STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
W 000 Bldg. 00	This visit was for an extended annual recertification and state licensure survey. Dates of Survey: March 31, April 6, 7, 8, 9, 10 and 13, 2015. Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000 These federal deficiencies also reflect state findings in accordance with 460 IAC 9.	W 000		
W 104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2), the governing body failed to exercise general policy and operating direction over the facility: To ensure the facility staff immediately reported all allegations of abuse, neglect and/or injuries of unknown origin to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC	W 104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically, the governing body has facilitated the following: Facility staff have been retrained regarding procedures for immediate notification of	05/13/2015

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1 and to ensure all allegations of neglect, abuse, and/or injuries of unknown origin were investigated. To ensure the rights of client #1 by not ensuring a legally sanctioned representative or a health care representative was provided for client #1 when making informed decisions in regard to the client's medical and psychological needs. To prevent neglect and/or abuse in regard to the failure to review and/or look at the patterns and number of injuries incurring after the use of restraints for client #1 and to ensure the implementation of the restraint techniques was not causing further injury to client #1. To ensure health care services developed and implemented a specific plan of care and/or a protocol to address clients with probable head injuries due to accidents, behaviors and/or falls, to ensure the plan included what staff were to monitor after clients hit their head, how long staff were to		supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. The Operations Team, including the Program Manager, will directly oversee all investigations. The QIDP 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. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	monitor the clients, what staff were to report to nursing in regard to monitoring for a possible head injury and what staff were to document when monitoring a client for possible head injury for clients #1 and #2, to ensure the dietary recommendations of the dietician were addressed with client #1's physician and to ensure client #1 was provided an annual physical examination by the physician. To ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' active treatment programs. Findings include: 1. The governing body failed to ensure the rights of the client by not ensuring a legally sanctioned representative or a health care representative for client #1 when making informed decisions in regard to the client's medical and psychological needs. Please see W125. 2. The governing body failed to implement its policy and procedures to ensure facility staff immediately reported all allegations of abuse, neglect and/or		All facility staff have been retrained regarding proper documentation of behavioral incidents including providing a specific description of interventions used including but not limited to physical restraint and gentle blocking techniques. Improved documentation will nurse and QIDP to identify patterns and frequency and origin of injuries occurring during behavioral episodes. When injuries occur that may have resulted from improper application of approved restraint techniques or the use of unapproved techniques, the facility will follow the agency's protocols for investigation of allegations of abuse, neglect and mistreatment, including suspension of involved staff during the course of the investigation. The facility has reassessed Client 1's ability to give informed consent and will arrange to obtain a legal guardian for Client #1. The facility has obtained an annual physical examination for Client #1. A review of medical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	injuries of unknown origin to the administrator and to the BDDS and to APS according to state law for client #1 and to ensure all allegations of neglect, abuse, and/or injuries of unknown origin were investigated. The governing body failed to implement its policy and procedures to prevent neglect and/or abuse in regard to the failure to review and/or look at the patterns and number of injuries incurring after the use of restraints for client #1 and to ensure the implementation of the restraint techniques was not causing further injury to client #1. The governing body failed to implement its policy and procedures to ensure health care services developed and implemented a specific plan of care and/or a protocol to address clients with probable head injuries due to accidents, behaviors and/or falls, to ensure the plan included what staff were to monitor after clients hit their head, how long staff were to monitor the clients, what staff were to report to nursing in regard to monitoring for a possible head injury and what staff were to document when monitoring a client for possible head injury for clients #1 and #2, to ensure the dietary recommendations of the dietician were addressed with client #1's physician and to ensure client #1 was provided an annual physical examination by the physician.		records indicated this deficient practice did not affect any additional clients. Specifically for Clients#1 and #2, the facility nurse will develop Comprehensive High Risk Plan with protocols to address probable head injuries due to accidents, behaviors and/or falls. The plans will include but not be limited to instructing staff on what to monitor after clients hit their head, how long staff are to monitor clients, what staff are to report to nursing in regard to what monitoring for possible head injuries and what staff are to document when monitoring clients for possible head injury. A review of documentation indicated this deficient practice could have affected other clients and therefore similar risk plans will be developed for Client #3 and Client #4. Additionally, the nurse will provide Client #1's primary care physician with current dietary recommendations to obtain clarified diet orders from the physician. A review of facility documentation indicated this deficient practice did not affect other clients.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	Please see W149. 3. The governing body failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' active treatment programs. The QIDP failed: __To review and revise client #1's financial program objective. __To ensure the IDT (Interdisciplinary Team) assessed/reassessed client #2's dining needs. __To ensure client #2's ISP (Individual Support Plan) addressed client #2's identified need for training in regard to dining to ensure the client ate at a safe pace and took small bites. __To ensure client #2's ISP addressed how the staff were to assist and monitor client #2 while dining to ensure the client took small bites of food and small sips of liquids. __To review and/or look at the patterns and number of injuries incurring after restraints for client #1 to ensure the implementation of the restraint techniques was not causing injury to client #1. __To ensure client #2 was provided with the recommended diet texture of a mechanical soft diet. __To ensure the staff provided training in meal preparation and family style dining		**PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	when formal and informal training opportunities existed for client #2. Please see W159. 9-3-1(a)		intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. 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. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			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. Client #1 will receive complete body checks no less than twice weekly and daily during periods of high agitation and frequent episodes of targeted behaviors. Other clients will continue to received weekly body checks, unless the interdisciplinary team determines more frequent checks are indicated based on an increase in targeted behaviors. The QIDP and nurse will review all incident documentation upon receipt and will compare it with injury follow-up documentation no less than weekly to check for and identify patterns of injuries occurring during behavioral episodes and incidents in which restraints were utilized. The interdisciplinary team will develop and implement protective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			measures when patterns of injuries emerge. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will include assuring patterns of injuries occurring after restraints and other behavioral episodes are identified and appropriate protective measures developed as appropriate. Professional staff will be retrained regarding the need to assure that all individuals have appropriate assistance making major life decision, based on their assessed ability to give informed consent. The interdisciplinary team with assistance from the Operations team is reviewing informed consent assessments for all clients and will obtain appropriate legal representation for clients as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that examinations including but not limited to physical evaluations take place as required. The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			facility risk plans on an ongoing basis. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. Administrative monitoring will focus on 1. Identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. 2. Assuring the team identifies patterns of injuries resulting from behavioral episodes, the use of restraints and other trends and develops additional protective and preventative measures accordingly. 3. Assuring all relevant assessments have corresponding physician's orders as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
			4. Assuring correct implementation of diet orders. 5. Assuring meal preparation training occurs and family style dining is supported with all clients.	
W 122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (#1 and #2). The facility failed to implement its policy and procedures to ensure facility staff immediately reported all allegations of abuse, neglect and/or injuries of unknown origin to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1 and to ensure all allegations of neglect, abuse, and/or injuries of unknown origin were investigated. The facility failed to prevent neglect/abuse in regard to the failure to review and/or look at the patterns and	W 122	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically, the governing body has facilitated the following: Facility staff have been retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. The Operations Team, including	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	number of injuries incurring after the use of restraints for client #1 and to ensure the implementation of the restraint techniques was not causing further injury to client #1. The facility failed to ensure health care services developed and implemented a specific plan of care and/or protocol to address clients with probable head injuries due to accidents, behaviors and/or falls, to ensure the plan included what staff were to monitor after clients hit their head, how long staff were to monitor the clients, what staff were to report to nursing in regard to monitoring for a possible head injury and what staff were to document when monitoring a client for possible head injury for clients #1 and #2, to ensure the dietary recommendations of the dietician were addressed with client #1's physician and to ensure client #1 was provided an annual physical examination by the physician. Findings include: 1. The facility neglected to implement its policy and procedures to ensure facility staff immediately reported all allegations of abuse, neglect and/or injuries of unknown origin to the administrator and to the BDDS and to APS according to		the Program Manager, will directly oversee all investigations. The QIDP 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. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days. All facility staff have been retrained regarding proper documentation of behavioral incidents including providing a specific description of interventions used including but not limited to physical restraint and gentle blocking techniques. Improved documentation will nurse and QIDP to identify patterns and frequency and origin of injuries occurring during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	state law for client #1 and to ensure all allegations of neglect, abuse, and/or injuries of unknown origin were investigated. The facility failed to implement its policy and procedures to prevent neglect and/or abuse in regard to the failure to review and/or look at the patterns and number of injuries incurring after the use of restraints for client #1 and to ensure the implementation of the restraint techniques was not causing further injury to client #1. The facility failed to implement its policy and procedures to ensure health care services developed and implemented a specific plan of care and/or a protocol to address clients with probable head injuries due to accidents, behaviors and/or falls, to ensure the plan included what staff were to monitor after clients hit their head, how long staff were to monitor the clients, what staff were to report to nursing in regard to monitoring for a possible head injury and what staff were to document when monitoring a client for possible head injury for clients #1 and #2, to ensure the dietary recommendations of the dietician were addressed with client #1's physician and to ensure client #1 was provided an annual physical examination by the physician. Please see W149. 2. The facility failed to immediately report all allegations of abuse to the		behavioral episodes. When injuries occur that may have resulted from improper application of approved restraint techniques or the use of unapproved techniques, the facility will follow the agency's protocols for investigation of allegations of abuse, neglect and mistreatment, including suspension of involved staff during the course of the investigation. The facility has reassessed Client 1's ability to give informed consent and will arrange to obtain a legal guardian for Client #1. The facility has obtained an annual physical examination for Client #1. A review of medical records indicated this deficient practice did not affect any additional clients. **PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	administrator and to the BDDS and APS according to state law for client #1 and to ensure all injuries of unknown origin were reported immediately to the administrator. Please see W153. 3. The facility failed to ensure an investigation was conducted in regard to an allegation of abuse made by client #1 and to ensure all injuries of unknown origin were investigated for client #1. Please see W154. 9-3-2(a)		required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			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. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			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. Client #1 will receive complete body checks no less than twice weekly and daily during periods of high agitation and frequent episodes of targeted behaviors. Other clients will continue to received weekly body checks, unless the interdisciplinary team determines more frequent checks are indicated based on an increase in targeted behaviors. The QIDP and nurse will review all incident documentation upon receipt and will compare it with injury follow-up documentation no less than weekly to check for and identify patterns of injuries occurring during behavioral episodes and incidents in which restraints were utilized. The interdisciplinary team will develop and implement protective measures when patterns of injuries emerge. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
			days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will include assuring patterns of injuries occurring after restraints and other behavioral episodes are identified and appropriate protective measures developed as appropriate. Professional staff will be retrained regarding the need to assure that all individuals have appropriate assistance making major life decision, based on their assessed ability to give informed consent. The interdisciplinary team with assistance from the Operations team is reviewing informed consent assessments for all clients and will obtain appropriate legal representation for clients as needed. The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that examinations including but not limited to physical evaluations take place as required. The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
			days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. Administrative monitoring will focus on 1. Identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. 2. Assuring the team identifies patterns of injuries resulting from behavioral episodes, the use of restraints and other trends and develops additional protective and preventative measures accordingly. 3. Assuring all relevant assessments have corresponding physician's orders as appropriate. 4. Assuring correct implementation of diet orders. 5. Assuring meal preparation training occurs and family style dining is supported with all clients.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			RESPONSIBLE PARTIES: QIDP, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager	
W 125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 1 of 2 sampled clients (#1), the facility failed to ensure the rights of the client by not ensuring a legally sanctioned representative or a health care representative for client #1 when making informed decisions in regard to the client's medical and psychological needs. Findings include: Client #1's record was reviewed on 4/8/15 at 12:30 PM and on 4/9/15 at 11 AM. Client #1's record indicated diagnoses of, but not limited to, Mild MR (Mental	W 125	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.*Specifically, the facility has reassessed Client 1's ability to give informed consent and will arrange to obtain a legal guardian for Client #1. **PREVENTION:**	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	Retardation), IED (Intermittent Explosive Disorder), Disruptive Disorder, Depressive Disorder, Borderline Personality Disorders, Expressive language Disorder, Obesity, Seizure Disorder, GERD (Gastric Esophageal Reflux Disease), Asthma, Hypothyroidism, Chronic Constipation and High Cholesterol. Client #1's 3/2015 physician's orders indicated client #1 received the following behavior medications: Thorazine 50 mg (milligrams) three times a day for IED and Borderline Personality Disorders. Invega 117 mg IM (Intramuscularly) once a month for IED. Ritalin 15 mg twice a day for behavior control. Remeron 30 mg for depression. Zoloft 100 mg once a day for depression. Topamax 200 mg twice a day for mood disorders. Benztropine 1 mg (milligram) qd (once a day) for side effects of the behavior medications. Client #1's BSP (Behavior Support Plan) dated 3/27/15 indicated client #1 had the following targeted behaviors: SIB (Self Injurious Behaviors) of head banging, touching hot items, biting self, throwing herself		Professional staff will be retrained regarding the need to assure that all individuals have appropriate assistance making major life decision, based on their assessed ability to give informed consent. The interdisciplinary team with assistance from the Operations team is reviewing informed consent assessments for all clients and will obtain appropriate legal representation for clients as needed. **RESPONSIBLE PARTIES:** QIDP, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	against doors or walls, attempting to cut herself, attempting to ingest non-edible materials and/or objects, attempting to lick electrical outlets, attempting to gag herself, wrapping objects around her neck, crawling through the house, sitting down in parking lots - either in front of or in back of vehicles which she believes are going to move or sits in the drive way or in the road or refuses to wear a seat belt in the van. Physical aggression. Verbal aggression. Property disruption/destruction. Leaving her assigned area without supervision. Non-compliance with medical requests. Non-compliance with program tasks. False allegations of mistreatment. Socially offensive behaviors. Client #1's ISP (Individualized Support Plan) dated 3/16/15 indicated client #1's mother was still living but did not participate in client #1's development of her ISP and/or BSP (Behavior Support Plan). Client #1's Informed Consent Assessment dated 3/16/15 indicated client #1 was in need of a legal representative.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	During interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 4/7/15 at 2 PM, the QIDPD: __Indicated client #1's mother was not involved in client #1's care. __Indicated she had difficulty contacting client #1's mother. __Stated client #1's mother visited "maybe once a year." __Indicated the IDT (Interdisciplinary Team) advocated for client #1 when needed. __Indicated client #1 was not able to advocate for herself in regard to her medical and psychological needs and was in need of a representative. 9-3-2(a)			
