

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/20/2015
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8044 DARTMOUTH RD INDIANAPOLIS, IN 46260
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W 0000  Bldg. 00	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00174449.</p> <p>Complaint #IN00174449: Substantiated, Federal/state deficiencies related to the allegations are cited at W149 and W154.</p> <p>Dates of Survey: July 13, 14, 15, 16, 17 and 20, 2015.</p> <p>Facility number: 001189 Provider number: 15G627 AIM number: 100245700</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based upon observation, interview and</p>	W 0104	<b>CORRECTION:</b> <i>The Governing</i>	08/19/2015

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>record review, the governing body failed for 2 of 2 sampled clients (clients A and B), and 2 additional clients (clients C and D), to ensure clients did not pay for their replacement meals when dining out.</p> <p>Findings include:</p> <p>During observations on 7/13/15 from 5:50 PM until 6:30 PM clients A, B, C and D ate their evening meal at a local restaurant. Staff #6 indicated to the waiter the clients would need separate checks. At the conclusion of the meal, staff #6 paid for the meals with the checks divided with each clients' money.</p> <p>Staff #6 was interviewed on 7/13/15 at 6:25 PM and indicated the checks would paid with clients' personal money.</p> <p>Client personal financial records were reviewed on 7/14/15 at 4:18 PM and indicated the following instances of clients A, B, C and D eating out for a meal: 7/12/14 (clients A, B, C and D), 7/14/14 (clients A, C and D), 7/26/14 (clients A, C and D), twice on 8/11/14 (clients A, C and D), 8/15/14 (clients A, C and D), 9/16/14 (clients A, C and D), 9/19/14 (clients A, C and D), 9/26/14 (clients A, B, C and D), 10/1/14 (clients A, C and D), 10/18/14 (clients A, C and D), twice on 11/24/14 (clients A, B, C and D), 11/24/14 (clients A, B, C and D), 12/6/14 (clients A, B, C and D), 1/1/15 (clients A, C and D), 1/7/15 (clients A, C and D), 1/10/15 (clients A, B, C and D), 1/27/15 (clients A, B, C and D), 2/2/15 (clients A, C and D), 2/4/15 (clients A, C and D), 3/5/15 (clients A, B and D), 3/12/15 (clients A, B and D), twice on 3/20/15 (clients A, B, C and D), 3/27/15 (clients A, B, C and D), 4/8/15 (clients A, B, C and D), 4/11/15 (clients A, C and D),</p>		<p><i>body must exercise general policy, budget and operating direction over the facility.</i></p> <p>Specifically, the governing body has provided direction and oversight to assure that the facility does not use client funds to pay for replacement meals. <b>ADDENDUM:</b> The governing body is conducting an audit of individual financial records for all facility clients and any money that has been previously spent by clients for meal replacement will be reimbursed by the company. <b>PREVENTION:</b> Facility supervisory staff have been retrained regarding the need to use facility funds to pay for replacement meals when the clients go out to eat as a group and a meal is not prepared at the facility. The Clinical Supervisor, Business Manager and Program Manager will review receipts and transaction logs to assure clients do not pay for replacement meals with their personal funds. <b>RESPONSIBLE PARTIES:</b> QIDP, Direct Support Staff, Operations Team</p>	

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W 0126 Bldg. 00	<p>4/17/15 (clients A, B, C and D), 4/17/15 (clients A, B, C and D), 4/18/15 (clients A, C and D), 4/19/15 (clients A, C and D), 4/29/15 (clients A, C and D), 5/4/15 (clients A, C and D), 5/4/15 (clients A, C and D), 5/9/15 (clients A, C and D), 5/29/15 (clients A, C and D), and on 6/3/15, 6/15/15, 6/11/15, 6/12/15, 6/18/15 and 6/20/15 for clients A, C and D.</p> <p>The Clinical Supervisor was interviewed on 7/14/15 at 5:25 PM and indicated the facility was responsible for paying for replacement client meals if the clients went out to eat as a group.</p> <p>9-3-1(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based upon observation and interview, the facility failed for 2 of 2 sampled clients (clients A and B) and 2 additional clients (clients C and D) to encourage clients to participate in paying for their meals while dining out in a restaurant.</p>	W 0126	<p><b>CORRECTION:</b></p> <p><i>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so</i></p>	08/19/2015

