

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  09/04/2012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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W0000	<p>This visit was for a post certification revisit (PCR) to the investigation of complaint #IN00111284 completed on 07/19/2012.</p> <p>Complaint #IN00111284: Not Corrected.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: August 27 and 28, September 4, 2012</p> <p>Facility Number: 001065 Provider Number: 15G551 AIM Number: 100239840</p> <p>Survey Team: Brenda Nunan, RN, CDDN, PHNS III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/7/12 by Ruth Shackelford, 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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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W0104	<p><b>CORRECTION:</b></p> <p><i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the agency will oversee and facilitate the following systemic corrections at the facility:</i></p> <ol style="list-style-type: none"> <li>1. Specifically for Client C and Client D, the facility has scheduled physical therapy evaluations, with specific emphasis on the development of safe transfer procedures. The facility nurse will update Client C and Client D's Comprehensive High Risk Plans based on the physical therapist's recommendations.</li> <li>2. Client B has seen an optometrist for annual glaucoma monitoring and his treatment plan has been updated according to the optometrist's recommendations.</li> <li>3. Client C's Comprehensive High Risk Plan for Limited Mobility will be updated to include measures to prevent the development of decubitus ulcers.</li> <li>4. Specifically for Client A, staff will be retrained regarding proper completion of Weekly body Check Sheets and Injury Follow-up Flow charts.</li> </ol> <p><b>PREVENTION:</b></p>	10/04/2012	

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			<p>The agency will assure that the facility implements the following preventative measures</p> <ol style="list-style-type: none"> <li>1.The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly to assure the plans contain protocols developed by the appropriate medical discipline, as well as to assure all individuals have appropriately developed risk plans for all assessed needs. Additionally, members of the Operations and Quality Assurance Teams will review facility risk plans and assessment data as needed but no less than monthly to confirm the proper development of risk plans and protocols.</li> <li>2.The facility nurse will coordinate with professional and day shift support staff to develop a medical appointment tracking system. Additionally, members of the Operations and Quality Assurance Teams will perform spot checks of medical as needed but no less than monthly to confirm medical follow-up occurs as recommended.</li> <li>3.Day shift staff will conduct a daily review of injury follow-up flow charts and body check forms and report any discrepancies to the supervisor and nurse. Facility professional staff and team leads will also review injury</li> </ol>		

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	<p>Based on observation, interview and record review, the governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the health care needs of 3 of 3 sampled clients and 1 additional client (clients A, B, C and additional client D).</p> <p>Findings include:</p> <p>The governing body failed to exercise general policy and operating direction over the facility nursing services to ensure the health care needs of clients C and D were met in regard to safe transfer techniques. The governing body failed to exercise general policy and operating direction over the facility to ensure the</p>		<p>documentation and body checks to assure accuracy. Staff will be retrained regarding the need to fax Body Check forms and completed injury follow-up flow charts to the nurse to facilitate timely monitoring. Members of the Operations and Quality Assurance teams will incorporate reviews of injury documentation and body checks into their ongoing audit process that will occur as needed but no less than monthly.</p> <p><b>Responsible Parties:</b> QDDPD, Support Associates, Nursing Team, Operations Team, Quality Assurance Team</p>		

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	<p>facility's nursing services met the health care needs of client C in regard to post fracture care and pressure ulcer prevention. The facility's health care services failed to meet the nursing needs of client B in regard to monitoring glaucoma and failed to meet the nursing needs of client A in regard to ensuring accurate skin/body checks. Please see W331.</p> <p>This federal tag relates to complaint #IN00111284.</p> <p>This deficiency was cited on 07/19/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview, the facility failed to adequately train staff in safe transfer procedures for 1 of 3 sampled clients (client C) and 1 additional client (client D).</p> <p>Findings include:</p> <p>1. During observations at the group home on 08/27/2012 at 6:00 p.m., Client C transferred from his wheelchair to the sofa with staff assistance. He wore a gait belt around his waist. Direct Support Professional (DSP) #1 stood in front of client C and reached her arms around his waist. Qualified Developmental Professional (QDDP) #1 asked DSP #1 if she needed assistance with the transfer. QDDP #1 stood behind client C. Each staff held client C's gait belt. QDDP #1 also held the waistband of client C's shorts. Client C was lifted from the wheelchair to a standing position by pulling the gait belt and waist band of his shorts. The gait belt was loosely secured and slid under client C's arm pits. The arm fell out of the sling and dangled unsupported during the transfer. Client C</p>	W0189	<p><b>CORRECTION:</b> <i>The facility must provide each employee with, initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Specifically, the facility has scheduled physical therapy evaluations for Client C and Client D, with specific emphasis on the development of safe transfer procedures. The facility has arranged for the physical therapist to provide training to direct support staff toward proper transferring of Client C and Client D.</i></p> <p><b>PREVENTION:</b> The facility nurse will incorporate recommendations from appropriate medical professionals into clients' Comprehensive High Risk Plans and direct support staff will receive initial and ongoing training toward proper implementation of the plans as needed but no less than annually. Facility professional staff and team leads will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands</p>	10/04/2012			