W 149 Bldg. 00	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 on record review and interview for 2 of 2 sampled clients (#1 and #2), the facility neglected to implement its policy and procedures to ensure facility staff immediately reported all allegations of abuse, neglect and/or injuries of unknown origin to the administrator and to the BDDS (Bureau of Developmental Disabilities	W 149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically:	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1 and to ensure all allegations of neglect, abuse, and/or injuries of unknown origin were investigated. The facility failed to implement its policy and procedures to prevent neglect and/or abuse in regard to the failure to review and/or look at the patterns and number of injuries incurring after the use of restraints for client #1 and to ensure the implementation of the restraint techniques was not causing further injury to client #1. The facility failed to implement its policy and procedures to ensure health care services developed and implemented a specific plan of care and/or a protocol to address clients with probable head injuries due to accidents, behaviors and/or falls, to ensure the plan included what staff were to monitor after clients hit their head, how long staff were to monitor the clients, what staff were to report to nursing in regard to monitoring for a possible head injury and what staff were to document when monitoring a client for possible head injury for clients #1 and #2, to ensure the dietary recommendations of the dietician were addressed with client #1's physician and to ensure client #1 was provided an annual physical examination by the physician. Findings include:		Facility staff have been retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients. The Operations Team, including the Program Manager, will directly oversee all investigations. The QIDP 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. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	1. The facility's reportable and investigative records for 2015 were reviewed on 3/31/15 at 1:30 PM, 4/6/15 at 11 AM and 4/7/15 at 1 PM. The facility records indicated no allegation of abuse made by client #1. The 2/19/15 BDDS report indicated on 2/18/15 "[Client #1] complained of a headache and showed staff a bump along with a red/purple area on the back of her head that resulted from a previous behavior and head banging on 2/12/15. As of 2/13/15 it was documented the bump was quarter sized and was now a half dollar sized bump. Staff notified the nurse, [name of nurse], who then instructed staff to take [client #1] out to be seen at the Urgent Care. When staff arrived at the Urgent Care, they were instructed to take [client #1] out to the ER (Emergency Room). Staff then transported [client #1] to [name of hospital]. When they arrived at [name of hospital], the doctor ordered a CT Scan (x-ray)." The report indicated client #1 was treated and released to return to her home. The report indicated "Staff will continue to monitor the bump on [client #1's] head using the injury flow sheets provided until the injury is healed. Staff will immediately notify the nurse if her condition worsens." Client #1's record was reviewed on 4/8/15 at 12:30 PM and 4/9/15 at 11 AM. Client #1's hospital record for the visit of 2/18/15 indicated "HISTORY OF PRESENT ILLNESS: This is a... female with chief		of the QIDP throughout the investigation process for the next 90 days. **PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	complaint of head injury. She has a right posterior hematoma (a localized swelling filled with blood). She (client #1)... lives in a group home and they (the staff) are not exactly sure when she sustained the injury. She does wear a helmet at times when she has behavioral issues and does do some head banging with that but they do not believe it was during one of those episodes. The patient actually reported a caregiver at the facility named (name of staff) pulled her down on the ground and when she (the staff) did, she (client #1) hit her head but she does not know when it occurred and neither does the caregiver that is here with her from the facility though they (the facility) are investigating the issue per their report." During telephone interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 4/10/15 at 1 PM, the QIDPD: __Stated, "I must have missed that when I read her paperwork from the hospital." __Indicated she was not aware of the allegation of abuse made by client #1 while at the hospital and was on vacation during this time. __Indicated the QIDPD covering for her should have addressed the allegation of abuse made by client #1 while in the hospital. __Indicated all allegations of abuse were to be reported to the administrator, to the BDDS and to APS. __Indicated all allegations of abuse were to be thoroughly investigated.		for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	2. The facility's reportable records and the IFFCs (Injury Follow-up Flow Charts) for 2015 were reviewed on 3/31/15 at 1:30 PM, on 4/6/15 at 11 AM and on 4/7/15 at 1 PM. The IFFCs indicated for client #1: 2/5/15 "Inner left thigh cluster of small purple bruises." 2/12/15 "Both thighs by vagina have several bruises pea size and pin dot." 2/18/15 "Left inner thigh by vagina dime size bruise. Right inner thigh (sic)." 2/19/15 "Left inner thigh by vagina has quarter size bruise." 2/25/15 "Cluster of bruises by left boob." 2/27/15 "Right thigh three nickel size bruises and two one inch bruises, right inner thigh four pea size bruises." 3/5/15 "Left side near breast quarter size bruises." During interview with the QIDPD on 4/9/15 at 2 PM, the QIDPD: __Indicated all injuries of unknown origin were to be reported immediately to the administrator and were to be investigated __Stated all injuries "suspicious of abuse" were to be reported immediately to the administrator, to the BDDS and to APS. __Indicated she had not been made aware of the bruises on client #1's inner thighs and/or breasts at the time the staff made the documentation on the IFFCs. __Indicated she had reviewed the IFFCs and stated, "I don't know how I missed seeing that."		will not designate an investigation, as completed, if it does not meet these criteria. 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. **RESPONSIBLE PARTIES:** QIDP, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	__Stated client #1's injuries in regard to her inner thighs and breasts "should have been reported" to the administrator, to BDDS and to APS as injuries of unknown origin and "should have been investigated." 3. The facility failed to implement its policy and procedures to immediately report all allegations of abuse to the administrator and to the BDDS and APS according to state law, to ensure all injuries of unknown origin were reported immediately to the administrator and investigated for client #1. Please see W153 and W154. 4. The facility failed to implement its policy and procedures to prevent neglect and/or abuse in regard to the failure to review and/or look at the patterns and number of injuries incurring after the use of restraints for client #1 and to ensure the implementation of the restraint techniques was not causing further injury to client #1. Please see W285. 5. The facility failed to implement its policy and procedures to ensure health care services developed and implemented a specific plan of care and/or a protocol to address clients with probable head injuries due to accidents, behaviors and/or falls, to ensure the plan included what staff were to monitor after clients hit their head, how long staff were to monitor the clients, what staff were to report to nursing in regard to monitoring for a possible head injury and what staff were to document when monitoring a client for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	possible head injury for clients #1 and #2, to ensure the dietary recommendations of the dietician were addressed with client #1's physician and to ensure client #1 was provided an annual physical examination by the physician. Please see W331. The facility's policies and procedures were reviewed on 4/6/15 at 11 AM. The 9/14/07 facility policy entitled "Abuse, Neglect, Exploitation" 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." __ "Intimidation/emotional abuse: the act of failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation. Discouraging or inhibiting behavior by threatening both actual or implied. Attitude or acts that interfere with the psychological and social well being of an individual." __"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. Failure to meet the basic need requirements such as food, shelter, clothing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	and to provide a safe environment." 9-3-2(a)			
W 153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 2 allegations of abuse, the facility failed to immediately report all allegations of abuse to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1 and to ensure all injuries of unknown origin were reported immediately to the administrator. Findings include: The facility's reportable and investigative records for December 2014 through April 2015 were reviewed on 3/31/15 at 1:30 PM, 4/6/15 at 11 AM and 4/7/15 at 1 PM. The facility records indicated no allegation of abuse made by client #1.	W 153	**CORRECTION:** *The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.* Facility staff have been retrained regarding procedures for immediate notification of supervisors and the Operations Team, which will in turn facilitate reporting of incidents to outside state agencies as required. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	The 2/19/15 BDDS report indicated on 2/18/15 "[Client #1] complained of a headache and showed staff a bump along with a red/purple area on the back of her head that resulted from a previous behavior and head banging on 2/12/15. As of 2/13/15 it was documented the bump was quarter sized and was now a half dollar sized bump. Staff notified the nurse, [name of nurse], who then instructed staff to take [client #1] out to be seen at the Urgent Care. When staff arrived at the Urgent Care, they were instructed to take [client #1] out to the ER. Staff then transported [client #1] to [name of hospital]. When they arrived at [name of hospital], the doctor ordered a CT Scan (x-ray)." The report indicated client #1 was treated and released to return to her home. The report indicated "Staff will continue to monitor the bump on [client #1's] head using the injury flow sheets provided until the injury is healed. Staff will immediately notify the nurse if her condition worsens." Client #1's record was reviewed on 4/8/15 at 12:30 PM and 4/9/15 at 11 AM. Client #1's hospital record for the visit of 2/18/15 indicated "HISTORY OF PRESENT ILLNESS: This is a... female with chief complaint of head injury. She		**PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, Team Leads will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation the governing body will administer written corrective action up to and including termination of employment. Members of the Operations Team will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	has a right posterior hematoma (a localized swelling filled with blood). She (client #1)... lives in a group home and they (the staff) are not exactly sure when she sustained the injury. She does wear a helmet at times when she has behavioral issues and does do some head banging with that but they do not believe it was during one of those episodes. The patient actually reported a caregiver at the facility named (name of staff) pulled her down on the ground and when she (the staff) did, she (client #1) hit her head but she does not know when it occurred and neither does the caregiver that is here with her from the facility though they (the facility) are investigating the issue per their report." During telephone interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 4/10/15 at 1 PM, the QIDPD: __Stated, "I must have missed that when I read her paperwork from the hospital." __Indicated she was not aware of the allegation of abuse made by client #1 while at the hospital. __Indicated all allegations of abuse were to be reported to the administrator, the BDDS and to APS. 2. The facility's reportable records and the IFFCs (Injury Follow-up Flow		These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	Charts) for 2015 were reviewed on 3/31/15 at 1:30 PM, on 4/6/15 at 11 AM and on 4/7/15 at 1 PM. The IFFCs indicated for client #1: 2/5/15 "Inner left thigh cluster of small purple bruises." 2/12/15 "Both thighs by vagina have several bruises pea size and pin dot." 2/18/15 "Left inner thigh by vagina dime size bruise. Right inner thigh (sic)." 2/19/15 "Left inner thigh by vagina has quarter size bruise." 2/25/15 "Cluster of bruises by left boob." 2/27/15 "Right thigh three nickel size bruises and two one inch bruises, right inner thigh four pea size bruises." 3/5/15 "Left side near breast quarter size bruises." During interview with the QIDPD on 4/9/15 at 2 PM, the QIDPD: __Indicated all injuries of unknown origin were to be reported immediately to the administrator. __Indicated all injuries suspicious of abuse were to be reported to the BDDS and to APS. __Indicated she had not been made aware of the bruises on client #1's inner thighs and/or breasts at the time the staff made			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	the documentation. __Indicated she had reviewed client #1's IFFCs and stated, "I don't know how I missed seeing that." __Stated client #1's injuries in regard to her inner thighs and breasts "should have been reported" to the administrator, to BDDS and to APS as injuries of unknown origin. 9-3-2(a)			
W 154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 2 allegations of abuse, the facility failed to ensure an investigation was conducted in regard to an allegation of abuse made by client #1 and to ensure all injuries of unknown origin were investigated for client #1. Findings include: The facility's reportable and investigative records for December 2014 through April 2015 were reviewed on 3/31/15 at 1:30 PM, 4/6/15 at 11 AM and 4/7/15 at 1	W 154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: the Operations Team, including the Program Manager, will directly oversee all investigations. The QIDP 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	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	PM. The facility records indicated no investigation of an allegation of abuse made by client #1. Client #1's record was reviewed on 4/8/15 at 12:30 PM and 4/9/15 at 11 AM. Client #1's hospital record for the visit of 2/18/15 indicated "HISTORY OF PRESENT ILLNESS: This is a... female with chief complaint of head injury. She has a right posterior hematoma (a localized swelling filled with blood). She (client #1)... lives in a group home and they (the staff) are not exactly sure when she sustained the injury. She does wear a helmet at times when she has behavioral issues and does do some head banging with that but they do not believe it was during one of those episodes. The patient actually reported a caregiver at the facility named (name of staff) pulled her down on the ground and when she (the staff) did, she (client #1) hit her head but she does not know when it occurred and neither does the caregiver that is here with her from the facility though they (the facility) are investigating the issue per their report." During telephone interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 4/10/15 at 1 PM, the QIDPD: __Stated, "I must have missed that when		collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the Clinical Supervisor will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days. **PREVENTION:** 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	I read her paperwork from the hospital." __Indicated she was not aware of an investigation in regard to an allegation of abuse made by client #1. __Indicated all allegations of abuse were to be thoroughly investigated. 2. The facility's reportable records, investigative records and the IFFCs (Injury Follow-up Flow Charts) for 2015 were reviewed on 3/31/15 at 1:30 PM, on 4/6/15 at 11 AM and on 4/7/15 at 1 PM. The IFFCs indicated the following for client #1: 2/5/15 "Inner left thigh cluster of small purple bruises." 2/12/15 "Both thighs by vagina have several bruises pea size and pin dot." 2/18/15 "Left inner thigh by vagina dime size bruise. Right inner thigh (sic)." 2/19/15 "Left inner thigh by vagina has quarter size bruise." 2/25/15 "Cluster of bruises by left boob." 2/27/15 "Right thigh three nickel size bruises and two one inch bruises, right inner thigh four pea size bruises." 3/5/15 "Left side near breast quarter size bruises." During interview with the QIDPD on		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. 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. **RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	4/9/15 at 2 PM, the QIDPD: __Indicated all injuries of unknown origin were to be thoroughly investigated. __Indicated she had not been made aware of the bruises on client #1's inner thighs and/or breasts. __Stated client #1's injuries in regard to her inner thighs and breasts "should have been investigated" as injuries of unknown origin. 9-3-2(a)			
