>up and walked past [client #7] and slapped her forcefully on the left thigh before staff could intervene. Staff separated the two individuals with [client #1] threatening to hit staff...Later in the day [client #6] walked past [client #1] and [client #1] slapped her in the leg without much force. The team will investigate the circumstances of [client #1's] aggression toward her housemates and the team will meet to re-evaluate [client #1's] current behavior supports...."</p> <p>-BDDS report dated 11/8/11 indicated on 11/8/11, "[Client #3] was sitting in the living room by the medication room door and [client #1] was sitting on the living room couch. Without apparent antecedent, [client #1] walked over to [client #3] and grabbed her face. Staff came out of the medication room immediately and separated the two individuals. As a result of the incident [client #3] sustained a two inch scratch on the left side of her face... The team has initiated an investigation into the circumstances of the altercation and will meet to discuss [client #1's] ongoing cycle of aggression."</p> <p>Interview with PD (Program Director) #1 on 12/7/11 at 12:30 PM indicated she had completed an investigation in the 11/4/11 incident regarding client #1 and client #3's incident on the group home van. When</p>			

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W0157	<p>asked what the outcome of the investigation was, PD #1 indicated she had not completed that portion of the investigation. When asked if the investigation contained a summary of findings, PD #1 indicated she had not completed that portion of the investigation. When asked if the investigation was thorough, PD #1 indicated no. When asked if there were any additional investigations regarding client #1 and the 11/6/11 and/or 11/8/11 incidents of client to client aggression, PD #1 indicated no. When asked if incidents of client to client aggression should be investigated, PD #1 indicated yes.</p> <p>Interview with AS (Administrative Staff) #1 on 12/7/11 at 1:40 PM indicated there were no additional investigations available for review.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on interview and record review for 6 of 6 allegations of abuse/mistreatment reviewed, the facility failed to put in place corrective actions/measures to prevent client #1's aggression toward clients #3, #6 and #7.</p> <p>Findings include:</p>	W0157	<p>CORRECTION: <i>If the alleged violation is verified, appropriate action must be taken.</i></p> <p>Specifically, Client #1 has moved to a facility better suited to Client #1's behavioral, social and developmental needs and there have been no further incidents of client to client abuse.</p> <p>PREVENTION: The Program</p>	01/15/2012

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	<p>The facility's reportable incident reports were reviewed on 12/5/11 at 12:00 PM. The facility's reportable incident reports indicated the following:</p> <p>- BDDS (Bureau of Developmental Disabilities Services) report dated 11/5/11 indicated on 11/4/11, "[Client #1] and [client #3] were returning from going out to dinner with their housemates in the facility van. Without apparent antecedent, [client #1] hit [client #3] in the back of the head with a closed hand and pulled her hair."</p> <p>-BDDS reported dated 11/5/11 indicated on 11/5/11, "[Client #1] was sitting on the couch and without apparent antecedent got up approached [client #3] and hit her in the chest."</p> <p>-BDDS report dated 11/6/11 indicated on 11/6/11, "All consumers and staff were sitting in the living room. [Client #1] got up and walked past [client #7] and slapped her forcefully on the left thigh before staff could intervene. Staff separated the two individuals with [client #1] threatening to hit staff... Later in the day [client #6] walked past [client #1] and [client #1] slapped her in the leg without much force. The team will investigate the circumstances of [client #1's] aggression</p>		<p>Coordinator/QDDPD will be retrained on the need to bring all elements of the interdisciplinary team together to implement protective measures when incidents of client to client aggression and intimidation occur. (Addendum, 1/13/12: Retraining will focus on the need to develop modified support strategies as soon as the team identifies a problem, as opposed for allowing a pattern of potentially abusive behavior to develop. Additionally, training will stress the importance of prioritizing facility support tasks to assure that alleged violations are corrected without delay.) Members of the Operations Team will review interdisciplinary team notes and follow-up with facility supervisory staff to oversee the implementation of protective measures when investigations indicate they are indicated. RESPONSIBLE PARTIES: QDDPD, Support Associates, 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 12/16/2011