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	<p>pivoted on his left leg and dropped to a seated position on the sofa. Client C used his right arm to push against the sofa cushion and position himself against the backrest of the sofa.</p> <p>Client C's record was reviewed on 08/27/2012 at 1:18 p.m. An undated "PROCEDURE FOR TRANSFERRING [CLIENT C]," indicated, "...The taller lifter behind [client C] should use the gait belt and/or the waistband of his shorts to do the actual lifting. The shorter lifter should place both arms under [client C's] thighs in order to support his buttocks and lower legs...the lifters should count to 3 and lift in unison...his right arm should remain in his sling with waist support during the transfer...."</p> <p>Staff training records were reviewed on 08/27/2012 at 9:30 a.m. The record indicated staff were trained to apply and use a gait belt on 06/29/2012.</p> <p>During an interview on 08/27/2012 at 3:15 p.m., LPN #1 indicated client C had a schedule for changing position every two hours. She stated, "A position shift is adequate to prevent pressure sores." LPN #1 stated, "If [client C] moves from his wheelchair to a regular chair, that is a position shift." She indicated there was no rotation/position chart to ensure</p>		<p>on coaching and training toward proper implementation of Individual high risk plans, including but not limited to safe transferring. Additionally members of the Operations and Quality Assurance Teams will periodically monitor active treatment on an ongoing basis to assure quality service delivery.</p> <p><b>Responsible Parties:</b> QDDPD, Support Associates, Nursing Team, Operations Team, Quality Assurance Team</p>		

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	<p>pressure was relieved to the coccyx (tailbone). LPN #1 indicated the pressure ulcer was healed. She indicated a risk plan was not developed for pressure ulcer prevention. LPN #1 stated, "A risk plan is not necessary because position changes are listed on the MAR (Medication Administration Record)."</p> <p>During an interview on 08/27/2012 at 5:15 p.m., House Manager (HM) #1, stated, "It's best if 2 people assist with the transfer (of client C)." She indicated one staff should position self in front or at the side of client C and the second staff should stand behind the client. She indicated the client is lifted to an upright position with the gait belt and pivoted towards his uninjured side.</p> <p>During an interview on 08/27/2012 at 5:30 p.m., QDDP #1 indicated staff are supposed to supervise and ensure client C keeps his injured arm in the sling. She indicated client C is assisted with transfers by 2 people. QDDP #1 indicated the taller staff should stand behind the client and the other staff in front of him. She stated, "[Client C] braces his legs against the staff positioned in front." She indicated the 2 staff should lift client C to an upright position in unison.</p> <p>During an interview on 08/27/2012 at</p>			

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	<p>5:45 p.m., DSP #1 stated, "[Client C] is monitored all day to ensure he keeps his arm in the sling." DSP #1 indicated the gait belt should have been tight enough to prevent slipping from client C's waist.</p> <p>During an interview on 08/27/2012 at 6:15 p.m., DSP #2 indicated client C had one on one staffing at night. She stated, "We keep an eye on him all day long." DSP #2 indicated the gait belt was not supposed to slide up to client C's armpits during transfers. She indicated staff use the gait belt to pull client C to a standing position for transfers. DSP #2 "[Client C] spends most of his day sitting in the wheelchair or on the sofa." She indicated he lays in his bed for a few hours in the afternoon.</p> <p>During an interview on 08/28/2012 at 1:30 p.m., QDDP #1 indicated she had been trained to transfer client C by using the gait belt and the waist band of his pants to lift him to an upright position. She stated, "Training was talking and motion demonstration." QDDP #1 indicated skill verification was not required during the training.</p> <p>During a phone interview on 08/28/2012 at 1:40 p.m., LPN #1 stated, "I read that it is acceptable to use the waistband of pants to transfer." She stated, "I researched for</p>			