W 159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor the clients' active treatment programs. The QIDP failed: __To review and revise client #1's financial program objective. __To ensure the IDT (Interdisciplinary Team) assessed/reassessed client #2's dining needs. __To ensure client #2's ISP (Individual Support Plan) addressed client #2's	W 159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.* Specifically, The QIDP has reviewed and Revised Client #1's Financial objective.	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	identified need for training in regard to dining to ensure the client ate at a safe pace and took small bites. __To ensure client #2's ISP addressed how the staff were to assist and monitor client #2 while dining to ensure the client took small bites of food and small sips of liquids. __To review and/or look at the patterns and number of injuries incurring after restraints for client #1 to ensure the implementation of the restraint techniques was not causing injury to client #1. __To ensure client #2 was provided with the recommended diet texture of a mechanical soft diet. __To ensure the staff provided training in meal preparation and family style dining when formal and informal training opportunities existed for client #2. Findings include: 1. Client #1's record was reviewed on 4/8/15 at 12:30 PM and on 4/9/15 at 11 AM. Client #1's ISP dated 3/16/15 indicated client #1 had an objective to budget her weekly spending once a week. Client #1's data sheets for money management indicated client #1 was		The QIDP will facilitate reassessment of Client #2's dining needs. The QIDP will revise the ISP based on updated assessment data to develop a plan to assure Client #2 is trained to eat at a slow pace with small bites and to provide staff with guidance on how to monitor Client #2 during mealtime to assure safety. The QIDP and nurse will review all incident documentation upon receipt and will compare it with injury follow-up documentation no less than weekly to check for and identify patterns of injuries occurring during behavioral episodes and incidents in which restraints were utilized. The interdisciplinary team will develop and implement protective measures when patterns of injuries emerge. The QIDP has retrained facility staff regarding proper implementation of Client #2's Mechanical soft food, ground meat…small bites diet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	provided this training twice in the previous 6 months from 10/1/14 through 3/31/15. Client #1's monthly summaries from the QIDPD indicated the QIDPD had reviewed client #1's objectives monthly and had made no changes to client #1's financial objective. During interview with the QIDPD on 4/7/15 at 2 PM, the QIDPD indicated due to client #1's behaviors, client #1 no longer attended a workshop and was not making any money to budget. The QIDPD indicated the facility was trying to get client #1 back into a work environment but was having problems because of her history of behaviors. The QIDPD stated, "I need to revise her money goal." 2. The QIDP failed to ensure the IDT assessed/reassessed client #2's dining needs. Please see W210. 3. The QIDP failed to ensure client #2's ISP (Individual Support Plan) addressed client #2's identified need for training in regard to dining to ensure the client ate at a safe pace and took small bites. Please see W227. 4. The QIDP failed to review and/or look		The QIDP will retrain facility staff regarding the need to assure Client #2 is encouraged to participate in meal preparation and family style dining. **PREVENTION:** The QIDP has been retrained regarding the need to review and revised prioritized learning objectives based on clients' current status. The QIDP has also received additional training regarding the need to facilitate ongoing assessment of client needs and to develop training programs based on current assessment data. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct active treatment observations and document reviews no less than twice weekly for the next 30 days and weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	at the patterns and number of injuries incurring after restraints for client #1 to ensure the implementation of the restraint techniques was not causing injury to client #1. Please see W285. 5. The QIDP failed to ensure client #2 was provided with the recommended diet texture of a mechanical soft diet. Please see W460. 6. The QIDP failed to ensure the staff provided training in meal preparation and family style dining when formal and informal training opportunities existed for client #2. Please see W488. 9-3-3(a)		needed at the facility, which will occur no less than twice monthly. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			shift no less than twice monthly –more frequently if training issues or problems are discovered. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility and the Director of Operations/Regional Manager no less than monthly for the next 60 days. Administrative monitoring will focus on 1. Identifying potentially reportable incidents, providing opportunities for training and on site coaching of direct support staff to assure all incidents are reported in a timely manner. 2. Assuring the team identifies patterns of injuries resulting from behavioral episodes, the use of restraints and other trends and develops additional protective and preventative measures	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
			accordingly. 3. Assuring all relevant assessments have corresponding physician's orders as appropriate. 4. Assuring correct implementation of diet orders. 5. Assuring meal preparation training occurs and family style dining is supported with all clients. **RESPONSIBLE PARTIES:** QIDP, Health Services Team, Direct Support Staff, Operations Team, Director of Operations/General Manager	
W 210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the facility failed to ensure the IDT (Interdisciplinary Team) assessed/reassessed client #2's dining needs. Findings include: Observations were conducted at the	W 210	**CORRECTION:** *Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.* Specifically, Client #2 will receive an assessment from a speech pathologist to determine	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	group home on 3/31/15 between 4 PM and 7 PM. __Client #2 was observed eating her evening meal of a pasta bake, a salad and pudding. __Client #2's food was prepared by the staff in the kitchen and brought to the table for client #2 who was sitting in her wheel chair at the dining room table. __Client #2 was provided an empty plate and an empty cup. __Staff #3 sat down beside client #2. __Staff #3 pre filled a spoon with food and placed the spoon of food on client #2's empty plate. __Client #2 picked up the spoon with food, placed the spoon in her mouth and then returned the empty spoon to the empty plate in front of her. __Staff #3 then poured a small amount of liquid into the empty cup in front of client #2. __Client #2 picked up the cup, drank the liquid and sat the cup down for the staff to refill. __The process of one bite, one sip, one bite and one sip continued throughout the meal until client #2 finished her evening meal. Observations were conducted at the group home on 4/7/15 between 5:45 AM and 7:45 AM. __Client #2 was observed eating her		her current swallowing needs and Client #2's dining plan will be modified accordingly. A review of support documents and assessments indicated this deficient practice did not affect other clients. **PERVENTION:** The QIDP has been retrained regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission and as needed but no less than annually thereafter. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will include assuring all relevant assessments are current and that support documents correspond to needs identified through ongoing assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	morning meal of cereal and juice. __Staff #6 sat down beside client #2. __Staff #6 gave client #2 one pre filled spoon of food at a time followed with one swallow of liquid. __The process of one bite and one sip continued throughout the meal until client #2 had finished consuming her morning meal. Client #2's record was reviewed on 4/7/15 at 1 PM and 4/8/15 at 2:30 PM. Client #2's physician's orders for 2015 indicated client #2 was to have a "Dysphagia diet - Mechanical soft food, ground meat, no straws, aspiration precautions sit at 90 degree angle, 1:1 (one staff to one client) supervision, small bites, small sips." Client #2's 6/11/14 dietary assessment from the dietician indicated "Swallowing difficulty... aspiration precaution as evidenced by mechanical soft diet with ground meat and no straw ordered and small bites/small sips ordered." Client #2's record indicated a swallow study conducted on 4/21/14 with recommendations to continue aspiration precautions. Client #2's record did not indicate client		**RESPONSIBLE PARTIES:** QIDP, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	#2 was to be restricted to one bite of food and/or one sip of food at a time while eating. During interview with staff #3 on 3/31/15 at 6:15 PM, staff #3 indicated client #2 had a history of choking and had a tendency to eat too fast and to take large bites. When asked if client #2 was able to feed herself, staff #3 stated, "Yes, she can feed herself. We just do it this way to keep her from taking too big of bites." The facility's LPN and the QIDPD (Qualified Intellectual Disabilities Professional Designee) were interviewed on 4/7/15 at 2 PM. __The LPN indicated there was no assessment for the need to restrict client #2 from her food and/or to provide client #2 with one bite of food at a time and/or one sip of liquids at a time. __The LPN and the QIDPD stated, "We have just always done it that way." __The QIDPD stated, "I think there was an assessment on her record at some point in time by the SLP (Speech and Language Professional) but I think it's been removed. We need to get another assessment done to see if she needs that." __The QIDPD indicated no assessment by the IDT for the need for the restrictive dietary method of providing client #2 with one bite of food at a time and/or one			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	sip of liquids at a time. 9-3-4(a)			
W 227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 2 sampled clients (#2), client #2's ISP (Individual Support Plan) failed to address client #2's identified need for training in regard to dining to ensure the client ate at a safe pace and took small bites. Findings include: Observations were conducted at the group home on 3/31/15 between 4 PM and 7 PM. __Client #2 was observed eating her evening meal of pasta, salad and pudding. __Client #2's food was prepared by the staff in the kitchen and brought to the table for client #2 who was sitting in her wheel chair at the dining room table. __Client #2 was provided an empty plate and an empty cup.	W 227	**CORRECTION:** *The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment.* Specifically, Client #2 will receive an assessment from a speech pathologist to determine her current swallowing needs and Client #2's dining plan will be modified accordingly. A review of support documents and assessments indicated this deficient practice did not affect other clients. **PREVENTION:** The QIDP will assure that all relevant interdisciplinary team	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	__Staff #3 sat down beside client #2. __Staff #3 pre filled a spoon with food and placed the spoon of food on client #2's empty plate. __Client #2 picked up the spoon with food, placed the spoon in her mouth and then returned the empty spoon to the empty plate in front of her. __Staff #3 then poured a small amount of liquid into the empty cup in front of client #2. __Client #2 picked up the cup, drank the liquid and sat the cup down for the staff to refill. __The process of one bite, one sip, one bite and one sip continued throughout the meal until client #2 finished her evening meal. Observations were conducted at the group home on 4/7/15 between 5:45 AM and 7:45 AM. __During this observation period client #2 was observed eating her morning meal. __Staff #6 sat down beside client #2. __Staff #6 gave client #2 one pre filled spoon of food at a time followed with one swallow of liquid. __The process of one bite and one sip continued throughout the meal until client #2 had finished consuming her meal.		members are included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Individual Support Plans and Behavior Support Plans accordingly. The QIDP will be retrained regarding the need to assure that needs identified through the ongoing assessment process are incorporated promptly into the appropriate support document. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will include assuring all relevant assessments are current and that support documents correspond to needs identified through ongoing assessment. **RESPONSIBLE PARTIES:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	Client #2's record was reviewed on 4/7/15 at 1 PM and 4/8/15 at 2:30 PM. Client #2's physician's orders for 2015 indicated client #2 was to have a "Dysphagia diet - Mechanical soft food, ground meat, no straws, aspiration precautions sit at 90 degree angle, 1:1 (one staff to one client) supervision, small bites, small sips." Client #2's 6/11/14 dietary assessment from the dietician indicated "Swallowing difficulty... aspiration precaution as evidenced by mechanical soft diet with ground meat and no straw ordered and small bites/small sips ordered." Client #2's ISP dated 3/16/15 indicated no training objectives and/or goals to assist client #2 with her identified training in regard to slowing her pace of eating and/or to take small bites and small sips of liquids. During interview with staff #3 on 3/31/15 at 6:15 PM, staff #3 indicated client #2 had a history of choking and had a tendency to eat too fast and to take large bites. When asked if client #2 was able to feed herself, staff #3 stated," Yes, she can feed herself. We just do it this way to keep her from taking too big of bites."		QIDP, Health Services Team, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	The facility's LPN and the QIDPD (Qualified Intellectual Disabilities Professional Designee) were interviewed on 4/7/15 at 2 PM. __When asked why client #2 was provided only one bite of food and/or one sip of liquids at a time, the LPN and the QIDPD stated, "We have just always done it that way." __The LPN stated client #2 had a risk plan for dysphagia but "I apparently overlooked it when printing her plans off." __The QIDPD indicated no dysphagia plan for client #2 in the facility's program book. __The QIDPD indicated client #2 had a physician's order for 1:1 supervision while eating and she was to take small bites and sips. __The QIDPD indicated client #2 was to count to ten between bites. __The QIDPD indicated client #2's ISP indicated no training objectives in regard to dining for client #1 to assist client #1 in taking small bites and/or to slow her rate of eating. 9-3-4(a)			
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
Bldg. 00	BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. Based on interview and record review for 1 of 2 sampled clients (#1), the facility failed to review and/or look at the patterns and number of injuries incurring after restraints for client #1 and to ensure the implementation of the restraint techniques was not causing injury to client #1. Findings include: The facility's reportable records and IFFC (Injury Follow-up Flow Charts) were reviewed on 3/31/15 at 1:30 PM, on 4/6/15 at 11 AM and on 4/7/15 at 1 PM. The 1/12/15 BDDS report indicated on 1/12/15 at 6:30 AM "As staff were coming in for their shift, [client #1] requested breakfast. Staff asked [client #1] to be patient as they were completing shift count and was almost done. [Client #1] sat outside the med room door and began banging her head, staff gently blocked. [Client #1] then attempted to bite staff, staff gently blocked and offered coping skills and a 1:1 (one staff to one client) talk, [client #1] refused all offered to her. She (client #1) then became	W 285	**CORRECTION:** Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. A review of incident documentation and injury records conducted by administrative staff indicated the deficient practice identified during the survey could have affected other clients who reside in the facility. All facility staff have been retrained regarding proper documentation of behavioral incidents including providing a specific description of interventions used including but not limited to physical restraint and gentle blocking techniques. Improved documentation will nurse and QIDP to identify patterns and frequency and origin of injuries occurring during behavioral episodes. When injuries occur that may have resulted from improper application of approved restraint techniques or the use of unapproved techniques, the	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	physically aggressive towards staff and was placed in a 1 person YSIS (You're Safe I'm Safe) hold. While in the hold, staff placed [client #1's] helmet on her head per her BSP (Behavior Support Plan). While in the hold [client #1] remained agitated and attempted aggression towards staff and became verbally aggressive. Staff reminded [client #1] that when she was calm, they would release the hold. After 15 minutes, with staff attempting to release every 5 minutes but being unsuccessful, the hold was released. Staff provided [client #1] with space to calm but kept her in eyesight at all times. [Client #1] laid (sic) on the floor and cried for 25 minutes. She then got up, went to her room, slammed her door, and turned her music up very loudly. A couple minutes she yelled at staff demanding her glasses (sic). Staff reminded [client #1] that when she was calm she could have them back. [Client #1] remained verbally aggressive, self injurious, and engaged in property disruption/destruction, staff gently blocked. Staff asked [client #1] to take her 7 am meds, she refused and went into the laundry room and sat underneath the counter. After 15 minutes staff prompted [client #1] to take her meds again, once again she refused. [Client #1] then entered the garage without telling staff. Staff followed and [client #1] began		facility will follow the agency's protocols for investigation of allegations of abuse, neglect and mistreatment, including suspension of involved staff during the course of the investigation. **PREVENTION:** Client #1 will receive complete body checks no less than twice weekly and daily during periods of high agitation and frequent episodes of targeted behaviors. Other clients will continue to receive weekly body checks, unless the interdisciplinary team determines more frequent checks are indicated based on an increase in targeted behaviors. The QIDP and nurse will review all incident documentation upon receipt and will compare it with injury follow-up documentation no less than weekly to check for and identify patterns of injuries occurring during behavioral episodes and incidents in which restraints were utilized. The interdisciplinary team will develop and implement protective measures when patterns of injuries emerge. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	punching the punching bag in the garage. [Client #1] hit the punching bag hard causing it to come back and hit her in the face. She continued to punch the punching bag then went back inside the house. She threw her helmet 5 times before sitting on the floor and hit her head on the wall once, bit both of her forearms, and attempted to bite her toenail off. Staff attempted to verbally redirect [client #1] but she yelled at staff and went to her room where she screamed and cried. She done (sic) this for 15 minutes. Staff gave [client #1] her third prompt to take her meds, she refused. [Client #1] cried for a little bit longer and began calming. Once completely calm, [Client #1] asked staff if she could take her shower, staff complied." The report indicated no injury to client #1 from the behaviors. The 1/15/15 BDDS report indicated on 1/15/15 at 6:30 AM "Staff prompted [client #1], whom was in bed still, that it was time to take her medications and to complete her hygiene. [Client #1] ignored all 3 prompts. Staff then reminded [client #1] that in order for her to go to [name of day program] all of her hygiene needs to be completed and all medications need to be taken. A couple of minutes later, [client #1] came to the med room and began kicking the door and attempting to		documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will include assuring patterns of injuries occurring after restraints and other behavioral episodes are identified and appropriate protective measures developed as appropriate. **RESPONSIBLE PARTIES:** Health Services Team, QIDP, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	break the door knob. Once the specific staff that had prompted [client #1] earlier exited the med room, [client #1] instantly attacked them. Staff gently blocked and [client #1] continued to be aggressive. [Client #1] remained aggressive and staff continued to gently block. [Client #1] then bit staff's shirt. Staff initiated a 1 person YSIS hold. While in the hold, [client #1] attempted to bite herself and staff. After a few minutes, [client #1] was calm and the hold was released. Once staff stepped away from her (client #1), [client #1] began biting her upper left bicep. [Client #1] refused to release her bite so staff used a YSIS lock jaw technique to release her arm. [Client #1] then crawled to her room where she calmed with no further incidents." The report indicated no injury to client #1 from the behaviors and/or the hold. The IFFC (Injury Follow-up Flow Chart) dated 1/15/15 at 6:30 AM indicated "Biting.... Watch for bruising/bite marks on left upper bicep and forearm. No injury noted." 