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	<p><b>Findings include:</b></p> <p>During observations on 7/13/15 from 5:50 PM until 6:30 PM clients A, B, C and D ate their evening meal at a local restaurant. Staff #6 indicated to the waiter the clients would need separate checks. At the conclusion of the meal, staff #6 paid for the meals with the checks divided with each clients' money.</p> <p>Staff #6 was interviewed on 7/13/15 at 6:25 PM and indicated the checks would paid with clients' personal money.</p> <p>The Clinical Supervisor was interviewed on 7/14/15 at 5:25 PM and indicated the staff should encourage clients to participate in training to increase their skills in paying for their own meals.</p> <p>9-3-2(a)</p>		<p><i>to the extent of their capabilities.</i> Specifically, the facility staff will be retrained regarding the need to allow clients to carry their own money, unless otherwise specified in the Individual Support Plan and to participate in making purchases during community outings.</p> <p><b>PREVENTION:</b></p> <p>Facility professional staff will be retrained regarding each client's right to carry personal spending money and to participate in making purchases. Supervisory staff will observe direct support professionals during recreational outings and shopping environments no less than monthly to assure clients participate in spending their money. The QIDP and members of the Operations Team comprised of Clinical Supervisors, Program Manager, Nurse Manager and Executive Director will review the facility activity calendar and perform unannounced spot checks during scheduled community outings to assure clients participate in making purchases. This administrative monitoring will occur no less than twice per quarter and more frequently if deficiencies are noted.</p>	

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based upon record review and interview, the facility failed for 2 of 2 sampled clients (clients A and B), to implement policy and procedures to protect clients from abuse, neglect and mistreatment by failing to document a thorough investigation into an allegation of neglect.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS), internal incident reports and investigations were reviewed on 7/14/15 at 8:45 AM. BDDS reports for clients A and B dated 5/23/15 indicated on 5/23/15, at 10:30 PM evening shift staff #4 called to inform the Residential Manager "that night shift was leaving and she had already clocked out. It was brought to the managers (sic) attention that both parties had left individuals unattended." Corrective action indicated the staff had been suspended pending investigation of the incident.</p>	W 0149	<p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Clinical Supervisor</p> <p><b>CORRECTION:</b></p> <p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence and assure that discrepancies in testimony are reconciled and addressed in the documentation of the investigation.</i></p>	08/19/2015

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	<p>An Investigative Summary dated 5/26/15-5/28/15 indicated the following:</p> <p>An undated statement from staff #2 "DSP (Direct Support Professional)/alleged perpetrator 'I was told to help out by coming in at 10 pm...When I arrived, I met [staff #4] standing outside next to the car. I saw the front door open. When I parked my car. (sic) I walked to the door and she was away from the home (by the driveway) her car was parked in front of the van. She waved to me and said 'I see you' (sic) I tried to stop her but she was done. I went in the house (sic) walked through and called [Residential Manager (RM)] and explained what has happened. She (RM) said I will talk to her. I did not clock in due to the situation. I did my work though the nite (sic) and she did not call back. I do not know if she [staff #4] has to leave the house without me being there. We have to change shifts in the house and this has never happened before...My main concern is that she was outside and the front door was wide open."</p> <p>An undated statement from the RM indicated "[Group Home] [staff #4] called and informed me that [staff #2] (night shift) never clocked in and was leaving. I told [staff #4] to stay at the site until I called [staff #2]. I called [staff #2] and he informed me that [staff #4] was clocked out when he arrived and she refused to do the buddy check so he left. I asked [staff #2] to go back to the site. When [staff #2] arrived back at the site he informed me that [staff #4] was gone and the door was wide open. Consumers were left in the house unattended."</p> <p>Undated statements by clients A and B indicated client B was unaware of an incident on 5/23/15 and client A indicated clients A and B were the only clients in the group home on 5/23/15.</p>		<p><b>PREVENTION:</b></p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. These criteria will include but not be limited to assuring that documentation of the investigation includes</p>	

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	<p>An undated statement by the RM #2 indicated she had received a call from staff #4 "saying that [staff #2] had come in and said he had gotten stopped by the police. He got in about 10:10 pm. She (staff #2) was already clocked out and [staff #2] had left. I asked [staff #4] to repeat herself to make sure I understood. She said she had already clocked out and no one was at the home. [Staff #2] had just left with the door open...[Staff #2] called me on 5/25/15...When he got to the group home [Staff #4] was outside with her boyfriend. He (staff #2) walked up the grass and came up to the house. [Staff #2] said he went and checked the rooms and doors in the bedrooms as he always does when he comes on. [Staff #2] said he forgot to clock in." Staff #2 indicated he called the RM to let her know that staff #4 "was outside with her boyfriend and they did not do the count (of medications), she just left."</p> <p>Progress notes included in the investigation for clients A and B failed to indicate documentation for 10:00 PM and 11:00 PM. Time detail records included in the the investigation for the group home on 5/23/15 indicated staff #4 clocked out at 10:12 PM and staff #2 clocked in at 10:34 PM.</p> <p>The conclusion of the investigation indicated "The evidence does not substantiate that [staff #4] left the clients unattended during her shift. The evidence does not substantiate that [staff #2] left the clients unattended during his shift." The investigation failed to identify the discrepancies between the witness statements and to clarify or explain why the conclusion of the investigation was unsubstantiated.</p> <p>The Clinical Supervisor was interviewed on 7/14/15 at 5:25 PM and indicated the allegation was unsubstantiated as there was not sufficient</p>		<p>consideration of all gathered evidence, with emphasis on resolving discrepancies noted during the investigation process. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team</p>		