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	<p>ways to transfer someone who is non weight bearing on line." LPN #1 indicated she did not consult Occupational/Physical Therapy (OT/PT) for transfer and mobility techniques. LPN #1 indicated she did not verify skills competency with transfer techniques when she trained staff. LPN #1 indicated the gait belt should not have slid under client C's armpits during transfers. She indicated client C should have kept his arm in the sling and indicated the chest/waist strap should have been secured around the waist and should not have been under client C's chin.</p> <p>2. During observations on 08/27/2012 at 4:20 p.m., DSP #2 held client D's wrists and pulled her from a seated position on the sofa to a standing position. Client D dropped to the floor. DSP #2 placed her arms under client D's armpits and pulled her off the floor to a slumped standing position, then sat her on the sofa.</p> <p>During an observation on 08/27/2012 at 4:45 p.m., DSP #2 placed a wheelchair in front of the sofa cushion where client D sat. She held the back of client D's shorts and pulled her from the sofa into the wheelchair. Client D entered the wheelchair on her knees and was facing the back of the chair. Client D turned herself around in the seat of the</p>						

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	<p>wheelchair and DSP #2 pushed her in the wheelchair to the dining table.</p> <p>During an observation on 08/27/2012 at 5:55 p.m., DSP #2 pushed client D in her wheelchair from the dining table to the living room. The wheelchair was positioned in front of the sofa with the seat of the wheelchair directly in front of the sofa cushion. DSP #2 lifted client D to a standing position by reaching under her armpits. Client D fell forward onto the sofa cushion facing the back of the sofa. Client D repositioned herself to a forward facing position.</p> <p>During an interview on 08/27/2012 at 5:15 p.m., House Manager (HM) #1 indicated she had not been trained in transfer techniques for client D.</p> <p>During an interview on 08/27/2012 at 5:30 p.m., QDDP #1 indicated she had not been trained in transfer techniques for client D.</p> <p>During an interview on 08/27/2012 at 5:45 p.m., DSP #1 indicated she had not been trained in transfer techniques for client D.</p> <p>During an interview on 08/27/2012 at 6:15 p.m., DSP #2 indicated she had not been trained in transfer techniques for</p>			

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	<p>client D.</p> <p>During an interview on 08/28/2012 at 1:40 p.m., LPN #1 indicated she had not trained staff in transfer techniques for client D.</p> <p>9-3-3(a)</p>			
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W0218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview, the facility failed to assess safe transfer procedures for 1 of 3 sampled clients (client C) and 1 additional client (client D).</p> <p>Findings include:</p> <p>1. During observations at the group home on 08/27/2012 at 6:00 p.m., Client C transferred from his wheelchair to the sofa with staff assistance. He wore a gait belt around his waist. DSP #1 stood in front of client C and reached her arms around his waist. Qualified Developmental Professional (QDDP) #1 asked DSP #1 if she needed assistance with the transfer. QDDP #1 stood behind client C. Each staff held client C's gait belt. QDDP #1 also held the waistband of client C's shorts. Client C was lifted from the wheelchair to a standing position by pulling the gait belt and waist band of his shorts. The gait belt was loosely secured and slid under client C's arm pits. The arm fell out of the sling and dangled unsupported during the transfer. Client C pivoted on his left leg and dropped to a seated position on the sofa. Client C used his right arm to push against the sofa cushion and position himself against the</p>	W0218	<p><b>CORRECTION:</b> <i>The comprehensive functional assessment must include sensorimotor development. Specifically, the Facility has scheduled physical therapy evaluations for Client C and Client D, with specific emphasis on the development of safe transfer procedures. The facility nurse will update Client C and Client D's Comprehensive High Risk Plans based on the physical therapist's recommendations.</i></p> <p><b>PREVENTION:</b> The facility Nurse will receive training regarding the need to develop risk plans based on the recommendations of appropriate medical professionals. The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly, to assure the plans contain protocols developed by the appropriate medical discipline. Additionally, members of the Operations and Quality Assurance Teams will review facility risk plans and assessment data as needed but no less than monthly to confirm the proper development of risk plans and protocols.</p>	10/04/2012			