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>toward her housemates and the team will meet to re-evaluate [client #1's] current behavior supports..."</p> <p>-BDDS report dated 11/8/11 indicated on 11/8/11, "[Client #3] was sitting in the living room by the medication room door and [client #1] was sitting on the living room couch. Without apparent antecedent, [client #1] walked over to [client #3] and grabbed her face. Staff came out of the medication room immediately and separated the two individuals. As a result of the incident [client #3] sustained a two inch scratch on the left side of her face... The team has initiated an investigation into the circumstances of the altercation and will meet to discuss [client #1's] ongoing cycle of aggression."</p> <p>-BDDS report dated 11/12/11 indicated on 11/12/11, "[Client #3] was sitting in her wheelchair watching television. [Client #1] was standing in the middle of the living room floor. Staff was on the couch doing paper work, [client #1] quickly walked over to [client #3] and scratched her on the nose."</p> <p>-BDDS report dated 12/1/11 indicated on 12/1/11, "...[client #1] went to her room, laid down in her bed and appeared to be calm. Fifteen minutes later staff heard [client #1] and her roommate [client #6]</p>				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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	<p>screaming. Staff went other room and observed [client #1] hitting [client #6]...."</p> <p>Client #1's record was reviewed on 12/6/11 at 12:00 PM. Client #1's IDT (Interdisciplinary Team Meeting) notes indicated the following:</p> <p>-6/7/11 IDT agenda indicated PT (Physical Therapy) assessment scheduled and transfer difficulties.</p> <p>-9/8/11 IDT agenda indicated the team discussed possibility of a wheelchair alarm and bedrails.</p> <p>-9/30/11 IDT agenda indicated discussion of neurologist for multiple falls and eye doctor visit, recent PT (Physical Therapy) recommendations and the use of a gait belt.</p> <p>Client #1's BSP (Behavior Support Plan) indicated a dated of 4/26/11.</p> <p>Interview with AS (Administrative Staff) #1 on 12/6/11 at 3:00 PM indicated there were additional IDT notes available for review regarding client #1's physical aggression. AS #1 provided the following IDT notes on 12/6/11 at 4:28 PM. The IDT notes regarding client #1 that were provided by AS #1 included the following:</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 12/16/2011
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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	<p>-9/7/11 IDT indicated, "[Client #1] was supposed to start day program at [day services] today. But was unable because having an incident at home. I explained to [DSA (Day Service Administrator) #1] that until wee were able to find a solution or med's to help relax [client #1] she would not be able to attend program. [DSA #1] agreed and give her a call when she is ready to start program." The IDT attendance rooster indicated the meeting was attended by PD (Program Director) #1 and DSA #1.</p> <p>-10/11/11 IDT indicated, "[Guardian #1] stated that what ever it takes to help [client #1] she is willing to give her. Okay, (sic) she is also concerned about the past medical issue of a hernia. a (sic) was concerned if that could be contributing to [client #1's] behavior." The IDT attendance rooster indicated the meeting was attended by PD #1 and Guardian #1 via phone.</p> <p>--11/12/11 IDT indicated, "I spoke with [guardian #1] over the phone to get approval for moving [client #1] to another bedroom because of aggression towards her roommate and [guardian #1] agreed to the move." The IDT attendance rooster indicated the meeting was attended by PD #1 and guardian #1 via phone.</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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	<p>PD #1 was interviewed on 12/7/11 at 1:30 PM. When asked if there were any additional IDT notes to review, PD #1 indicated there were no additional IDT notes. When asked who should attend an IDT, PD #1 indicated a formal IDT meeting should have herself, the Operations Director, the Licensure/Quality Coordinator, the Group Home Director, the client, the guardian, the nurse if applicable, staff that work with the client and outside agency staff as appropriate. PD #1 indicated no additional people were included in the 9/7/11, 10/11/11 and/or 11/12/11 IDT meetings. When asked if the 9/7/11, 10/11/11 and /or 11/12/11 meetings were considered to be IDT meetings, PD #1 indicated the meetings were more emergent in nature and not actual IDT meetings. When asked if during the 9/7/11, 10/11/11, 11/12/11 and/or any other recent IDT the team had discussed client #1's BSP, staffing protocols, monitoring and/or supervision supports, and/or other programming supports to address client #1's aggression towards her peers, PD #1 indicated the Group Home Director had initiated contact with a behavior consultant and an emergency 1:1 protocol but no IDT discussion had occurred. When asked if the 1:1 protocol that the Group Home Director had implemented on an</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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W0407	<p>emergency basis had been developed into a plan, a written protocol and/or if staff had received training regarding the specialized monitoring, PD #1 indicated the 1:1 written protocol had been developed on 12/6/11 and staff had not been trained regarding special supervision, additional supports or monitoring regarding client #1. When asked if any of the initiatives implemented by either the IDT or the Group Home Director had prevented further reoccurrences of client #1's aggression, PD #1 indicated no.</p> <p>AS #1 was interviewed on 12/6/11 at 3:30 PM. AS #1 indicated the behavior consultant had been conducting an assessment and was in the process of developing a new BSP for client #1. AS #1 indicated the BSP was completed but was not yet distributed and/or implemented. AS #1 provided client #1's new BSP on 12/6/11 at 5:38 PM. Client #1's revised BSP was dated 11/16/11.</p> <p>9-3-2(a)</p> <p>The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on record review and interview for</p>	W0407	CORRECTION: <i>The facility must</i>	01/15/2012