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W 0154  Bldg. 00	<p>evidence to indicate clients had been left alone. She indicated the discrepancies in the statements had been identified and discussed during the course of the investigation, but were not addressed in the documentation of the investigation.</p> <p>The facility's Abuse, Neglect, Exploitation Operating Standard revised 9/14/07 was reviewed on 7/16/15 at 1:00 PM and indicated "Adept employees actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, and local, state and federal guidelines."</p> <p>This federal tag relates to complaint #IN00174449.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly</p>			

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	<p>investigated.</p> <p>Based upon record review and interview, the facility failed for 2 of 2 sampled clients (clients A and B), to implement policy and procedures to protect clients from abuse, neglect and mistreatment by failing to document a thorough investigation into an allegation of neglect.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS), internal incident reports and investigations were reviewed on 7/14/15 at 8:45 AM. BDDS reports for clients A and B dated 5/23/15 indicated on 5/23/15, at 10:30 PM evening shift staff #4 called to inform the Residential Manager "that night shift was leaving and she had already clocked out. It was brought to the managers (sic) attention that both parties had left individuals unattended." Corrective action indicated the staff had been suspended pending investigation of the incident.</p> <p>An Investigative Summary dated 5/26/15-5/28/15 indicated the following:</p> <p>An undated statement from staff #2 "DSP (Direct Support Professional)/alleged perpetrator 'I was told to help out by coming in at 10 pm...When I arrived, I met [staff #4] standing outside next to the car. I saw the front door open. When I parked my car. (sic) I walked to the door and she was away from the home (by the driveway) her car was parked in front of the van. She waved to me and said 'I see you' (sic) I tried to stop her but she was done. I went in the house (sic) walked through and called [Residential Manager (RM)]</p>	W 0154	<p><i>The facility must have evidence that all alleged violations are thoroughly investigated.</i></p> <p>Specifically, the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence and assure that discrepancies in testimony are reconciled and addressed in the documentation of the investigation.</p> <p><b>PREVENTION:</b></p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all</p>	08/19/2015	

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	<p>and explained what has happened. She (RM) said I will talk to her. I did not clock in due to the situation. I did my work though the nite (sic) and she did not call back. I do not know if she [staff #4] has to leave the house without me being there. We have to change shifts in the house and this has never happened before...My main concern is that she was outside and the front door was wide open."</p> <p>An undated statement from the RM indicated "[Group Home] [staff #4] called and informed me that [staff #2] (night shift) never clocked in and was leaving. I told [staff #4] to stay at the site until I called [staff #2]. I called [staff #2] and he informed me that [staff #4] was clocked out when he arrived and she refused to do the buddy check so he left. I asked [staff #2] to go back to the site. When [staff #2] arrived back at the site he informed me that [staff #4] was gone and the door was wide open. Consumers were left in the house unattended."</p> <p>Undated statements by clients A and B indicated client B was unaware of an incident on 5/23/15 and client A indicated clients A and B were the only clients in the group home on 5/23/15.</p> <p>An undated statement by the RM #2 indicated she had received a call from staff #4 "saying that [staff #2] had come in and said he had gotten stopped by the police. He got in about 10:10 pm. She (staff #2) was already clocked out and [staff #2] had left. I asked [staff #4] to repeat herself to make sure I understood. She said she had already clocked out and no one was at the home. [Staff #2] had just left with the door open...[Staff #2] called me on 5/25/15...When he got to the group home [Staff #4] was outside with her boyfriend. He (staff #2) walked up the grass and came up to the house. [Staff #2] said he went and checked the</p>		<p>investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. These criteria will include but not be limited to assuring that documentation of the investigation includes consideration of all gathered evidence, with emphasis on resolving discrepancies noted during the investigation process. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in</p>	

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	<p>rooms and doors in the bedrooms as he always does when he comes on. [Staff #2] said he forgot to clock in." Staff #2 indicated he called the RM to let her know that staff #4 "was outside with her boyfriend and they did not do the count (of medications), she just left."</p> <p>Progress notes included in the investigation for clients A and B failed to indicate documentation for 10:00 PM and 11:00 PM. Time detail records included in the the investigation for the group home on 5/23/15 indicated staff #4 clocked out at 10:12 PM and staff #2 clocked in at 10:34 PM.</p> <p>The conclusion of the investigation indicated "The evidence does not substantiate that [staff #4] left the clients unattended during her shift. The evidence does not substantiate that [staff #2] left the clients unattended during his shift." The investigation failed to identify the discrepancies between the witness statements and to clarify or explain why the conclusion of the investigation was unsubstantiated.</p> <p>The Clinical Supervisor was interviewed on 7/14/15 at 5:25 PM and indicated the allegation was unsubstantiated as there was not sufficient evidence to indicate clients had been left alone. She indicated the discrepancies in the statements had been identified and discussed during the course of the investigation, but were not addressed in the documentation of the investigation.</p> <p>This federal tag relates to complaint #IN00174449.</p> <p>9-3-2(a)</p>		<p>progressive corrective action to all applicable team members.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/20/2015
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 8044 DARTMOUTH RD INDIANAPOLIS, IN 46260		
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