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	<p>backrest of the sofa.</p> <p>Client C's record was reviewed on 08/27/2012 at 1:18 p.m. A risk plan for decreased mobility, dated 02/20/2012, indicated, "...[Client C] is NON-WEIGHT BEARING...Provide standby assistance during transfers and hands on-if needed...Gait belt may be used during transfers if needed...." The risk plan had not been updated to reflect the instructions for care related to the fractured clavicle and did not include accurate information in regard to the transfer technique.</p> <p>An undated "PROCEDURE FOR TRANSFERRING [CLIENT C]," indicated, "...The taller lifter behind [client C] should use the gait belt and/or the waistband of his shorts to do the actual lifting. The shorter lifter should place both arms under [client C's] thighs in order to support his buttocks and lower legs...the lifters should count to 3 and lift in unison...his right arm should remain in his sling with waist support during the transfer...."</p> <p>The record did not indicate an OT/PT evaluation for safe mobility/transfers had been completed.</p> <p>During a phone interview on 08/28/2012</p>		<p><b>Responsible Parties:</b> QDDPD, Support Associates, Nursing Team, Operations Team, Quality Assurance Team</p>	

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  09/04/2012
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256		
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	<p>at 1:40 p.m., LPN #1 stated, "I read that it is acceptable to use the waistband of pants to transfer." She stated, "I researched for ways to transfer someone who is non weight bearing on line." LPN #1 indicated she did not consult OT/PT for transfer and mobility techniques.</p> <p>2. During observations on 08/27/2012 at 4:20 p.m., DSP #2 held client D's wrists and pulled her from a seated position on the sofa to a standing position. Client D dropped to the floor. DSP #2 placed her arms under client D's armpits and pulled her off the floor to a slumped standing position, then sat her on the sofa.</p> <p>During an observation on 08/27/2012 at 4:45 p.m., DSP #2 placed a wheelchair in front of the sofa cushion where client D sat. She held the back of client D's shorts and pulled her from the sofa into the wheelchair. Client D entered the wheelchair on her knees and was facing the back of the chair. Client D turned herself around in the seat of the wheelchair and DSP #2 pushed her in the wheelchair to the dining table.</p> <p>During an observation on 08/27/2012 at 5:55 p.m., DSP #2 pushed client D in her wheelchair from the dining table to the living room. The wheelchair was positioned in front of the sofa with the</p>				

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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	<p>seat of the wheelchair directly in front of the sofa cushion. DSP #2 lifted client D to a standing position by reaching under her armpits. Client D fell forward onto the sofa cushion facing the back of the sofa. Client D repositioned herself to a forward facing position.</p> <p>Client D's record was reviewed on 08/28/2012 at 10:40 a.m. The record did not indicate an OT/PT evaluation had been completed to assess mobility/transfer safety for client D.</p> <p>During an interview on 08/28/2012 at 1:40 p.m., LPN #1 indicated an OT/PT evaluation for mobility/transfer techniques had not been completed for client D.</p> <p>9-3-4(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256		
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W0318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.	W0318	<b>CORRECTION:</b> <i>The facility must ensure that specific health care services requirements are met.</i> 1. Specifically for Client C and Client D, the facility has scheduled physical therapy evaluations, with specific emphasis on the development of safe transfer procedures. The facility nurse will update Client C and Client D's Comprehensive High Risk Plans based on the physical therapist's recommendations. 2. Client B has seen an optometrist for annual glaucoma monitoring and his treatment plan has been updated according to the optometrist's recommendations. 3. Client C's Comprehensive High Risk Plan for Limited Mobility will be updated to include measures to prevent the development of decubitus ulcers. 4. Specifically for Client A, staff will be retrained regarding proper completion of Weekly body Check Sheets and Injury Follow-up Flow charts. <b>PREVENTION:</b> 1. The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly to assure	10/04/2012	

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  09/04/2012
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256		
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			<p>the plans contain protocols developed by the appropriate medical discipline, as well as to assure all individuals have appropriately developed risk plans for all assessed needs. Additionally, members of the Operations and Quality Assurance Teams will review facility risk plans and assessment data as needed but no less than monthly to confirm the proper development of risk plans and protocols.</p> <p>2.The facility nurse will coordinate with professional and day shift support staff to develop a medical appointment tracking system. Additionally, members of the Operations and Quality Assurance Teams will perform spot checks of medical as needed but no less than monthly to confirm medical follow-up occurs as recommended.</p> <p>3.Day shift staff will conduct a daily review of injury follow-up flow charts and body check forms and report any discrepancies to the supervisor and nurse. Facility professional staff and team leads will also review injury documentation and body checks to assure accuracy. Staff will be retrained regarding the need to fax Body Check forms and completed injury follow-up flow charts to the nurse to facilitate timely monitoring. Members of the Operations and Quality Assurance teams will incorporate reviews of injury documentation</p>		