1/15/15 "Bite marks on left upper bicep, right lower forearm." 1/22/15 "8 pea size bruises on inner left bicep, pea size purple bruise on left forearm." 1/23/15 "8 pea size purple bruises on inner left bicep, dime size purple			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	bruise on left forearm." The IFFC dated 1/15/15 at 6:30 AM indicated "Lock jaw.... Watch for bruising on right cheek. No new injury noted." 1/16/15 "Left cheek as pea sized bruise." 1/17/15 "Left cheek faint bruise." 1/21/15 "Right cheek has 2 small green, purple bruises." 1/22/15 "Pea size green bruise on right cheek and 1/2 pea size brown bruise lower down on right cheek." 1/25/15 "Very faint pea size bruise on right cheek." 1/27/15 "Pea size faint green bruise on right cheek." 1/28/15 "Very faint pea size bruise on right cheek." 1/30/15 "Right cheek by jaw has a faint bruise." 2/1/15 "3 pea size bruises on right cheek." 2/3/15 "3 pea size bruises on right cheek." 2/4/15 "3 faint bruises on right cheek." 2/5/15 "2 pea size brown and green bruises on right cheek also, 1/2 cm (centimeter) scratch on right cheek also." 2/6/15 "Faint pea size bruises on right cheek." 2/7/15 "Faint pea size bruises on right			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	cheek." 2/9/15 "Faint pea size bruise on right cheek." 2/10/15 "Right cheek has very faint pea size bruise." 2/11/15 "1 pea size gray bruise on right cheek." 2/12/15 "Pea size bruise on right cheek." 2/13/15 "Fading pea size bruise on right cheek." 2/16/15 "Left side of face has 5 cm x 2 cm purple bruise and corner of left eye has 2 cm long green - purple - brown bruise." 2/18/15 "Left cheek 3 cm bruise by mouth." 2/18/15 (second entry) "Left cheek 3 cm bruise by mouth area." 2/19/15 "Left cheek has 3 inch bruise." 2/20/15 "Left eye area has slight bruise and left cheek has 5 cm x 2 cm greenish/purple bruising. 2/21/15 "Left cheek dime size bruise, by left eye faint bruising." 2/21/15 (second entry) "Pea size bruise between nose and eye left side cluster of greenish bruises by mouth." 2/21/15 (third entry) "Left eye area has bruising underneath left side cluster of bruises by mouth." 2/22/15 "Left side of face under eye area fading bruises, fading bruising by mouth."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	2/23/15 "Left eye has very faded pea size bruise, cluster of bruises left side of mouth." 2/23/15 (second entry) "Left side of face under eye area fading bruises, fading bruising by mouth." 2/24/15 "Bruise by mouth and eye." 2/25/15 "Left cheek has faint blue bruising by mouth." 2/27/15 "Left cheek by mouth faint bruise." 2/28/15 "Left cheek by mouth bruise." 3/2/15 "Faint bruise on left side cheek." 3/3/15 "Pea size gray bruise on right cheek. Left cheek, jaw line has 2 - 1/2 pea size purple bruises and left cheek quarter size purple, green bruise." 3/4/15 "Left cheek - quarter size purple bruise, left jaw line 2 - 1/2 pea sized bruises, right cheek faint pea size gray bruise." 3/5/15 "Right cheek bruise, right above eye pea size bruise." 3/7/15 "Left cheek by mouth pea size bruise, right cheek has pea size bruise." 3/8/15 Left cheek by mouth pea size bruise, right cheek has pea size bruise." 3/11/15 "Above right eyebrow pea size brown bruise and right cheek dime size brown bruise." 3/12/15 "Above right eyebrow pea size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	bluish/brown bruise, right cheek blue dime size bruise." 3/13/15 "Right cheek faded pea size bruise." 3/14/15 "Faint bruise on right cheek." 3/17/15 "Faint gray bruise on right side of cheek." 3/18/15 "Very faint gray bruise right cheek." 3/20/15 "Brownish bruise on right cheek." The I/A (Incident/Accident) report dated 1/19/15 at 7:15 AM indicated client #1 became upset while in the medication room and was physically escorted from the medication room into another room. The report indicated no injury to client #1. The IFFC dated 1/19/15 at 7:15 AM indicated "[Client #1] had to be removed from the med room.... Watch arms and legs for bruising." 1/21/15 "Left top wrist has dime size pink bruise. Top right shoulder pea size purple bruise and an inch scratch. Right top forearm 1/2 inch red scratch, 1/2 inch red scratch on bottom right forearm, left bottom bicep 1/2 inch scratch, Inner right biceps purple bruise." 1/22/15 "Top left arm dime size purple bruises, top left wrist pea size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	pink bruise, small red scratch on lower right bicep, right upper bicep has pea size purple bruise and red scratch, top right forearm has 1/2 inch red scratch." 1/22/15 (second entry) "Top right thigh has pea size brown bruise pin dot purple bruise and inner right thigh has pea size brown bruise, top left thigh two faint gray bruises pea size." 1/22/15 (third entry) "Top right bicep pea size purple bruise and scratch mark. Inner right bicep three pea size purple bruises. Front left shoulder has quarter size dark purple bruise. One inch red scratch right forearm. Back left bicep quarter size dark brown bruise." 1/27/15 "1/2 inch scratch on top right forearm, top right bicep long scratch with green bruising, pea size purple bruise on left forearm, back left calf quarter size gray bruise." 1/28/15 "Red 1/2 inch scratch on top of right forearm, quarter size bruise back of left calf." 1/29/15 "Bruise on the underneath side of left forearm, scratches on left and right forearm, bruises on the backside of left leg." 1/30/15 "Right knee 1/2 dollar size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	bruise, right thigh dime size bruise, right ankle red and pea size bruise. Left shin dime size bruise left forearm. Two bruises by left armpit." The 2/1/15 I/A report indicated at 10:30 AM client #1 was prompted to complete her hygiene. Client #1 went to the bathroom, laid on the floor and screamed. Client #1 then crawled to her bedroom and continued to scream. Client #1 came out of her bedroom into the living room, "picked up the end of the couch and slammed it down causing it to break. [Client #1] then went running and crying into her room. [Client #1] began to bang her head on the wall. Staff put her helmet on her for her safety. Client #1 tried to remove the helmet and was blocked. Client #1 later attacked the staff and was placed in a YSIS hold. The I/A report indicated no injuries to client #1. The IFFC dated 2/1/15 at 10:30 AM indicated "SIB Behavior.... Watch for bruises on legs and ankles." 2/2/15 "Left shin nickel size bruise, quarter size bruise four pea size bruises. Right thigh nickel size bruise. Right thigh quarter size bruise. Both ankles are red." 2/4/15 "Pin dot/pea size bruises on left thigh by vagina from pinching."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	Left shin two quarter size bruises. Bruise above right knee. Faint pea size bruise on right thigh." 2/5/15 "Inner left thigh cluster of small purple bruises, left shin quarter size and two dime size bruises gray in color. Dime size purple bruise on left knee. Dime size pink - gray bruise on inner right ankle." 2/6/15 "Left shin has one and one half inch bruise and nickel size bruise. Dime size bruise above left knee. Inside of right ankle has dime size bruises on vagina from pinching. Right thigh by vagina several pin dot bruises from pinching." 2/11/15 "Dime size pink/brown bruise back left thigh. Dime size pink brown bruise outer left thigh. Nickel and dime size brown bruises on left shin. One dime size faint pink bruise on right shin, top of both thighs has brown bruises." 2/18/15 "Back right calf dime size bruise, left inner thigh by vagina dime size bruise. Right inner thigh (sic). 2/19/15 "Back of right calf has dime size bruise. Left inner thigh by vagina has quarter size bruise. Left inner calf two quarter size bruises. Right inner thigh has nickel size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	bruises." 2/21/15 "Left shin small bruise, left thigh small bruise, right calf several small bruises, right knee small scratch." 2/20/15 "Four gray dime size bruises on right calf/shin. Small scratch on right knee. Pea size bruise on upper right thigh. Left shin has quarter size pink bruise and golf ball size dark purple bruise on left shin, upper left thigh pea size purple bruise." 2/20/15 (second entry) "Four dime size bruises on right calf/shin. Scratch very small on right knee. Upper right thigh pea size bruise. Left shin quarter size bruise and golf (sic) size bruise on left shin. Upper left thigh has pea size bruise." The IFFC dated 2/1/15 at 10:30 AM indicated "SIB (Self Injurious Behavior).... Watch for bruises on arms and wrists." 2/2/15 "Right forearm 1/4 inch scratch, two inch bruise inner left forearm. Left bicep by armpit has two nickel size bruises." 2/3/15 "Left hand four pea size bruises, left wrist two quarter size bruises, left inner forearm one and one half inch bruise and pea size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	bruise left bicep by armpit, right forearm 1/4 inch scratch." 2/5/15 "Dime size pink purple bruise above right elbow. Dime size green bruise and small scratch on right forearm. Dime size red bruise inner left bicep. Cluster two dime size bruises purple left forearm. Left wrist quarter and dime size green bruises." 2/9/15 "Right elbow has quarter size bruise. 1 1/4 inch bruise on inner right forearm. Inner left forearm one inch bruise. Two pea size bruises under left forearm." 2/11/15 "Right elbow quarter size pink bruise, oblong brown bruise two cm (centimeters) x (by) one cm on right forearm, two pink bruises on right wrist, back right shoulder one dime size brown bruise, one cm long scratch on right bicep, inner right forearm two pea size pink/red bruises, top left shoulder. The 2/10/15 BDDS report indicated on 2/10/15 at 5:20 AM client #1 became upset when denied a request from staff. Client #1 was placed in a two person YSIS physical escort and was removed from the medication room. Client #1 then ran into the laundry room and began pushing all the buttons on the washer at the same time. Staff shut the washer off			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	and client #1 crawled under the counter and began banging her head. Client #1 then crawled out of the laundry room and into the dining room under the table. The table leg was loose so staff moved the table against the wall to prevent any injuries. Client #1 became upset and staff physically redirected client #1 away from the table. Client #1 remained upset and attempted to leaved the assigned area, to claw at staff, and to bite staff. Client #1 then attempted to self harm and attack staff. Client #1 was placed in a one person YSIS hold. The report indicated no injury to client #1 due to her behaviors and/or the holds. The IFFC dated 2/10/15 at 5:20 AM indicated "One person hold.... Watch for bruising on left and right wrists and thighs." 2/12/15 "Left forearm has several bruises varying in size and shape. Both thighs by vagina have several bruises pea size and pin dot. Both knees have bruising." The I/A report dated 2/11/15 indicated at 7:30 AM client #1 scratched her abdomen while in the shower. The report indicated client #1 had "multiple red scratches on inner right forearm, 2 - 3 three - four inch long red scratches on stomach."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	The IFFC dated 2/11/15 at 7:30 AM indicated "[Client #1] was scratching stomach and right inner forearm while in the shower.... "Multiple scratches on inner right forearm...." 2/11/15 "Several very small bruises on inner right forearm purple and blue." 2/13/15 "Several bruises up and down inner left forearm." 2/18/15 "Right side has three pea size bruises. Left backside of shoulder has nickel size bruise and two one inch scratches. Right inner elbow has multiple bruises different shapes and colors. Left forearm dime size bruise." 2/19/15 "Back of left shoulder has two nickel size bruises purple in color and two one inch scratches (fading) right side has three fading pea size bruises. Right bicep has two inch scratches under left elbow two pea size bruises. One nickel size bruise on bicep." 2/22/15 "Three pea size bruises on right side, pea size bruise in center of belly." 2/24/15 "Three dime size bruises left side of stomach. Right side three fading bruises." 2/25/15 "Two faded pea size (sic) on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	right side of stomach. Two bruises on left side of stomach. Cluster of bruises by left boob. Peas size bruise on outer left bicep." 3/5/15 "Right side hip faded bruise. Right side of stomach faded dime size bruise. Right side faded golf ball size bruise. Left side near breast quarter size bruises. Left outer bicep two faded bruises." 3/10/15 "Two pea size bruises on stomach left side upper." 3/13/15 "1/4 inch scratch between shoulder blade. Left side of stomach two pea size bruises." The 2/13/15 BDDS report indicated on 2/12/15 at 2:45 PM "[Client #1] had been in her room listening to her music. She came out, sat on the floor in the living room, and began banging her head on the wall with her helmet on. Staff attempted to talk with [client #1] but she refused to answer. [Client #1] attempted to bang her head again, staff gently blocked. [Client #1] then leaned forward and attempted to bang her head on the floor, staff continued to gently block. Staff attempted another (1:1 one staff to one client) talk with [client #1] but she continued to refuse. [Client #1] continued to attempt to bang her head, staff gently blocked. She then took off her helmet and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	threw it at her housemates and staff but made no contact. Staff placed her helmet back on her head.... [Client #1] immediately removed the helmet and threw it at her housemates and staff, making no contact. She (client #1) then attempted to exit out the back door, staff gently blocked. [Client #1] then became physically aggressive towards staff so staff initiated a 2 person YSIS hold." The IFFC dated 2/12/15 at 2:45 PM indicated "Head banging.... Watch for redness, bruising on forehead." 2/13/15 "Goose egg shaped knot on back of head with quarter size deep purple bruise." 2/14/15 through 2/17/15 client #1 refused to let staff assess her." 2/18/15 "Right back side of head has 1/2 dollar size reddish purplish raised bump." The IFFC dated 2/12/15 at 2:45 PM indicated "two person YSIS.... Watch for bruising on wrists and ankles." 2/13/15 "Pink bruising on both ankles and wrist. Right food scab by toes." 2/16/15 "Inner right elbow has cluster of five dime pea size purple, pink bruises. Inner right bicep has a pea size purple bruise. One (cm) centimeter scratch on right wrist.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	Left forearm two pea size green brown bruises. Left inner bicep splotchy purple bruise. Top left shoulder has dime size purple and a pea size pink bruise. Left hand by thumb dime size purple bruise. 2/18/15 "Above left inner ankle three fading dime size bruises. Left wrist above thumb has a nickel size bruise." 2/19/15 "Left foot above big toes has pea size scab." 2/20/15 "Small red spot on right ankle. Left hand by thumb has two separate purple bruises pea size and dime size." 2/20/15 "Right ankle has small red area left hand next to the thumb had two purple bruises; one dime size, one pea size." 2/21/15 "Left hand by thumb has two small bruises. Right ankle red area small in size." The 2/19/15 BDDS report indicated on 2/18/15 "[Client #1] complained of a headache and showed staff a bump along with a red/purple area on the back of her head that resulted from a previous behavior and head banging on 2/12/15. As of 2/13/15 it was documented the bump was quarter sized and was now a half dollar sized bump. Staff notified the nurse, [name of nurse], who then			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	instructed staff to take [client #1] out to be seen at the Urgent Care. When staff arrived at the Urgent Care, they were instructed to take [client #1] out to the ER (Emergency Room). Staff then transported [client #1] to [name of hospital]. When they arrived at [name of hospital], the doctor ordered a CT Scan (xray)." The report indicated client #1 was treated and released to return to her home. The report indicated "Staff will continue to monitor the bump on [client #1's] head using the injury flow sheets provided until the injury is healed. Staff will immediately notify the nurse if her condition worsens." The IFFC dated 2/18/15 at 8:45 AM indicated "previous behavior 2/12/15, [client #1] hitting head seen at ER today (2/18/15) for injury.... 1/2 dollar size bump with red/purple raised area on back right side of head." 2/19/15 "1/2 dollar size bump with red/purple raised area on back right side of head." 2/20/15 "Softball size knot on outer right side of head with a light purple bruise in center - dime size." 2/20/15 (second entry) "Dime size brownish bruise and a golf (sic) size knot on outer right side of head." 2/21/15 "Right side of head, golf ball size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	knot with bruising." 2/21/15 (second entry) "Pea size faded bruise on back side on head with a bump under skin." 2/21/15 (third entry) "Dime size bruise brownish in color and knot under skin." 2/22/15 "Knot under skin on back of head." 2/22/15 (second entry) "Pea size fading bruise back of head on right side, raised bump." 2/22/15 (third entry) "Small bruise right side of back of head, bump under the skin." 2/23/15 through 3/1/15 small bump/knot on right side of head. The 2/19/15 BDDS report indicated on 2/19/15 at 8:15 AM when client #1 was prompted to shut the medication room door and knock client #1 became upset, went to her room, slammed her door and began crying. Client #1 threw herself to the floor and began screaming and attempted to kick staff. Client #1 was placed in a YSIS physical escort and escorted from the dining room into the living room away from a housemate that was eating and the kitchen door. Client #1 attempted to go back into the dining room area and was placed in a 2 person YSIS hold. Once calm client #1 was released and went to her bedroom A few			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	minutes later client #1 began banging her head and staff placed client #1's helmet on her. Client #1 became physically aggressive towards staff and was placed in a one person YSIS hold. The IFFC dated 2/19/15 at 8:15 AM indicated "YSIS.... Watch for bruising on both ankles and legs. No new injury noted." 2/21/15 "Side of right calf has clusters of fading purple bruises different shapes and colors, inner left calf has two nickel size bruises, left shin has two inch blue bruise, left knee has a fading quarter size bruise, right knee has four pea size bruises and one half inch scab." 2/22/15 "Left shin has two inch by one inch dark purple/brown bruise. Left ankle has quarter size gray bruise, left inner calf pea size gray bruise, left knee has two pea size brown bruises upper left thigh has pea size bruise, right outer hip pea size dark purple bruise, right outer thigh has three pea size gray bruises. Right shin one half dollar size brown bruise, right outer calf three pea size gray bruises." 2/23/15 "Left shin three inch fading bruise, blue in the middle. Right shin half dollar size bruise, right			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	calf two pea size bruises, left hip area two pea size bruises, right knee three pea size bruises, left ankle fading pea size bruise." The IFFC dated 2/19/15 at 8:15 AM indicated "YSIS.... Watch for bruising on both arms/wrists. No new injury noted." 