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 12/16/2011
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260		
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	<p>1 of 4 sampled clients (#1), the facility failed to ensure client #1 was not placed in a home with housemates that are of significantly different social needs.</p> <p>Findings include:</p> <p>Client #1's Interdisciplinary Diagnostic and Evaluation Center Form dated 6/22/10 was reviewed on 12/6/11 at 12:00 PM. The form indicated, "It was noted that her housemates often complain and generally tend to avoid [client #1]. [Client #1] often will keep them up all night and can be very aggressive and her constant screaming is very disconcerting to everyone. It was observed that a housemate who came home from some type of activity during the midmorning was almost wincing listening to [client #1] yell in another room and put her hands over her ears... [Client #1] can become aggressive and she will have very persistent screaming... [Client #1's] maladaptive behaviors are screaming and growling or even a high pitched scream that can go on for hours for up to 18 hours. [Client #1] is potentially dangerous to both herself and others... [Client #1] will grab staff and others around the neck. [Client #1] has been known to bite, kick and scratch staff. [Client #1] also has been noted to become physically aggressive towards more fragile individuals with</p>		<p><i>not house clients of grossly different ages, developmental levels and social needs in close physical or social proximity unless the housing is planned to promote the development of all those housed together. Specifically, Client #1 no longer is residing in the facility. The interdisciplinary team will inform the Bureau of Developmental Disability Services of the need to locate a residential setting that meets Client 1's developmental and behavioral needs with an appropriately matched peer group. The Operations Team will also informed BDDS that no such placement exists within Client 1's current agency. PREVENTION: The agency will access outside resources as needed in order to provide for the social and developmental needs of clients when such resources are not available within the agency.. The Operations Team will continue to monitor and oversee the referral process to assure that clients are placed in a socially and developmentally appropriate environment. RESPONSIBLE PARTIES: BDDS Service Coordinator, QDDPD, Support Associates, Operations Team</i></p>		

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260		
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	<p>whom she comes in contact with. [Client #1] is seen frequently by her psychiatrist and medications have been adjusted and changed with limited positive results. [Client #1's] behavior continues to be problematic in both group home and elsewhere. [Client #1's] constant screaming and periodic physical aggression are not only stressful for her and staff but also affecting the quality of life of her housemates. [Client #1] will ride with staff if her behavior is somewhat controlled but she is potentially dangerous to the driver if she is agitated.</p> <p>Recommendations:</p> <p>1. [Client #1] needs an alternative residential placement where [Client #1] can be supervised 24/7 that does not require participation in daily activities since [Client #1] resists these. Since [Client #1] can be aggressive towards others it would be best if [Client #1] were not around other individuals who are fragile and unable to protect themselves...</p> <p>3. Continued efforts need to be made to modify [Client #1's] behavior or treat it medically. Despite significant and ongoing efforts to address her behaviors [Client #1] is continuously disruptive to the group home and cannot be taken out into the community except perhaps going through a drive through at a restaurant. At times [Client #1] is not safe to be driven by another person to appointments</p>				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260		