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256		
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	<p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 3 of 3 sampled clients (Clients A, B and C) and 1 additional client (client D).</p> <p>Findings include:</p> <p>The facility's health care services failed to meet the nursing needs of client C in regard to post fracture care and failed to meet the nursing needs of clients C and D in regard to safe transfer techniques. The facility's health care services failed to meet the nursing needs of client C in regard to pressure ulcer prevention. The facility's health care services failed to meet the nursing needs of client B in regard to monitoring glaucoma and failed to meet the nursing needs of client A in regard to skin/body checks. Please see W331.</p> <p>This federal tag relates to complaint #IN00111284.</p>		<p>and body checks into their ongoing audit process that will occur as needed but no less than monthly.</p> <p><b>Responsible Parties:</b> QDDPD, Support Associates, Nursing Team, Operations Team, Quality Assurance Team</p>		

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  09/04/2012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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	<p>This deficiency was cited on 07/19/2012.</p> <p>The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256		
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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W0331	<p><b>CORRECTION:</b></p> <p><i>The facility must provide clients with nursing services in accordance with their needs.</i></p> <p>1. Specifically for Client C and Client D, the facility has scheduled physical therapy evaluations, with specific emphasis on the development of safe transfer procedures. The facility nurse will update Client C and Client D's Comprehensive High Risk Plans based on the physical therapist's recommendations.</p> <p>2. Client B has seen an optometrist for annual glaucoma monitoring and his treatment plan has been updated according to the optometrist's recommendations.</p> <p>3. Client C's Comprehensive High Risk Plan for Limited Mobility will be updated to include measures to prevent the development of decubitus ulcers.</p> <p>4. Specifically for Client A, staff will be retrained regarding proper completion of Weekly body Check Sheets and Injury Follow-up Flow charts.</p> <p><b>PREVENTION:</b></p> <p>1. The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility</p>	09/04/2012	

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  09/04/2012
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256		
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			<p>nursing care plans as needed but no less than quarterly to assure the plans contain protocols developed by the appropriate medical discipline, as well as to assure all individuals have appropriately developed risk plans for all assessed needs. Additionally, members of the Operations and Quality Assurance Teams will review facility risk plans and assessment data as needed but no less than monthly to confirm the proper development of risk plans and protocols.</p> <p>2.The facility nurse will coordinate with professional and day shift support staff to develop a medical appointment tracking system. Additionally, members of the Operations and Quality Assurance Teams will perform spot checks of medical as needed but no less than monthly to confirm medical follow-up occurs as recommended.</p> <p>3.Day shift staff will conduct a daily review of injury follow-up flow charts and body check forms and report any discrepancies to the supervisor and nurse. Facility professional staff and team leads will also review injury documentation and body checks to assure accuracy. Staff will be retrained regarding the need to fax Body Check forms and completed injury follow-up flow charts to the nurse to facilitate timely monitoring. Members of the Operations and Quality</p>		

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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	<p>Based on observation, interview and record review, the facility nursing services failed to ensure occupational/physical therapy evaluations for mobility and safe transfer procedures for 1 of 3 sampled clients (client C) and 1 additional client (client D). The facility nursing services failed to ensure post fracture care instructions were followed and failed to update risk plans when indicated for 1 of 3 sampled clients (client C). The facility nursing staff failed to ensure pressure ulcer prevention for 1 of 3 sampled clients (client C). The facility nursing services failed to ensure recommended medical evaluation/monitoring was completed for 1 of 3 sampled clients (client B) and 1 additional client (client D). The facility nursing services failed to ensure accurate/complete documentation of skin checks for 1 of 3 sampled clients (client A).</p> <p>Finding include:</p>		<p>Assurance teams will incorporate reviews of injury documentation and body checks into their ongoing audit process that will occur as needed but no less than monthly.</p> <p><b>Responsible Parties:</b> QDDPD, Support Associates, Nursing Team, Operations Team, Quality Assurance Team</p>	