2/20/15 "Inner right bicep quarter size dark purple bruise and three small 1/2 pea size purple bruises. Right forearm/wrist has dime size blue and pea size purple bruise. Left forearm dime size pink bruise. Inner left bicep two pea size purple bruises." 2/21/15 "Left inner forearm small pinkish bruise. Left bicep two small bruises. Right inner bicep dark bruises, quarter size along with three smaller bruises. Right wrist small purplish bruise." 2/21/15 (second entry) Right inner bicep four pea size bruises and 1/2 dollar purple bruise. Left forearm has three fading bruises." The 2/20/15 BDDS report indicated on 2/20/15 at 7:20 AM client #1 was prompted to come to the medication room to get her medications. Client #1 began crying and hit her head on the floor. The staff attempted to place client #1's helmet on her when client #1 threw			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	her helmet and got up, ran to her room, slammed her door and began head banging. Staff again attempted to put client #1's helmet on her head but blocked the staff. Client #1 tried to exit out the garage and was blocked by the staff when she began hitting her head on the floor. Staff initiated a one person YSIS hold until calmed. The 2/13/15 BDDS report indicated on 2/22/15 at 5:10 PM client #1 was in her bed room kicking the wall and banging her head. Staff attempted to put her helmet on her when she became physically aggressive toward the staff. Client #1 was placed in a two person YSIS hold until calm. The 2/23/15 BDDS report dated on 2/23/15 at 7:15 AM client #1 became physically aggressive and required a 1 person YSIS hold until calm. Client #1 remained on the floor but became physically aggressive again and was again placed in a one person YSIS hold until calm. After being released from the hold client #1 began hitting the center of her forehead on the Plexiglas in front of the television. When staff when to stop her client #1 threw herself to the floor and began to hit the side of her head on the floor.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	The 2/25/15 BDDS report indicated on 2/24/15 at 5:30 PM client #1 sat on the living room floor banging her head against the wall. The staff placed client #1's helmet on her. Client #1 became aggressive and took the helmet off and put her helmet strap in her mouth. Client #1 became physically aggressive and staff initiated a two person YSIS hold until the client calmed. The report indicated no injury to the client as a result of her behavior and/or the hold. The IFFC dated 2/24/15 at 5:30 PM indicated "Two person YSIS.... Watch for bruising on legs and ankles. No new injury noted." 2/27/15 "Right thigh three nickel size bruises and two one inch bruises, right inner thigh four pea size bruises, right hip two pea size bruises, left shin has two and one half inch bruise. Right outer ankle pea size red mark, left calf has two pea size bruises." 3/3/15 "Inside left ankle one half dollar size purple bruise, back of right ankle has one half dollar size purple bruise." 3/4/15 "Right ankle one half dollar size bruise back of right ankle one half dollar purple/blue bruise." 3/5/15 "Right ankle two half dollar size bruises."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	The IFFC dated 2/24/15 at 5:30 PM indicated "Two person YSIS.... Watch for bruising on arms and wrist. No new injury noted." 2/25/15 Pea size red bruise outer back left bicep, blue pea size bruise on left elbow, blue quarter size back of left hand." 2/27/15 "Right armpit area four quarter size bruises, right elbow has a cluster of bruises, right forearm three pea size bruises, left forearm three pea size bruises, back of left bicep one and one half inch bruise, left shoulder three fading dime size bruises and a quarter size bruise. Right shoulder three pea size bruises." 3/3/15 "Inner right bicep has cluster of purple bruises." 3/9/15 "Two pea size right inner bicep pea size bruise, right inner forearm left bicep two pea size bruises." The IFFC dated 2/25/15 at 8:05 AM indicated client #1 had "lightly tapped forehead on shower wall.... Watch for bruising and/or marks on front of forehead. No injury noted at this time." The 2/26/15 BDDS report indicated on 2/25/15 at 5:45 PM client #1 became			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	physically aggressive and "began to bang her head, staff gently blocked and implemented her soft helmet as stated in her BSP (Behavior Support Plan)." The I/A report dated 3/2/15 at 6:45 AM indicated client #1 "threw herself on the floor and began hitting the back of her head in the center. When staff retrieved [client #1's] helmet she stopped head banging." The IFFC dated 3/2/15 at 6:45 AM indicated "SIB.... Watch for bruising on left forearm. No new injury noted." 3/11/15 "Left forearm four one half pea size purple bruises, left elbow pea size raw spot." 3/17/15 "One inch red scratch, two pea size brown bruises and back elbow has pea size scab left forearm." 3/20/15 "Fading bruises on left and right inner and outer forearms." The IFFC dated 3/2/15 at 6:45 AM indicated "[Client #1] in behavior, SIB, physical aggression, staff blocking.... Watch for bruising both legs." 3/3/15 "Back of right thigh below buttocks has cluster of pink bruises, outer right thigh has two pea size brown bruises, behind right knee dime size pink bruise,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	right shin quarter size pink bruise." 3/3/15 (second entry) "Three pea size purple bruises on left thigh, dime size purple bruise on inside left knee." 3/5/15 "Left inner knee faded bruise, Left outer thigh two faded bruises, right thigh three dime size bruises." 3/6/15 "Left shin one and one half inch bruise." 3/7/15 "Front of right thigh one and one half inch faded bruise." 3/8/15 "Front of right thigh one and one half inch faded bruise." 3/9/15 "Front of right thigh one and one half inch faded bruise." 3/10/15 "Front of right thigh has black fading bruise one and one half inch." 3/11/15 "Back right thigh dime size brown bruise, right thigh three dime size purple bruises, inner left thigh oblong purple bruise, left outer and back of thigh dime size faint brown bruise, left shin two dime size gray bruises." 3/12/15 "Back right thigh very faint brown bruise, right thigh three dime size purple bruises, left thigh oblong, dark purple bruise, back outer left thigh pea size dime size faint brown bruise, left shin			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	two dark gray bruises." 3/13/15 "Back right calf two dime size bruises, right knee one pea size bruises, right shin pea size bruise, faded dime size bruise back of right knee, three nickel size bruises left shin." 3/16/15 "One faded bruise on right calf, left calf cluster of faded bruises, left knee faded pea size bruises, right shin quarter size gray bruise right knee." 3/17/15 "Three dime size left calf green bruises above left back knee dime size bruise, right shin nickel size purple bruise, right top outer shin dime size purple bruise front left thigh, three dime size purple bruises, left shin three faded busies pea size, quarter size and dime size pink/brown." The IFFC dated 3/2/15 at 6:45 AM indicated "[Client #1] in behavior, SIB, physical aggression, staff blocking.... Watch for bruising both arms." 3/3/15 "Right elbow has dime size pink bruise, left forearm has a total of five brown and purple bruises." 3/4/15 "Right elbow has dime size pink bruise, left forearm five purplish/brown bruises." 3/7/15 "Inner right forearm two pea size bruises, left forearm four pea size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	bruises, inner bicep pea size bruise, front right bicep pea size bruise." 3/11/15 "Right inner bicep pea size pink and green bruises, right forearm one half inch red scratch, inner forearm pea size blue bruise, two one half pea size purple bruises, left upper bicep pea size purple bruise." 3/12/15 "Right inner bicep pink and green bruise, right forearm one half inch red scratch, inner forearm pea size blue bruise, two small purple bruises, left upper bicep pea size purple bruise." 3/13/15 "Left inner bicep faded cluster of bruises, left shoulder area two pea size bruises, inner bicep two dime size bruises, left elbow pea size scab, left forearm two pea size bruises, left forearm two pea size bruises." 3/22/15 "Fading bruises up and down left and right arms." The IFFC dated 3/2/15 at 6:45 AM indicated "Blocking.... Watch for bruising on both shoulders. No new injury noted." 3/3/15 "Right shoulder had three pea size blue bruises, left shoulder has oblong purple bruise." 3/6/15 "Left shoulder one and one half inch bruise, right shoulder four			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	pea size bruises, back by left armpit has pin dot bruise." 3/7/15 "In between shoulder blades on back there is a small scratch, right shoulder has four pea size bruises under right shoulder there is a pea size bruise, left shoulder one half dollar size bruise." 3/10/15 "Top left shoulder pea size blue bruise, top right shoulder dime size brown purple bruises x (times) two." 3/16/15 "Left shoulder dime size faded bruise, right shoulder dime size x two faded one inch reddish purple bruise, two pea size purple bruises." 3/20/15 "Fading bruises on right and left shoulders, dark bruise on inner arm pit." 3/23/15 "Right shoulder four purple red bruises." 3/24/15 "Right shoulder two pea size bruises and two quarter size bruises, left shoulder has four pea size bruises and one dime size bruise." 3/26/15 "Right shoulder quarter size purple bruise, back top of shoulder right cluster of purple dime size bruises, front right shoulder dime size purple bruise, left back shoulder blade blue bruise, left shoulder three half pea			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	size red bruises, left shoulder top dime size purple bruise." 3/30/15 "Right shoulder pea size red bruise and quarter size red bruise, left shoulder four pea size red bruises." The 3/3/15 BDDS report indicated on 3/2/15 at 5:45 PM client #1 became physically aggressive and trying to hit, bite and kick the staff. Client #1 was placed in a two person YSIS hold until calm. The report indicated client #1 was not injured due to her behavior and/or the hold. The IFFC dated 3/2/15 at 5:45 PM indicated "two person YSIS hold.... Watch for bruising on wrist and ankles on both right and left side." 3/3/15 "Left hand close to wrist has a pink quarter size bruise." 3/4/15 "Left hand close to wrist has a quarter size bruise." 3/6/15 "Top left foot by ankle has a pin dot scab, top right hand pea size bruise." 3/7/15 "Above right outer ankle two inch bruise. Left outer ankle is red and has pea size bruise." 3/8/15 "Above right outer ankle two inch bruise, left outer ankle is red and pea size bruise."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	The 3/4/15 BDDS report indicated on 3/3/15 at 9:45 AM client #1 became upset with staff when they ceased playing a board game with her. The report indicated client #1 screamed and cried and attempted to exit the home through the garage. Staff blocked client #1 from exiting the home and client #1 sat down in the garage and cried. After a short period client #1 got up and went back into the home and sat in front of the medication room door and started banging her head on the door while crying. After a few minutes client #1 got up and went to her bedroom, slammed the door behind her and began banging her head on her bedroom door. "[Client #1] became physically aggressive towards staff, staff gently blocked and implemented her (client #1's) helmet to prevent injury. [Client #1] kept trying to remove her helmet and bang her head. Staff then initiated a 2 person YSIS hold.... Staff released the hold after 15 minutes. Staff attempted to release every 3-5 minutes but was unsuccessful. Client #1 then hit her head on her bedroom window and became physically aggressive towards staff. She [client #1] attempted to take her helmet off, staff gently blocked. She then became self injurious by biting her hands.... [Client #1] began physically attacking staff, staff initiated a second 2 person YSIS hold.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	[Client #1] attempted to pull off her helmet causing an immediate bruise on her neck. Staff gained approval for a PRN. [Client #1] took her PRN and calmed down after several minutes.... Staff will continue to flow on the immediate bruise on [client #1's] neck as a result of herself injurious behavior until the area is healed." The IFFC dated 3/3/15 at 9:45 AM indicated "[Client #1] was put in a two person YSIS hold.... Watch legs for bruising." 3/4/15 Right knee pea size purple bruise, left knee above reddish bruise." 3/5/15 "Right knee red/purple dime size bruise, left knee red bruise, right shin pink area, left shin faded bruise." 3/6/15 "Inner left thigh two pea size bruises inner right thigh dime size bruise, above right outer ankle is a two inch bruise. Right outer knee pea size bruise, right outer thigh three inch fading bruise. Right shin two pea size bruises." 3/7/15 "Right hip has a faded one and one half (inch) bruise, left inner thigh 1 1/2 inch bruise and a dime size bruise left hip two faded peas size bruises." 3/8/15 "Right hip one and one half inch fading bruise, left inner thigh one			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	and one half inch bruise and a dime size bruise. Left hip two fading pea size bruises." 3/9/15 "Left hip has two nickel size bruises, right hip two inch bruise almost gone, left inner thigh two dime size bruises, quarter size bruise left shin." 3/10/15 "Left hip two and one half inch bruise, right hip faded bruise left thigh two dime size bruises, Left shin quarter size bruise." The IFFC dated 3/3/15 at 9:45 AM indicated "[Client #1] was put in a two person YSIS hold.... Watch arms for bruising." 3/4/15 "Right bicep two pea size dark blue bruises, back of left forearm faint purple bruise." 3/5/15 "Right bicep two pea size bruises, right elbow red scratch, left near elbow red scabbed area two faded bruises." 3/6/15 "Right bicep by armpit has cluster of purple bruises. Left forearm five fading pea size bruises, inner right forearm three pea size bruises. Back of left bicep two pea size bruises." 3/7/15 "Right inner bicep two pea size bruises by arm pit, right bicep faded pea size bruise, right elbow pin dot scab, left elbow pea size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	scab, above left elbow has pea size bruise." 3/8/15 "Right inner bicep two pea size bruise towards arm pit. Right bicep fading pea size bruise, left elbow pea size bruise with scab same size. Right elbow pin dot scab." The IFFC dated 3/3/15 at 9:45 AM indicated "[Client #1] bit her hands in a behavior.... Watch hands for marks or bruising." 3/4/15 "No injury noted." 3/5/15 "Right top of hand red bruise." 3/6/15 "Right hand two fading pea size bruises." 3/7/15 "Top right hand has nickel size bruise, side of left wrist has nickel size bruise." 3/8/15 "Top of right hand and side of left wrist both has nickel size bruises." 3/10/15 "Three pea size black bruises right hand, left wrist nickel size bruise." The IFFC dated 3/3/15 at 9:45 AM indicated "[Client #1] tried to cut herself with a butter knife and the handle to the kitchen sink sprayer.... Watch both forearms for scratches." 3/4/15 "Right forearm one inch red scratch."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	3/5/15 "Right forearm one inch red scratch." 3/6/15 "Light pink scar on right forearm." 3/18/15 "Right forearm one inch red scratch." 3/19/15 "Faint pink scratch on right forearm." 3/23/15 "Pink scratch on left forearm." The IFFC dated 3/3/15 at 9:45 AM indicated "[Client #1] tried to pull her helmet off while in a hold.... Watch neck and chin area for marks or bruising and forehead. Left side of neck pea size dark purple bruise." 3/4/15 "Left side of neck dark purple pea size bruise, left side of chin two pea size bruises purple." 3/5/15 "Left side of neck red/purple quarter size bruise, left side chink two pea size bruises, left shoulder half dollar size purple bruise." 3/6/15 "Left side of neck has a pea size bruise under chin on left side had two pea size bruises above right eye has two pea size bruises." 3/7/15 "Above right eye has two pea size bruises, left side of neck has pea size bruise, pea size bruise under chin on left side." 3/8/15 "Pea size bruise under chin, left side above right eye two pea size bruises, left side of neck pea size bruise."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	3/11/15 "One inch red scratch and one half inch pea size faint gray bruise left side of neck." 3/13/15 "Faint bruise left side of neck." 3/14/15 "Faint bruise on left side of neck." 3/15/15 "Faint bruising on left side of cheek." 3/16/15 "Faint bruising on right side by chin." 3/17/15 "Left and right side of chin half pea size purple bruises." 3/18/15 "Left and right side of chin has pea size purple bruise." 3/20/15 "Fading bruises on both left and right chin." 3/22/15 "Fading bruises on both left and right chin." 3/23/15 "Left and right chin fading bruising, pink scratch left side." 3/24/15 "Fading bruising left and right chin, left side of chin pink scratch." 3/25/15 "Right side of neck has several pin dot red dot red bruises, three fading bruises." 3/26/15 Right front side of neck cluster of red half pea size bruises fading gray bruise." 3/26/15 (second entry) "Several fading pin size red dots on left side of neck, cluster of red small bruises on right front of neck." 3/28/15 "Cluster of fading red dots left of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	neck, cluster of bruises right side of neck." 3/30/15 "Very faded pea size greasy bruise center of neck." The 3/7/15 BDDS report indicated on 3/7/15 at 7:55 AM client #1 "started banging her head. Staff prompted helmet and talked to [client #1] about conversation with BC (Behavior Consultant) about what happens when [client #1] bangs her head. [Client #1] began to cry loudly and banged her head some more. Staff tried to assist with helmet and [client #1] hit and tried to scratch staff. Staff blocked. [Client #1] came crawling after staff. Staff tried to remove themselves from the area, [client #1] followed. Another staff blocked her so staff could get away. [Client #1] gave up on going after staff and made a pallet (a makeshift bed) of blankets on the floor by her bedroom door and calmed herself." The 3/11/15 BDDS report indicated on 3/10/15 at 10 AM while at the day program client #1 became upset and removed her helmet and began "to bang her head. When [client #1] pulled off the helmet, she broke it. [Client #1] became physically aggressive towards staff.... [Client #1 began hitting her head.... She (client #1) then attempted to head butt staff.... Staff shut the door and [client #1]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	became even more agitated and slid herself down the door to the floor. [Client #1] attempted to kick [day program] staff. [Day program staff] initiated a one person YSIS hold. While in the hold client #1 scratched herself on both sides of her stomach.... [Client #1] was not injured as a result of her behavior." The 3/12/15 BDDS report indicated on 3/11/15 at 8:15 AM client #1 followed staff and a housemate into the bathroom. When the staff redirected client #1 and shut the bathroom door, client #1 "sat on the floor in front of the (bathroom) door and began tapping her head on the door. [Client #1] then crawled into the living room where she sat in front of another housemate's door and began hitting her head. Staff placed [client #1's] helmet on her head to prevent injury. [Client #1] became physically aggressive... took off her helmet and threw it at staff and began hitting her head on the floor, staff placed helmet back on her head. [Client #1] continued to take it off and throw it at staff and hit her head. Staff then initiated a two person YSIS hold to prevent injury.... [Client #1] was not injured as a result of her behavior or as a result of being placed in a two person YSIS hold." The IFFC dated 3/11/15 at 8 AM indicated "Two person YSIS.... Watch for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	bruising on wrists/arms/hands. 