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	<p>because of her agitation...."</p> <p>DSP (Direct Support Staff) #1 was interviewed on 12/5/11 at 6:10 PM. DSP #1 indicated client #1 targeted client #3 and now client #6. When asked if client #3 was vulnerable and/or able to defend herself, DSP #1 indicated client #3 was in a wheelchair, on portable oxygen, older and not able to defend herself from client #1. When asked if client #3 was afraid and/or intimidated by client #1, DSP #1 indicated yes. When asked if any other clients were fearful of client #1 due to aggression and/or her verbal outbursts, DSP #1 indicated yes. DSP #1 stated client #1's behaviors are "unpredictable" and do not always have clear antecedents. DSP #1 indicated client #1 would attack clients and staff at random. DSP #1 indicated client #1 was not appropriate for the group home.</p> <p>Client #6 was interviewed on 12/6/11 at 11:45 AM. When asked if she liked having client #1 as a new roommate, Client #6 began shaking her head no, crossed her arms and stated, "NO!" When asked if client #1 had hit her, client #6 stated, "yes." When asked if client #1 made her feel afraid or scared, client #6 stated, "yes, uh-huh."</p> <p>DSP #2 was interviewed on 12/6/11 at</p>				

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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	<p>11:50 AM. DSP #2 was asked how client #1 was getting along with her peers in the home, DSP #2 stated client #1 was "disruptive" by yelling and "attacking" everyone. When asked which clients client #1 targeted, DSP #2 indicated client #1 targeted clients #3, #6 and #7 but has attacked all of her peers. DSP #2 indicated client #1's roommate was changed from client #3 to client #6. DSP #2 indicated client #6 had been fearful of client #1 and was showing increased self isolation behaviors and refusing to attend her day program since the change of roommates. DSP #1 stated all of the clients in the home are "uncomfortable and intimidated" by client #1. DSP #1 indicated the clients in the group home are elderly and have multiple health issues which makes them vulnerable for client #1's physical aggression. When asked if she had received any training on client #1's behavior, DSP #2 indicated she had not received any additional training on how to monitor/supervise client #1. DSP #2 indicated client #1 was not appropriate for the group home.</p> <p>Client #8 was interviewed on 12/7/11 at 3:10 PM. When asked how things were going in the group home, client #8 stated, "Well, that woman, she is mean." When asked who he meant by saying that 'mean woman', client #8 indicated client #1.</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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	<p>Client #8 indicated client #1 yells a lot and keeps him awake at night. Client #8 stated, "[Client #1] is always trying to fight everyone." When asked if he was afraid of client #1, client #8 stated, "Yes." When asked if he told his staff when he was feeling afraid of client #1, client #8 indicated his staff knew and that he tried to tell them.</p> <p>DSP #3 was interviewed on 12/7/11 at 3:20 PM. When asked how client #1 was doing in the group home, DSP #3 stated, "Not so good. [Client #1] is always up at night yelling and trying to attack her roommate. [Client #1] was hitting [client #6] like a windmill one night. I've never seen anything quite like it. [Client #1] was calm and went to bed and next thing you know she was attacking [client #6]." When asked if client #6 was able to defend herself from client #1's aggression, DSP #3 stated, "[Client #1] is smart, she goes for people she can get. [Client #6] was asleep and laying down in bed and was taken by surprise." When asked if the clients are fearful and/or intimidated by client #1, DSP #3 stated, "Well, I would be. If someone was screaming all the time and then trying to come at me with their fists and throwing things, I would be afraid. I think that they are." DSP #3 indicated client #1 was not appropriate for the group home.</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260
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	<p>PD #1 was interviewed on 12/7/11 at 1:30 PM. When asked if the clients in the group home were afraid and/or intimidated by client #1, PD #1 indicated yes. When asked if actual harm had occurred from client #1's physically aggression, PD #1 indicated yes. When asked if there is likelihood of potential harm to occur, PD #1 indicated yes. When asked how frequently client #1's physical and verbal behaviors occur, PD #1 indicated client #1 has verbal outbursts daily and physical outbursts of aggression three to four times a week. When asked if she and/or the team were aware of the pattern of client #1's behaviors and the fearfulness of the other clients in the home, PD #1 indicated the facility was aware of the pattern of aggression and was aware the other clients were not comfortable around client #1. When asked if the incidents of client to client aggression in which client #1 had assaulted her housemates had been thoroughly investigated, PD #1 indicated no. When asked if the fear and intimidation of clients #2, #3, #4, #5, #6, #7 and/or #8 was likely to continue, PD #1 indicated yes. When asked if the clients living in fear and intimidation of client #1 was considered neglect/abuse, PD #1 indicated yes. PD #1 indicated client #1 was not appropriate for the</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 1330 W SHAWNEE INDIANAPOLIS, IN46260		
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