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  09/04/2012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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	<p>1. During observations at the group home on 08/27/2012 between 4 p.m. and 6:00 p.m., client C sat on his buttocks in a wheelchair. He wore a sling on his right arm with a chest/waist strap to reduce mobilization of the arm. The chest/waist strap was loosely secured around client C's chest. At 4:55 p.m., the strap was under client C's chin and his right arm dangled away from his body. At 5:00 p.m., client C held his right arm at a 90 degree angle away from his body, resting his elbow on the dining table for 5 minutes. Direct Support Professional (DSP) #2 and House Manager (HM) #1 were present in the room and did not immediately redirect client C to return his arm to his sling. At 5:25 p.m., client C removed his arm from the sling. DSP #1 redirected him to place his arm in the sling but did not ensure the arm was adequately supported. The arm was placed in the sling to the mid forearm and client C's elbow was not supported, allowing him to lift his arm away from his body.</p> <p>During observations at the group home on 08/27/2012 at 6:00 p.m., Client C transferred from his wheelchair to the sofa with staff assistance. He wore a gait belt around his waist. DSP #1 stood in front of client C and reached her arms</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
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	<p>around his waist. Qualified Developmental Professional (QDDP) #1 asked DSP #1 if she needed assistance with the transfer. QDDP #1 stood behind client C. Each staff held client C's gait belt. QDDP #1 also held the waistband of client C's shorts. Client C was lifted from the wheelchair to a standing position by pulling the gait belt and waist band of his shorts. The gait belt was loosely secured and slid under client C's arm pits. The arm fell out of the sling and dangled unsupported during the transfer. Client C pivoted on his left leg and dropped to a seated position on the sofa. Client C used his right arm to push against the sofa cushion and position himself against the backrest of the sofa.</p> <p>Client C was seated on his buttocks during the observation period from 4 p.m. to 6:30 p.m. The seating location was changed but client C did not change sitting positions to relieve pressure to the buttocks.</p> <p>Client C's record was reviewed on 08/27/2012 at 1:18 p.m. An undated "Fracture Care," indicated, "...He (client C) should particularly, avoid raising arm above shoulder level, avoid reaching, pushing, pulling, lifting, stretching...Use sling until further notice. Ensure that it is on properly and adjust it as needed...."</p>						

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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	<p>An undated procedure for "USE AND APPLICATION OF ARM SLING," indicated, "...APPLY THE SLING IN A MANNER AS TO PREVENT MOVEMENT OF THE INJURED SITE OR EXTREMITY...." The procedure did not address use of the chest/waist strap for securing the arm to the body.</p> <p>An undated procedure for "APPLYING AND USE OF A GAIT BELT," indicated, "...WRAP THE BELT AROUND THE CONSUMER'S WAIST AND BUCKLE OR SNAP IT CLOSED...ONCE THE BELT IS BUCKLED, TIGHTEN THE BELT TIGHT ENOUGH SO THAT IT DOES NOT SLIP UP OR DOWN. REMEMBER, THE BELT NEEDS TO BE AROUND THE CONSUMER'S WAIST...."</p> <p>An undated "PROCEDURE FOR TRANSFERRING [CLIENT C]," indicated, "...The taller lifter behind [client C] should use the gait belt and/or the waistband of his shorts to do the actual lifting. The shorter lifter should place both arms under [client C's] thighs in order to support his buttocks and lower legs...the lifters should count to 3 and lift in unison...his right arm should remain in his sling with waist support during the transfer...."</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
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	<p>The record did not indicate an OT/PT evaluation for safe transfer techniques for client C.</p> <p>A risk plan for history of fractures, dated 02/20/2012, indicated, "...[Client C] is NON-WEIGHT BEARING...Staff to provide standby assistance during transfers and hands-on when needed...." The risk plan had not been updated to reflect the instructions for care related to the fractured clavicle and did not include accurate information in regard to the transfer technique.</p> <p>A risk plan for decreased mobility, dated 02/20/2012, indicated, "...[Client C] is NON-WEIGHT BEARING...Provide standby assistance during transfers and hands on-if needed...Gait belt may be used during transfers if needed...." The risk plan had not been updated to reflect the instructions for care related to the fractured clavicle and did not include accurate information in regard to the transfer technique.</p> <p>A nursing note, dated 07/18/2012, indicated, "...Noted L (left) side coccyx are small open area approx (approximately) 2 cm (centimeters) in diameter...Duoderm (hydrocolloid dressing used for pressure ulcers) applied</p>						