3/11/15 "Top left hand dime size pea size pink bruise, left forearm four dime size pink bruises, right wrist pea size pink bruise." 3/12/15 "Top left hand dime size pea size pink bruise, left forearm four dime size pink bruises, right wrist pea size faint pink." 3/13/15 "To left hand, dime size bruise, right hand pink bruise." 3/14/15 "Dime size bruise on top of left hand. Fading bruise on right hand." 3/15/15 "Fading bruise on top of left hand, fading bruise on right hand." 3/16/15 "Faded gray bruise on top of left hand." The IFFC dated 3/11/15 at 8 AM indicated "Two person YSIS.... Watch for bruising on ankles/legs/feet." 3/11/15 "Outer right ankle above and on ankle has pea size pink bruise, back right heel dime size pink bruise, right shin pea size pink bruise, below left knee dime size pink bruise." 3/13/15 "Outer right ankle above/on ankle pea size dark pink bruise, back right heel dime size pink bruise, right shin pea size dark pink, below left knee dime size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	dark pink bruise." 3/13/15 (second entry) "Right upper thigh four nickel size bruises. Back right knee dime size bruise. Back right calf two dime size bruises. Top left foot pin dot scab by ankle. Back left calf two nickel size bruises. Right big toe pin dot scab." 3/3/15 through 3/15/15 the staff documented the client refused to be assessed. 3/16/15 "Right upper thigh two faded pea size bruises, quarter size faded gray bruise right buttock, cluster of red bruises on right thigh above right knee." 3/17/15 "Right buttock outer pea size faint bruise, outer left buttock two quarter size brown bruises." 3/18/15 "Left side thigh/buttock has two quarter size brown bruises, right side thigh/buttock has two dime size brown bruises." 3/20/15 "Fading bruises right thigh, faint bruise on left buttocks, fading bruising on left thigh" 3/23/15 "Fading bruises on right and left thigh, faint bruises on left buttock." 3/24/15 "Fading bruising left and right thigh back left outer thigh dime size bruise, two faded bruises right thigh, left calf faded			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	bruises." 3/25/15 "Left shin four quarter size bruises, right outer thigh has three pea size bruises, inner left ankle has dime size bruise, left hip one inch bruise." 3/27/15 "Faded bruises on left shin and right thigh, two faded bruises left thigh, faded bruise right hip." The 3/13/15 I/A report indicated at 10:30 AM client #1 became upset with the staff after being denied the request to go into a housemate's bedroom. Client #1 started "crying, threw herself on the floor, tapped the back side of her head then began head banging. Staff blocked." The BDDS report dated 3/14/15 at 8 AM indicated client #1 was doing her laundry when staff suggested to client #1 she wash her blankets. Client #1 became upset and became physically aggressive with staff trying to hit, kick and bite the staff. Client #1 was placed in a two person YSIS hold until calmed. After being released client #1 crawled to the wall and tried to hit her head but was blocked by the staff. Staff placed client #1's helmet on her head and the client became aggressive again. Client #1 was placed in a one person YSIS hold until calm. Once released client #1 crawled to her bedroom and tried to strangle herself			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	with a pair of sweat pants. Staff removed the sweat pants from client #1's neck. Client #1 continued to be aggressive and staff blocked client #1 from hitting her head on the window sill in her bedroom. Client #1 bit her left hand but did not break the skin. The report indicated client #1 had a bruise on her neck and a 1/8 inch scratch on her neck. __The I/A report dated 3/14/15 at 8 AM indicated "Left side of neck, oblong swelling, tiny scratch, right side of neck cluster of bruises." The IFFC dated 3/14/15 at 8 AM indicated "YSIS.... Watch for bruising on knees/legs on both legs. No new injury noted." 3/16/15 "Right knee one centimeter reddish/purple bruise on side." 3/17/15 "Two pea size purple bruises outer knee, two faded bruises inner knee." 3/18/15 "Right knee on outer and inner has pea size purple bruises, kneecap has pea size purple bruise, right shin has nickel size purple bruise." 3/20/15 "Faint bruises around right knee above and below, fading bruises around left knee above and below." 3/22/15 "Faint bruises on right knee above/below, same on left knee."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	3/23/15 "Faint bruising on left and right knees." 3/24/15 "Bruising on left and right knees above and below." 3/25/15 "Right knee is red and slightly swollen with clusters of bruises and 1/4 inch scratch." 3/26/15 "Right knee two pea size scabs right knee side scratch/scabs right knee side faded bruise right knee inner purple bruising left shin faded bruise right shin faded pink scratch." 3/28/15 "Two scabs right knee, faded bruise right knee, faded bruise left shin." 3/30/15 "Inner right two inch faint gray bruise, above right knee nickel size gray bruise, pin dot scab left knee." 4/21/15 "Above right knee two bruises, scabbed area right knee, left knee pin size scab." 4/3/15 "Four small red scabs on right knee, faint dime size purplish gray bruise on right shin, two very faint dime size gray bruises back of right thigh, left shin two quarter size faint gray bruises." The 3/16/15 BDDS report indicated on 3/16/15 at 5:30 PM client #1 threw a water bottle at the staff and began banging her head on the kitchen table.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	"Staff implemented [client #1's] helmet to prevent injury." Client #1 became aggressive and a two person YSIS hold was initiated until the client calmed. After client #1 was released client #1 tried to exit the home and to remove her helmet. Client #1 was blocked by the staff. Client #1 began crying and scratching her fingers. Client #1 went to her room until she calmed. The report indicated "[Client #1] was not injured as a result of her behavior." __The 3/16/15 5:30 PM I/A report indicated "Right hand ring finger/index finger scratch/dots." The IFFC dated 3/16/15 at 5:30 PM indicated "SIB (Self Injurious Behaviors) at of start of behavior [client #1] hit forehead on dinner table.... Watch for bruising on front of forehead. 3/17/15 "No injury noted." 3/18/15 "No injury noted." 3/19/15 "No injury noted." 3/20/15 "Fading bruises on right side of neck." 3/22/15 "Faint bruises on right side of neck." The IFFC dated 3/16/15 at 5:30 PM indicated "Two person YSIS.... Watch for bruising/redness around ankles and wrists/biceps." 3/17/15 "Left bicep two purple dime size			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	bruises, inner elbow right dim size purple (sic)." 3/18/15 "Left front bicep two dime size purple bruises, inner right elbow faint purple pea size bruise." 3/20/15 Left bicep has several fading bruises on inside and outside on bicep. Cluster of fading bruises on right bicep, fading bruise on right hand." 3/23/15 "Left front bicep fading quarter size bruise, inner left bicep fading three bruises, inner left elbow fading bruise, right bicep two pea size bruises." 3/26/15 "Left front bicep faded bruise, quarter size left inner bicep three faded bruises, left near arm pit purple bruising, left elbow faded bruise, inner right bicep two pea size bruises." The 3/20/15 BDDS report indicated on 3/19/15 at 6:30 AM "Staff was in the process of making pancakes for breakfast and [client #1] was insisting that she have hers at the moment. Staff told [client #1] that they were in the process of making another housemate's pancake but they would make hers next.[Client] then stated that she did not want any. Staff continued to prepare breakfast. When housemates received their breakfast, [client #1] began yelling at staff stating that it was hers.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	Staff reminded [client] that she had told them that she did not want any. [Client] sat down on the floor and cried loudly while everyone was eating breakfast. She began to bang her head on the wall, staff gently blocked. [Client #1] attempted to crawl under the table several times to interrupt housemates' breakfast, staff physically redirected her to another area of the home then immediately released the 2 person YSIS physical escort. [Client #1] came after staff several times, staff gently blocked. [Client #1] then attempted to hit one of her housemates, staff quickly intervened and no contact was made. [Client #1] then attempted to attack staff, staff gently blocked. [Client #1] calmed a little, went to her room where she cried loudly and began banging her head again. [Client #1] then laid (sic) in her bed and began calming, staff continued to monitor. Staff continued to let [client #1] calm for 30 minutes. Staff then prompted [client #1] to complete her hygiene so that she could attend a scheduled eye appointment. [Client #1] ignored staff's prompts. Two minutes later [client #1] got up and began banging her head on the wall, staff gently blocked and placed [client #1's] helmet on her head. [Client #1] became physically aggressive towards staff, staff gently blocked. [Client #1] then removed her helmet, threw it across the room, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	immediately threw herself back onto the floor hitting the back of her head on the floor. Staff assisted [client #1] up and checked the back of her head and she appeared to have a bump. Staff notified the nurse and was instructed to have her taken to the ER. Staff called for non-emergency transport to [name of hospital] due to level of aggression displayed by [client #1]. [Client #1] requested to use the restroom, staff walked with her. While in the restroom, [client #1] attempted to bite staff. While staff was blocking, [client #1] began hitting her head on the wall. During this time [name of police department] arrived, non-emergency transport requested that they come. [Client #1] continued to be physically aggressive so the [name of police department] officer handcuffed her. Staff assisted [client #1] from the toilet to the floor. Once [client #1] was calm, the officer removed the handcuffs. Transport arrived and [client #1] was taken to [name of hospital], one staff and QIDP followed. When staff arrived, was laying calmly in her bed. Staff stood near the doorway to monitor. [Client #1] then got up and became self injurious and physically aggressive towards both ResCare staff and [name of hospital] staff.... [Client #1] continued to be self injurious and aggressive. [Client #1] was then admitted to adult psych assessment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	area where she was placed in a padded room to maintain her safety and the safety of others. [Client #1] sustained a small dime sized bump on the back of her head as a result of her behavior. Staff will continue to monitor the area and for signs and symptoms of a head injury and notify the nurse immediately if there is a change in [client #1's] health status.... [Client #1] was discharged from [name of hospital] on 3/20/15 and returned to the group home." The IFFC dated 3/19/15 at 6:30 AM indicated "[Client #1] was put in a YSIS 2 person hold.... Watch legs and feet for marks and bruising. 3/23/15 "Dime size red scabbed area on right heel." 3/24/15 "Right foot has pea size scab and bruise." 3/25/15 "Right heel dime size red scab. Right top of foot pink pea size area. Right top second toe scab." 3/27/15 "Right heel dark red dime size scab. Right big toe top pink area. Right top of second toe - red scab." 3/30/15 "Quarter size faint brown bruise left shin. Right knee two pea size faint brown bruises and a scab. Outer left thigh dime size faint brown bruise, above outer left knee dime size very faint gray			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	bruise." 3/31/15 "Left shin quarter size faint bruise. Right knee two faint pea size bruises and scab. Left outer thigh dime size faint bruise. Above left knee dime size brown bruise." The IFFC dated 3/19/15 at 6:30 AM indicated "[Client #1] in behavior crawling on floor.... 1/2 inch raw area on right arm below elbow, pink in color. 3/20/15 "Pink area on right elbow, scab on left elbow." 3/23/15 "Pink area on left elbow, right elbow scabbed area." 3/24/15 "Right elbow 1/2 inch scratch and dime size bruise. Left elbow has a pea size scab and a quarter size bruise." 3/26/15 "Pink area on right and left elbow." 3/27/15 "Pink area on right and left elbow." 3/28/15 "Pink area on right and left elbow." 3/30/15 "1/2 inch brown scab below right elbow, below left elbow pink area." 3/31/15 "1/2 inch brown scab below right elbow, below left elbow pink area." 4/2/15 "Pink scratch right elbow, left elbow pink area."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	4/3/15 "Quarter size red area with small scab in center on outer right elbow." 4/4/15 "Pea size pink area on right elbow, pea size gray bruise on inner right elbow." 4/5/15 "Right elbow pea size pink area and inner pea size gray bruise." 4/6/15 "Right elbow pink area and bruise." 4/7/15 "Pink pea size area left elbow, right elbow pink area." The IFFC dated 3/19/15 at 6:30 AM indicated "[Client #1] was put in YSIS two person hold.... Watch arms and hands for marks and bruising." 3/25/15 "Right inner bicep purple cluster of bruises, three dime size bruises and one quarter size bruise, six pea size bruises inner right forearm. Left armpit red quarter size bruise. Left inner elbow has two inch scratch/bruise. Left forearm 1/2 inch scratch." 3/26/15 "Right inner bicep cluster of pea and dime size purple bruises, right bicep near armpit four purple dime size bruises, right arm bend pea size bruise, right forearm three pea size purple bruises, two quarter size top forearm bruises, left forearm faded pink scratch." 3/27/15 "No new injuries noted, already			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	being flowed on." 3/28/15 "Already being flowed." 3/29/15 "Right forearm purple bruise shaped like a bite mark. Inner right forearm five pea size purple bruises. Inner right bicep cluster purple bruises, left forearm one inch faint scratch, left bicep two faint peas size gray bruises." 3/31/15 "Right forearm bite mark purple bruise. Right forearm five pea size purple bruises. Right inner bicep cluster purple bruises. Left bicep two faint gray bruises." 4/1/15 "Unable to assess." 4/2/15 "Right inner bicep cluster of purple bruises. Right bicep near armpit faded. Dime size bruises right arm bend faded bruise. Two faded bruises top left forearm. Left forearm faded pink scratch." 4/3/15 "Purplish gray nickel size bruise top of right forearm. Quarter size faint gray on right bicep. Scratch on inner left forearm." 4/4/15 Top center right forearm nickel size gray bruise, inner right bicep small cluster of purple bruises, left forearm one inch pink scratch." 4/5/15 "Nickel size gray bruise top center right forearm inner right bicep small cluster of purple bruises left forearm one inch pink scratch."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	4/6/15 "Right forearm bruise, right bicep small cluster." 4/7/15 "Top center right forearm nickel size gray bruise inner right bicep small cluster of purple bruises left forearm one inch pink scratch." The 3/23/15 I/A report indicated at 11 AM client #1 hit her head on a cabinet in the home and obtained a red area in the center of her forehead. The 3/25/15 BDDS report indicated on 3/24/15 at 2:30 PM client #1 came home from the workshop and went to the couch and started crying. Client #1 refused to take her medications, went outside of the home without supervision and became verbally aggressive with the staff, picked up rocks and threatened to throw the rocks at the staff. Client #1 then laid down on the ground and began crawling on her stomach. Staff assisted client #1 off the ground and back into the garage and when client #1 became physically aggressive toward the staff. Client #1 was placed in a two person YSIS hold. Client #1 continued to hit, bite and spit at staff while in the hold. After fifteen minutes client #1 calmed and the hold was released with no further incident. The report indicated client #1 obtained two red scratches on her abdomen and a dime size scratch on her left big toe and a one			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	inch scratch on her left pinky finger from crawling on the ground outside. The IFFC dated 3/24/15 at 2:30 PM indicated "2 person YSIS.... Watch for bruising/redness around wrists and ankles." The IFS indicated: 3/25/15 "left ankle dime size bruise." 3/27/15 "left ankle dime size bruise." 3/29/15 "front left ankle two pea size pink bruises right ankle pink pea size area." 3/30/15 "left ankle two pea size pink bruises front right ankle pea size pink area." 4/1/15 "left and right ankle pink areas." 4/4/15 "Lower inner left shin light purple/gray quarter size bruise, pea size faint gray bruise outer left thigh, purple bruise inner left thigh, two oblong purple bruises right front thigh, pea size brown back right calf dime size purple bruise." 4/5/15 "Lower inner left shin purple gray quarter size bruise, pea size faint gray outer left thigh, purple bruise left inner thigh, two oblong purple bruises right front thigh, pea size brown bruise back right calf, dime size purple bruise." 4/7/15 "Lower inner left shin purple/gray quarter size bruise pea size faint gray outer left thigh purple bruise			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	left inner calf dime size purple bruise." Client #1's record was reviewed on 4/7/15 at 3 PM, on 4/8/15 at 12:30 PM and on 4/9/15 at 11 AM. Client #1's revised BSP (Behavior Support Plan) dated 3/27/15 indicated the use of YSIS techniques "such as 1 or 2 person holds or lifts, are only to be used as a last resort when necessary to prevent imminent injury to [client #1] or others and after			
W 318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the facility failed to meet the Condition of Participation: Health Care Services. The facility health care services failed: __To develop and implement a specific plan of care and/or protocol to address clients with probable head injuries due to accidents, behaviors and/or falls, to ensure the plan included what staff were to monitor after clients hit their head, how long staff were to monitor the clients, what staff were to report to nursing in regard to monitoring for a possible head injury and what staff were to document when monitoring a client for possible head injury for clients #1 and #2. __To address the dietary	W 318	**CORRECTION:** *The facility must ensure that specific health care services requirements are met.* Specifically: Specifically for Clients#1 and #2, the facility nurse will develop Comprehensive High Risk Plan with protocols to address probable head injuries due to accidents, behaviors and/or falls. The plans will include but not be limited to instructing staff on what to monitor after clients hit their head, how long staff are to monitor clients, what staff are to report to nursing in regard to	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	recommendations of the dietician with client #1's physician. __To ensure client #1 was provided an annual physical examination. Findings include: 1. The facility's health care services failed to ensure client #1 was provided an annual physical examination. Please see W322. 2. The facility's health care services failed: __To develop and implement a specific plan of care and/or protocol to address clients with probable head injuries due to accidents, behaviors and/or falls, to ensure the plan included what staff were to monitor after clients hit their head, how long staff were to monitor the clients, what staff were to report to nursing in regard to monitoring for a possible head injury and what staff were to document when monitoring a client for possible head injury for clients #1 and #2. __To address the dietary recommendations with client #1's physician. Please see W331. 9-3-6(a)		what monitoring for possible head injuries and what staff are to document when monitoring clients for possible head injury. A review of documentation indicated this deficient practice could have affected other clients and therefore similar risk plans will be developed for Client #3 and Client #4. Additionally, the nurse will provide Client #1's primary care physician with current dietary recommendations to obtain clarified diet orders from the physician. A review of facility documentation indicated this deficient practice did not affect other clients. The facility has obtained an annual physical examination for Client #1. A review of medical records indicated this deficient practice did not affect any additional clients. **PREVENTION:** The QIDP will assure that the nursing team is included in all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
			discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will include assuring all relevant assessments have corresponding physician's orders as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER: COMMUNITY ALTERNATIVES ADEPT

STREET ADDRESS, CITY, STATE, ZIP CODE: 213 W WATER ST, CENTERVILLE, IN 47330

(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
			The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that examinations including but not limited to physical evaluations take place as required. **RESPONSIBLE PARTIES:** QIDP, Health Services Team, Operations Team	
W 322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 2 sampled clients (#1), the facility failed to ensure the client was provided an annual physical examination. Findings include: Client #1's record was reviewed on 4/8/15 at 12:30 PM and 4/9/15 at 11 AM. Client #1's record indicated client #1's	W 322	**CORRECTION:** The facility must provide or obtain preventive and general medical care. Specifically, the facility has obtained an annual physical examination for Client #1. A review of medical records indicated this deficient practice did not affect any additional clients.	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	most current annual physical by her physician was conducted on 9/11/13. Client #1's record indicated no annual physical by a physician since 9/11/13. During interview with the facility's LPN on 4/7/15 at 2 PM, the LPN: __Indicated all clients were to have an annual physical examination by their physician. __Indicated client #1's most current annual physical was the one of 9/11/13. __Stated, "I just started in October and I missed getting her scheduled. She has an appointment on 4/10/15." 9-3-6(a)		**PREVENTION:** The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical evaluations, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than quarterly to assure that examinations including but not limited to physical evaluations take place as required. **RESPONSIBLE PARTIES:** Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 2 sampled clients (#1 and #2), the facility nursing services failed: __To develop and implement a specific plan of care and/or protocol to address	W 331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.*	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	clients with probable head injuries due to accidents, behaviors and/or falls, to ensure the plan included what staff were to monitor after clients hit their head, how long staff were to monitor the clients, what staff were to report to nursing in regard to monitoring for a possible head injury and what staff were to document when monitoring a client for possible head injury for clients #1 and #2. __To address the dietary recommendations with client #1's physician. Findings include: The facility's reportable records for December 2014 through April 2015 were reviewed on 3/31/15 at 1:30 PM, on 4/6/15 at 11 AM and on 4/7/15 at 1 PM. The 12/1/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 12/1/14 client #1 had become physically aggressive toward staff; hitting, kicking, biting, and scratching. The report indicated client #1 went to her room and began tapping her head on the wall. Staff blocked and attempted to place client #1's helmet on her but client #1 grabbed the helmet and threw it at staff. Client #1 got up and attempted to bite another staff member and threw herself back and hit her head		Specifically for Clients#1 and #2, the facility nurse will develop Comprehensive High Risk Plan with protocols to address probable head injuries due to accidents, behaviors and/or falls. The plans will include but not be limited to instructing staff on what to monitor after clients hit their head, how long staff are to monitor clients, what staff are to report to nursing in regard to what monitoring for possible head injuries and what staff are to document when monitoring clients for possible head injury. A review of documentation indicated this deficient practice could have affected other clients and therefore similar risk plans will be developed for Client #3 and Client #4. Additionally, the nurse will provide Client #1's primary care physician with current dietary recommendations to obtain clarified diet orders from the physician. A review of facility documentation indicated this deficient practice did not affect other clients.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	against the wall and the edge of client #1's wooden bed frame. Client #1 told the staff she had hurt herself and she was bleeding. Staff checked client #1's head, applied a sterile gauze to the injury and contacted the facility's nurse. Client #1 was taken to the local hospital ER (Emergency Room) for treatment. A CAT (Computerized Axial Tomography - images of the body using X-rays and a computer) was performed and returned negative. The ER doctor placed two staples in client #1's head to close the laceration and released client #1 with instructions to care for the laceration and to return in ten days to have the staples removed. The 1/9/15 BDDS report indicated on 1/8/15 at 3:05 PM client #1 became upset when staff requested she do her laundry. Client #1 began banging her head. Staff placed client #1's helmet on client #1's head. Client #1 removed the helmet and became physically aggressive towards staff. The report indicated no injury to client #1 due to client #1's behaviors. The 1/11/15 BDDS report indicated on 1/10/15 at 5:20 PM while lying in bed client #1 began crying, kicking the wall with her feet and banging her head on the wall. When client #1 saw staff reach for her helmet, client #1 began hitting both		**PREVENTION:** The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will include assuring all relevant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	sides of her head with her hands. Client #1 became aggressive and was placed in a two person YSIS (You're Safe I'm Safe) hold until calm. The report indicated no injury to client #1 due to client #1's behaviors. The 1/12/15 BDDS report indicated client #1 sat outside the medication room door and banged her head. Client #1 became physically aggressive and was placed in a one person YSIS hold until calm. While in the hold, staff placed client #1's helmet on her. Later client #1 entered the garage without telling staff and began punching the punching bag hard enough to cause the bag to come back and hit client #1 in the face. Client #1 went back inside the house and threw her helmet and hit her head on the wall. The report indicated no injury to client #1 due to client #1's behaviors. The 2/1/15 I/A (Incident/Accident) report indicated at 10:30 AM client #1 came out of her bedroom into the living room, picked up the end of the couch, slammed the couch down causing it to break and then ran into her bedroom and began banging her head on the wall. The report indicated no injury to client #1 due to client #1's behaviors. The 2/4/15 BDDS report indicated on		assessments have corresponding physician's orders as appropriate. **RESPONSIBLE PARTIES:** QIDP, Health Services Team, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	2/4/15 at 6:30 PM client #2 was displaying SIB (Self Injurious Behaviors) when she began punching herself in the face. The report indicated no injury to client #2 due to client #2's behaviors. The 2/4/15 BDDS report indicated on 2/4/15 at 7:30 AM client #2 became physically aggressive and was placed in a two person YSIS physical escort and lowered out of her wheel chair onto the floor. Client #2 laid on her left side on the floor and began to tap her head on the floor. Staff retrieved client #2's helmet and tried to put it on her head but client #2 became physically aggressive again and was placed in another two person YSIS hold until calm. The report indicated no injury to client #2 due to client #2's behaviors. The 2/10/15 BDDS report indicated on 2/10/15 at 5:20 AM client #1 ran into the laundry room and began pushing all the buttons on the washer. Staff shut the washer off and client #1 crawled under the counter and began banging her head. The report indicated no injury to client #1 due to client #1's behaviors. The 2/13/15 BDDS report indicated on 2/12/15 at 2:45 PM client #1 came out of her bedroom, sat on the floor in the living room, and began banging her head on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	wall with her helmet on. Staff attempted to talk with client #1 but she refused to answer. Client #1 began banging her head again and staff blocked her. Client #1 then leaned forward and attempted to bang her head on the floor, staff continued to block. Client #1 continued to attempt to bang her head. Client #1 then took her helmet off and threw it at her housemates. Staff placed client #1's helmet back on her head.... Client #1 removed the helmet and threw it at her housemates and staff. The report indicated no injury to client #1 due to client #1's behaviors. The 2/16/15 BDDS report indicated on 2/16/15 at 10 AM during a behavior while sitting at the dining room table, client #2 began hitting her head on the table. The report indicated no injury to client #2 due to client #2's behaviors. The 2/19/15 BDDS report indicated on 2/18/15 "[Client #1] complained of a headache and showed staff a bump along with a red/purple area on the back of her head that resulted from a previous behavior and head banging on 2/12/15. As of 2/13/15 it was documented the bump was quarter sized and was now a half dollar sized bump. Staff notified the nurse, [name of nurse], who then instructed staff to take [client #1] out to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	be seen at the [local urgent care]. When staff arrived at the [local urgent care], they were instructed to take [client #1] out to the ER. Staff then transported [client #1] to [name of hospital]. When they arrived at [name of hospital], the doctor ordered a CT Scan." The report indicated client #1 was treated and released to return to her home and "Staff will continue to monitor the bump on [client #1's] head using the injury flow sheets provided until the injury is healed. Staff will immediately notify the nurse if her condition worsens." The 2/19/15 BDDS report indicated on 2/19/15 at 8:15 AM client #1 was in her bedroom, became upset and began banging her head. The report indicated no injury to client #1 due to client #1's behaviors. The 2/20/15 BDDS report indicated on 2/20/15 at 7:20 AM client #1 was prompted to come to the medication room to get her medications. Client #1 began crying and hit her head on the floor. Staff attempted to place client #1's helmet on client #1 when client #1 threw her helmet, got up, ran to her room, slammed her door and began "head banging." Staff again attempted to put client #1's helmet on client #1's head but was blocked by client #1. Client #1 tried			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	to exit the home through the garage and was blocked by staff when she began hitting her head on the floor. Staff initiated a one person YSIS hold until the client calmed. The report indicated no injury to client #1 due to client #1's behaviors. The 2/20/15 BDDS report indicated on 2/20/15 at 7:30 PM after being released from a two person YSIS hold, client #2 crawled to the medication room door and began banging her head on the door. The report indicated no injury to client #2 due to client #2's behaviors. The 2/23/15 BDDS report indicated on 2/22/15 at 5:10 PM client #1 was in her bed room kicking the wall and banging her head. Staff attempted to put her helmet on her when she became physically aggressive toward the staff. Client #1 was placed in a two person YSIS hold until calm. The report indicated no injury to client #1 due to client #1's behaviors. The 2/23/15 BDDS report indicated on 2/23/15 at 7:15 AM during a behavior client #1 began hitting the center of her forehead on the Plexiglas in front of the television. When staff tried to stop client #1 she (client #1) threw herself to the floor and began hitting the side of her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	head on the floor. The report indicated no injury to client #1 due to client #1's behaviors. The 2/25/15 BDDS report indicated on 2/24/15 at 5:30 PM client #1 sat on the living room floor banging her head against the wall. Staff placed client #1's helmet on her. Client #1 became aggressive with staff, took the helmet off and put her helmet strap in her mouth. Staff initiated a two person YSIS hold until the client calmed. The report indicated no injury to client #1 due to client #1's behaviors. The 2/26/15 BDDS report indicated on 2/25/15 at 5:45 PM client #1 became physically aggressive and "began to bang her head, staff gently blocked and implemented her soft helmet...." The report indicated no injury to client #1 due to client #1's behaviors. The I/A report dated 3/2/15 at 6:45 AM indicated client #1 threw herself on the floor and began hitting the back of her head. The report indicated client #1 stopped hitting her head when the staff retrieved client #1's helmet. The report indicated no injury to client #1 due to client #1's behaviors. The 3/4/15 BDDS report indicated on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	3/3/15 at 9:45 AM client #1 sat in front of the medication room door and started banging her head on the door while crying. After a few minutes client #1 got up, went to her bedroom, slammed the door behind her and began banging her head on her bedroom door. "[Client #1] became physically aggressive towards staff, staff gently blocked and implemented her (client #1's) helmet to prevent injury. [Client #1] kept trying to remove her helmet and bang her head. Staff then initiated a 2 person YSIS hold.... Staff released the hold after 15 minutes. Staff attempted to release every 3-5 minutes but was unsuccessful. [Client #1] then hit her head on her bedroom window and became physically aggressive towards staff. She [client #1] attempted to take her helmet off, staff gently blocked. She then became self injurious by biting her hands.... [Client #1] began physically attacking staff, staff initiated a second 2 person YSIS hold. [Client #1] attempted to pull off her helmet causing an immediate bruise on her neck.... Staff will continue to flow on the immediate bruise on [client #1's] neck as a result of her self injurious behavior until the area is healed." The 3/7/15 BDDS report indicated on 3/7/15 at 7:55 AM client #1 "started banging her head. Staff prompted helmet			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	and talked to [client #1] about conversation with BC (Behavior Consultant) about what happens when [client #1] bangs her head. [Client #1] began to cry loudly and banged her head some more. Staff tried to assist with helmet and [client #1] hit and tried to scratch staff. Staff blocked. [Client #1] came crawling after staff. Staff tried to remove themselves from the area, [client #1] followed. Another staff blocked her (client #1) so staff could get away. [Client #1] gave up on going after staff and made a pallet (a makeshift bed) of blankets on the floor by her bedroom door and calmed herself." The report indicated no injury to client #1 due to client #1's behaviors. The 3/11/15 BDDS report indicated on 3/10/15 at 10 AM while at the day program client #1 became upset, removed her helmet and began "to bang her head. When [client #1] pulled off the helmet, she broke it. [Client #1] became physically aggressive towards staff.... [Client #1 began hitting her head.... She (client #1) then attempted to head butt staff.... Staff shut the door and [client #1] became even more agitated and slid herself down the door to the floor. [Client #1] attempted to kick [day program] staff. [Day program staff] initiated a one person YSIS hold." The report indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	no injury to client #1 due to client #1's behaviors. The 3/12/15 BDDS report indicated on 3/11/15 at 8:15 AM client #1 followed staff and a housemate into the bathroom. When staff redirected client #1 to leave the bathroom and shut the bathroom door, client #1 "sat on the floor in front of the (bathroom) door and began tapping her head on the door. [Client #1] then crawled into the living room where she sat in front of another housemate's door and began hitting her head. Staff placed [client #1's] helmet on her head to prevent injury. [Client #1] became physically aggressive... took off her helmet and threw it at staff and began hitting her head on the floor, staff placed helmet back on her head. [Client #1] continued to take it off and throw it at staff and hit her head. Staff then initiated a two person YSIS hold to prevent injury.... [Client #1] was not injured as a result of her behavior or as a result of being placed in a two person YSIS hold." The 3/12/15 BDDS report indicated on 3/11/15 at 10 AM client #2 became agitated and hit staff in the nose and then head butted staff. Staff unbuckled client #2's seatbelt of her wheelchair and assisted client #2 to the floor. Client #2 began to banging her head and staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	placed client #2's helmet on client #2. Client #2 continued to be self injurious and physically aggressive and was placed in a 2 person YSIS hold until calm. The report indicated no injury to client #2 due to client #2's behaviors. The 3/13/15 I/A report indicated at 10:30 AM client #1 became upset with the staff after being denied the request to go into a housemate's bedroom. Client #1 started "crying, threw herself on the floor, tapped the back side of her head then began head banging. Staff blocked." The report indicated no injury to client #1 due to client #1's behaviors. The 3/14/15 BDDS report indicated on 3/14/15 at 8 AM after being released from a YSIS hold client #1 crawled to a nearby wall and tried to hit her head but was blocked by the staff. Staff placed client #1's helmet on her head and client #1 became aggressive and was placed in a one person YSIS hold until calm. Once released client #1 crawled to her bedroom and tried to strangle herself with a pair of sweat pants. Staff removed the sweat pants from client #1's neck. Client #1 continued to be aggressive and staff blocked client #1 from hitting her head on the window sill in her bedroom. The report indicated client #1 had a bruise on her neck and a 1/8 inch scratch on her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	neck. The 3/16/15 BDDS report indicated on 3/16/15 at 5:30 PM client #1 threw a water bottle at staff and began banging her head on the kitchen table. "Staff implemented [client #1's] helmet to prevent injury." The report indicated no injury to client #1 due to client #1's behaviors. The 3/20/15 BDDS report indicated on 3/19/15 at 6:30 AM "[Client #1] began to bang her head on the wall, staff gently blocked. [Client #1] attempted to crawl under the table several times to interrupt housemate's breakfast, staff physically redirected her to another area of the home then immediately released the 