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
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	<p>to site...."</p> <p>A nursing note, dated 07/22/2012, indicated, "...Noted area on L coccyx approx 3 cm...Encouraged staff to reposition q (every) 2 (symbol for hour)...."</p> <p>A physician's "Record of Visit," dated 07/24/2012, indicated, "...Keep patient from sitting on pressure ulcer as much as possible...."</p> <p>During an interview on 08/27/2012 at 3:15 p.m., LPN #1 indicated client C had a schedule for changing position every two hours. She stated, "A position shift is adequate to prevent pressure sores." LPN #1 stated, "If [client C] moves from his wheelchair to a regular chair, that is a position shift." She indicated there was no rotation/position chart to ensure pressure was relieved to the coccyx (tailbone). LPN #1 indicated the pressure ulcer was healed. She indicated a risk plan was not developed for pressure ulcer prevention. LPN #1 stated, "A risk plan is not necessary because position changes are listed on the MAR (Medication Administration Record)."</p> <p>During an interview on 08/27/2012 at 5:15 p.m., House Manager (HM) #1, stated, "It's best if 2 people assist with the</p>						

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
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	<p>transfer (of client C)." She indicated one staff should position self in front or at the side of client C and the second staff should stand behind the client. She indicated the client is lifted to an upright position with the gait belt and pivoted towards his uninjured side.</p> <p>During an interview on 08/27/2012 at 5:30 p.m., QDDP #1 indicated staff are supposed to supervise and ensure client C keeps his injured arm in the sling. She indicated client C is assisted with transfers by 2 people. QDDP #1 indicated the taller staff should stand behind the client and the other staff in front of him. She stated, "[Client C] braces his legs against the staff positioned in front." She indicated the 2 staff should lift client C to an upright position in unison.</p> <p>During an interview on 08/27/2012 at 5:45 p.m., DSP #1 stated, "[Client C] is monitored all day to ensure he keeps his arm in the sling." DSP #1 indicated the gait belt should have been tight enough to prevent slipping from client C's waist.</p> <p>During an interview on 08/27/2012 at 6:15 p.m., DSP #2 indicated client C had one on one staffing at night. She stated, "We keep an eye on him all day long." DSP #2 indicated the gait belt was not supposed to slide up to client C's armpits</p>						

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  09/04/2012	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256			
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	<p>during transfers. She indicated staff use the gait belt to pull client C to a standing position for transfers. DSP #2 "[Client C] spends most of his day sitting in the wheelchair or on the sofa." She indicated he lays in his bed for a few hours in the afternoon.</p> <p>During an interview on 08/28/2012 at 1:30 p.m., QDDP #1 indicated she had been trained to transfer client C by using the gait belt and the waist band of his pants to lift him to an upright position. She stated, "Training was talking and motion demonstration." QDDP #1 indicated skill verification was not required during the training.</p> <p>During a phone interview on 08/28/2012 at 1:40 p.m., LPN #1 stated, "I read that it is acceptable to use the waistband of pants to transfer." She stated, "I researched for ways to transfer someone who is non weight bearing on line." LPN #1 indicated she did not consult Occupational/Physical Therapy (OT/PT) for transfer and mobility techniques. LPN #1 indicated she did not verify skills competency with transfer techniques when she trained staff. LPN #1 indicated the gait belt should not have slid under client C's armpits during transfers. She indicated client C should have kept his arm in the sling and indicated the</p>						

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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	<p>chest/waist strap should have been secured around the waist and should not have been under client C's chin.</p> <p>2. During observations on 08/27/2012 at 4:20 p.m., DSP #2 held client D's wrists and pulled her from a seated position on the sofa to a standing position. Client D dropped to the floor. DSP #2 placed her arms under client D's armpits and pulled her off the floor to a slumped standing position, then sat her on the sofa.</p> <p>During an observation on 08/27/2012 at 4:45 p.m., DSP #2 placed a wheelchair in front of the sofa cushion where client D sat. She held the back of client D's shorts and pulled her from the sofa into the wheelchair. Client D entered the wheelchair on her knees and was facing the back of the chair. Client D turned herself around in the seat of the wheelchair and DSP #2 pushed her in the wheelchair to the dining table.</p> <p>During an observation on 08/27/2012 at 5:55 p.m., DSP #2 pushed client D in her wheelchair from the dining table to the living room. The wheelchair was positioned in front of the sofa with the seat of the wheelchair directly in front of the sofa cushion. DSP #2 lifted client D to a standing position by reaching under her armpits. Client D fell forward onto</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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	<p>the sofa cushion facing the back of the sofa. Client D repositioned herself to a forward facing position.</p> <p>Client D's record was reviewed on 08/28/2012 at 10:40 a.m. The record did not indicate an OT/PT evaluation had been completed to assess mobility/transfer safety for client D.</p> <p>A physician's recapitulation order, dated 08/01/2012-08/31/2012, indicated, "...CHECK WEIGHT ONCE A WEEK AT [DAY PROGRAM] OR GROUP HOME...." The record indicated client D had not been weighed since 5/30/2012.</p> <p>A neurology "Record of Visit," dated 08/01/2012, indicated client D was evaluated for dementia and "marked weight loss."</p> <p>A nutritional assessment for 2012 indicated fluctuation in weight. Client D weighed 105 pounds in 12/2011, 95 pounds in 01/2012, 120 pounds in 2/2012, no weight was recorded for 3/2012, 100 pounds in 4/2012. No additional weights were recorded for the year.</p> <p>During an interview on 08/27/2012 at 5:15 p.m., House Manager (HM) #1 indicated she had not been trained in transfer techniques for client D.</p>			

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	<p>During an interview on 08/27/2012 at 5:30 p.m., QDDP #1 indicated she had not been trained in transfer techniques for client D.</p> <p>During an interview on 08/27/2012 at 5:45 p.m., DSP #1 indicated she had not been trained in transfer techniques for client D.</p> <p>During an interview on 08/27/2012 at 6:15 p.m., DSP #2 indicated she had not been trained in transfer techniques for client D.</p> <p>During an interview on 08/28/2012 at 1:40 p.m., LPN #1 indicated an OT/PT evaluation for mobility/transfer techniques had not been completed for client D. She indicated she had not trained staff in transfer techniques for client D. LPN #1 indicated client D had not been referred to the dietitian for weight loss since it was identified at a medical appointment on 08/01/2012. She indicated weights should have been monitored weekly. LPN #1 did not provide a response when asked how "marked weight loss" was identified since there were no weights recorded since 05/31/2012.</p> <p>3. Client B's record was reviewed on</p>				

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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	<p>08/28/2012 at 10:28 a.m. Diagnosis included, but was not limited to glaucoma. The record indicated a vision exam was completed on 12/21/2011. The record indicated, "Future Appointment Date 6 mo (months) (for) glaucoma check...." The record did not indicate the glaucoma check was completed.</p> <p>During an interview on 08/28/2012 at 1:40 p.m., LPN #1 stated, "I keep a tracking sheet for medical appointments. My record indicates the appointment was completed 05/01/2012." LPN #1 indicated a "Record of Visit" was supposed to be obtained for all medical appointments. A "Record of Visit" for the appointment was not provided.</p> <p>4. Client A's record was reviewed on 08/27/2012 at 2:40 p.m. The record indicated client A had a risk plan for skin infections.</p> <p>A physician's recapitulation order, dated 08/01/2012-08/31/2012, indicated, "...SKIN ASSESSMENT WEEKLY ON TUESDAY AT 9 PM...."</p> <p>A "BODY CHECK" sheet, dated 08/20/2012 at 9 p.m., indicated all areas of the body were checked and no marks were found.</p>			

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	<p>A Dermatology note, dated 08/20/2012 at 9:29 a.m., indicated, "...He (client A) presented with blisters...excoriation...on the hand...excoriation...on the calf...RASH &amp; OTH (other) NONSPECIFIC SKIN ERUPTION...."</p> <p>A "BODY CHECK" sheet, dated 08/21/2012 at 9 p.m., "...NO UNUSUAL MARKS FOUND...ointment apply (sic) visible marks..." The body diagram indicated marks were located on the right shoulder, left inner wrist, and right, outer calf.</p> <p>A "BODY CHECK" sheet, dated 08/22/2012 at 9 p.m., indicated, "...NO UNUSUAL MARKS FOUND...marks almost faded..." The body diagram did not indicate a location for the marks.</p> <p>A "BODY CHECK" sheet, dated 08/22/2012 at 9 p.m., indicated, "...NO UNUSUAL MARKS FOUND..marks visible already documented ointment apply (sic)..." The body diagram did not indicate a location for the marks.</p> <p>During an interview on 08/28/2012 at 1:40 p.m., LPN #1 indicated staff were trained to complete the body check form. She indicated staff should have indicated on the body diagram the location of the marks and should have described the</p>			

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	<p>appearance of the marks on the form.</p> <p>This federal tag relates to complaint #IN00111284.</p> <p>This deficiency was cited on 07/19/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			