2 person YSIS physical escort. [Client #1] came after staff several times, staff gently blocked. [Client #1] then attempted to hit one of her housemates, staff quickly intervened and no contact was made. [Client #1] then attempted to attack staff, staff gently blocked. [Client #1] calmed a little, went to her room where she cried loudly and began banging her head again. [Client #1] then laid (sic) in her bed and began calming, staff continued to monitor. Staff continued to let [client #1] calm for 30 minutes. Staff then prompted [client #1] to complete her hygiene so that she could attend a scheduled eye			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	appointment. [Client #1] ignored staff's prompts. Two minutes later [client #1] got up and began banging her head on the wall, staff gently blocked and placed [client #1's] helmet on her head. [Client #1] became physically aggressive towards staff, staff gently blocked. [Client #1] then removed her helmet, threw it across the room, and immediately threw herself back onto the floor hitting the back of her head on the floor. Staff assisted [client #1] up and checked the back of her head and she appeared to have a bump. Staff notified the nurse and was instructed to have her taken to the ER. Staff called for non-emergency transport to [name of hospital] due to level of aggression displayed by [client #1]. [Client #1] requested to use the restroom, staff walked with her. While in the restroom, [client #1] attempted to bite staff. While staff was blocking, [client #1] began hitting her head on the wall. During this time [name of police department] arrived, non-emergency transport requested that they come. [Client #1] continued to be physically aggressive so the [name of police department] officer handcuffed her. Staff assisted [client #1] from the toilet to the floor. Once [client #1] was calm, the officer removed the handcuffs. Transport arrived and [client #1] was taken to [name of hospital], one staff and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	QIDP followed. When staff arrived, [client #1] was laying calmly in her bed. Staff stood near the doorway to monitor. [Client #1] then got up and became self injurious and physically aggressive towards both ResCare staff and [name of hospital] staff.... [Client #1] continued to be self injurious and aggressive. [Client #1] was then admitted to adult psych assessment area where she was placed in a padded room to maintain her safety and the safety of others. [Client #1] sustained a small dime sized bump on the back of her head as a result of her behavior. Staff will continue to monitor the area and for signs and symptoms of a head injury and notify the nurse immediately if there is a change in [client #2's] health status.... [Client #1] was discharged from [name of hospital] on 3/20/15 and returned to the group home." The 3/23/15 I/A report indicated at 11 AM client #1 hit her head on a cabinet in the home and obtained a red area in the center of her forehead. The 3/26/15 BDDS report indicated on 3/25/15 at 6:15 AM client #1 "became physically aggressive toward staff (hitting, kicking). Staff was able to block and then [client #1] attempted to climb through the kitchen window.... [Client #1] attempted again and fell and hit her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	side and her back. [Client #1] sat against the wall and started to tap her head against the wall. Staff blocked and [client #1] stopped when staff attempted to place her helmet on." The report indicated no injury to client #1 due to client #1's behaviors. The 3/27/15 BDDS report indicated on 3/27/15 at 9 AM client #2 refused to attend her appointment and "began to bang her head, staff gently blocked." The report indicated no injury to client #2 due to client #2's behaviors. The I/A report dated 3/27/15 indicated at 12:30 PM client #1 became upset and began hitting her head on the wall. The report indicated no injury to client #1 due to client #1's behaviors. The 4/2/15 BDDS report indicated on 4/2/15 at 5:30 AM client #1 woke up and requested to take a shower. Staff was in the process of preparing AM medications and asked client #1 to wait a minute and they would assist her. Client #1 became upset and returned to her room, slammed her bedroom door and turned the volume of her music up. The staff cracked client #1's bedroom door to be courteous to the clients still sleeping and client #1 opened her door and turned her music up louder and began banging her head on the wall.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	Staff blocked client #1 and placed her helmet on her head to prevent injury. Client #1 attempted to remove the helmet while still banging her head on the wall. Staff initiated a one person YSIS hold until calm. The report indicated no injury to client #1 due to client #1's behaviors. Client #1's Injury Follow-up Flow Charts (IFFCs) for December 2014 through April 2015 were reviewed on 3/31/15 at 1:30 PM, 4/6/15 at 11 AM and 4/7/15 at 1 PM. The IFFCs indicated documentation of injuries observed by staff. Client #1's IFFCs indicated the following: The IFFC dated 12/1/14 indicated client #1 had a two inch "gash" that required two staples on the back left side of client #1's head. 12/3/14 - "2 inch gash with staples." 12/4/14 - "2 staples healing left side of back of her head." 12/5/14 - "healing open area with two staples." 12/6/14 - "left back of head staples." 12/7/14 - "left side of back head two staples." 12/8/14 - "Dry blood on scab, healing with two staples present." 12/9/14 - "2 staples with scab area." 12/10/14 - "2 staples on back of head left			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	side." 12/11/14 - "staples removed, pea size scab with dry blood on left side back of head." The IFFC dated 1/19/15 at 7:15 AM indicated "[Client #1] was banging her head in a behavior.... Watch head and face because of head banging." The IFFC indicated no injury. The IFFC dated 1/20/15 at 5:20 AM indicated "[Client #1] head banging.... Watch for knot on back and front of head. 1/21/15 "Back of right side of head sore to touch, can't feel any knots." The IFFC dated 1/30/15 at 6 AM indicated "[Client #1] hit her face on the wall and punching bag.... Watch head and face for marks/bruising." 2/2/15 "Right cheek has three pea size bruises." The IFFC dated 2/12/15 at 2:45 PM indicated "Head banging.... Watch for redness, bruising on forehead." 2/13/15 "Goose egg shaped knot on back of head with quarter size deep purple bruise." 2/14/15 through 2/17/15 client #1 refused to let staff assess her." 2/18/15 "Right back side of head has 1/2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	dollar size reddish purplish raised bump." The IFFC dated 2/18/15 at 8:45 AM indicated "previous behavior 2/12/15, [client #1] hitting head seen at ER today (2/18/15) for injury.... 1/2 dollar size bump with red/purple raised area on back right side of head. 2/19/15 "1/2 dollar size bump with red/purple raised area on back right side of head." 2/20/15 "Softball size know (sic) on outer right side of head with a light purple bruise in center - dime size." 2/20/15 (second entry) "Dime size brownish bruise and a golf (sic) size knot on outer right side of head." 2/21/15 "Right side of head, golf ball size knot with bruising." 2/21/15 (second entry) "Pea size faded bruise on back side on head with a bump under skin." 2/21/15 (third entry) "Dime size bruise brownish in color and knot under skin." 2/22/15 "Knot under skin on back of head." 2/22/15 (second entry) "Peas size fading bruise back of head on right side, raised bump." 2/22/15 (third entry) "Small bruise right			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	side of back of head, bump under the skin." 2/23/15 through 3/1/15 small bump/knot on right side of head. The IFFC dated 2/25/15 at 8:05 AM indicated client #1 had "lightly tapped forehead on shower wall.... Watch for bruising and/or marks on front of forehead. No injury noted at this time." The IFFC dated 3/16/15 at 5:30 PM indicated "SIB at start of behavior [client #1] hit forehead on dinner table.... Watch for bruising on front of forehead." 3/17/15 "No injury noted." 3/18/15 "No injury noted." 3/19/15 "No injury noted." 3/20/15 "Fading bruises on right side of neck." 3/22/15 "Faint bruises on right side of neck." The facility's I/A reports and BDDS reports indicated nursing services was notified after each reported incident of client #1 and client #2 hitting their head and/or head banging. 1. a. Client #1's record was reviewed on 4/8/15 at 12:30 PM and on 4/9/15 at 11 AM. Client #1's record indicated diagnoses of,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	but not limited to, IED (Intermittent Explosive Disorder), Disruptive Disorder and Depressive Disorder. Client #1's BSP (Behavior Support Plan) dated 3/27/15 indicated client #1 had SIB of, not all inclusive, head banging and throwing herself against doors and/or walls. Client #1's hospital records for the visit of 12/1/14 indicated "HISTORY OF PRESENT ILLNESS: This is a... female with underlying behavioral disturbances, who took her helmet off at the group home this morning and started hitting her head against a wall, sustained a laceration to the left posterior scalp which is the main reason for them bringing her. The behavior is normal for her and she has been acting normally since then. Ambulating without difficulty. There has been no vomiting...." The record indicated a full neurological assessment without findings. The record indicated the ER doctor placed 2 staples in client #1's wound after the client was sedated with 10 mg of IM (Intramuscular) Haldol (an antipsychotic). Client #1's hospital record for the visit of 2/18/15 indicated "HISTORY OF PRESENT ILLNESS: This is a... female with chief complaint of head injury. She			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	has a right posterior hematoma (a localized swelling filled with blood). She has some MR (Mental Retardation) and some behavioral disorders and so lives in a group home and they are not exactly sure when she sustained the injury. She does wear a helmet at times when she has behavioral issues and does do some head banging with that but they do not believe it was during one of those episodes. The patient actually reported at a caregiver at the facility named (name of staff) pulled her down on the ground and when she did, she hit her head but she does know when it occurred and neither does the caregiver that is here with her from the facility though they are investigating the issue per their report. She complains of having a headache and being dizzy. She has no nausea or vomiting. She has no neck pain. she has no numbness or weakness. No extremity injury. No chest pain. No abdominal pain and other systems reviewed and were negative." Client #1's physician's order dated 2/27/15 indicated client #1 was to wear a helmet at all times. Client #1's nursing notes from December 2014 through March 2015 indicated, all inclusive: 12/ 4/14 "Appt (appointment) with neurologist. No new orders...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	12/4/14 (second entry) "90 day follow up...." 12/8/14 "Seen at [name of doctor's] office. Cerumen cleaned from ears." 12/11/14 "[Name of doctor] office to remove staples wound healing well. Will cont (continue) to observe area. Staff will also clean area and observe for any s/s (sign/symptoms) of infection." 12/22/14 "[Name of counseling services] therapy. [Client #1] to use cope (sic) skills. Use deep breathing, talk to staff before getting angry." 12/27/14 "Breakthrough seizure noted taking (sic) to [name of hospital]...." 12/31 14 "Released from [name of hospital]. VS (vital signs) stable. [Client #1] denies any pain at this time. Will cont with orders from [name of hospital] follow up appts." 2/8/15 "Sent to hospital for possible overdose (accidental). No new orders. Discharge with orders to return if vomiting. Abd (abdominal pain). Change in mental status." 2/17/15 "Sent to ER after behavior and banging head. CT scan." 2/19/15 "Seen at house. Denies any pain or discomfort."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	2/20/15 "Partial assessment done. Refused genital area check. Wearing glasses. Noted small bruises all over body. Flow sheets being done on all areas. Breath sounds clear. BS (bowel sounds) x4 (times four quadrants of abdomen). Denies any pain. Obsessing about going to work." 3/10/15 "Appt with Neuro (Neurology) doctor [name of doctor] F/U (follow up) apt for concussion. Non-focal neurological exam done. No new treatments noted." 3/13/15 "90 day F/U (follow up) with [name of doctor's] office. No changes made...." 3/19/15 "Refused appt at [name of eye doctor]...." 3/19/15 (second entry) "Continue (sic) behaviors throughout morning sent to [name of hospital] for evaluation (psych). Admitted to [name of hospital.]" 3/20/15 "Released from [name of hospital] to group home." 3/23/15 "Seen at [name of doctor] office (psych Dr.) R/U from discharge from [name of hospital]. N.O's (no orders)...." 3/30/15 medication changes "seem to be working. Less behaviors since started." 3/31/15 "[name of doctor's] office for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	annual physical...." 3/31/15 (second entry) "Sent to [name of hospital] by on call nurse. IV (Intravenous) fluids given - sent home." Client #1's nursing notes indicated nursing services failed to assess and/or monitor client #1 for head injury after reported incidents of client #1 hitting and/or banging her head. __Client #1's record indicated no nursing care plan and/or risk plan in regard to client #1's history of hitting her head and/or head banging. __Client #1's record indicated no neurological and/or health assessments by nursing services after each incident of client #1 hittin g and/or banging her head. __Client #1's record indicated client #1 was not monitored for probable head injury after each incident of hitting and/or banging her head. 1. b. Client #2's record was reviewed on 4/7/15 at 1 PM and at 4/8/15 at 2:30 PM. Client #2's record indicated diagnoses of, but not limited to, Mild MR, Social Anxiety Disorder, Psychotic Mood Disorder, Schizophrenia, ADHD (Attention Deficit Disorder) and IED.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	Client #2's BSP dated 3/13/15 indicated SIB of, not all inclusive, hitting her head and throwing herself out of her chair and/or bed. Client #2's nursing notes for 2014/2015 indicated no nursing assessment or neurological assessment of client #2 by the nurse after the documented incidents of client #2 hitting her head on 2/4/15, 2/16/15, 2/20/15, 3/11/15 and 3/27/15. __Client #2's record indicated no nursing care plan and/or risk plan in regard to client #2's history of hitting her head and/or head banging. __Client #2's record indicated no neurological and/or health assessments by nursing services after each incident of client #2 hitting and/or banging her head. __Client #2's record indicated client #2 was not monitored for probable head injury after each incident of hitting and/or banging her head. During interview with staff #4 on 4/7/15 at 6:15 AM, staff #4: __Indicated staff did not do neuro assessments and/or vital signs when clients had incidents of hitting their head. __Stated the staff would "flow on" (fill out the injury flow sheets) if they saw an injury.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	__Indicated when a client hit their head during a behavior staff would notify the QIDPD (Qualified Intellectual Disabilities Professional Designee), the nurse and the BC (Behavior Consultant). __Indicated client #1 was to wear her helmet at all times but would take it off and throw it when in behaviors and use it as a weapon. During interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 4/9/15 at 12 PM, the QIDPD: __Indicated staff failed to notify the QIDPD and/or nursing when doing the flow sheets on 2/13/15 after client #1 hit her head on 2/12/15 and a quarter size lump was noted. __Indicated on 2/18/15 the staff conducting the assessment noted an increase in the size of the injury and then notified nursing. __Indicated nursing instructed the staff to take client #1 to the hospital for an assessment on 2/18/15. During interview with the facility's LPN on 4/9/15 at 2 PM, the LPN: __Indicated no facility protocol and/or procedure in place in regard to monitoring clients for probable head injury after incidents of the clients hitting their head.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	__Indicated nursing services was notified after client #1's and client #2's behaviors including those of hitting their heads and head banging. __Indicated staff observed client #1 and client #2 for injuries after each behavior and documented their findings on the flow sheets (the IFFCs). __Stated staff "are supposed to" notify nursing and the QIDPD when new injuries are noted on the IFFCs. __Indicated the staff were not trained to conduct neurological assessments. __Indicated the staff did not conduct and/or record a full set of vital signs (blood pressure, pulse, respirations) after behavior incidents that included client #1 and client #2 hitting their head. __Indicated no neurological assessment and/or health assessment by nursing was conducted on client #1 or client #2 after each incident of hitting their head and/or head banging. __Indicated client #1 and client #2 did not have a risk plan and/or health care plan in regard to frequent behavior of hitting their head and/or monitoring for probable head injury after behaviors. __Stated, "I can put something in place to do neuro assessments if you want." On 4/7/15 at 3 PM the LPN provided a sheet of paper for review and stated, "I found this. Is this what you were talking			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	about?" The paper was titled "Post Head Injury/Concussion Precaution" and did not include a date or the facility name. The paper indicated: "Watch for: 1. Unusual drowsiness, especially progressive drowsiness. Arouse every 1-2 hours for the 1st 24 hours following head injury. Call nurse if difficult to awaken. 2. Dizziness 3. Nausea and/or vomiting 4. Stiff neck 5. Blood or fluid oozing from nose or ears 6. Sudden or progressive vision impairment 7. Weakness, numbness or tingling in arms or legs 8. Unexplained fever. 9. Pupils that are unequal in size. 10. Severe or persistent headache that is not relieved by Tylenol (pain medication). 11. Confusion, unusual drowsiness or difficulty thinking, remembering or speaking. Strange behavior. 12. Problems with sense of balance or equilibrium. 13. Convulsions or seizures." 3. Observations were conducted at the group home on 3/31/15 between 4 PM and 7 PM. Client #2 was a large woman in a wheelchair.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	Client #2's record was reviewed on 4/7/15 at 1 PM and 4/8/15 at 2:30 PM. Client #2's 2015 physician's orders indicated client #2 was to have a "Dysphagia diet - mechanical soft food, ground meat, no straws, aspiration precautions sit at 90 degree angle, 1:1 (one staff to one client) supervision, small bites, small sips." Client #2's 3/10/15 dietary assessment from the dietician indicated client #2 weighed 195 pounds and had an ideal body weight of 112 to 138 pounds. The assessment indicated a recommendation for client #2 to have 6 to 8 ounces of fluids before meals to aid with "satiety" (feeling full). "May also suggest NEP (no extra portions) except non starchy veggies and lean protein to aid with goal of weight loss of 2 to 3 pounds x 2 - 4 months." During interview with the facility's LPN on 4/7/15 at 2 PM, the LPN: __Indicated she was not aware of the recommendations made by the dietician on 3/10/15 and stated, "I just started in October and I'm still trying to get to know everyone." __Indicated client #2 had a physician's order to receive 6 to 8 ounces of water six times a day for hydration. __Indicated client #2 was not currently			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	encouraged fluids prior to eating to aid in her weight loss. __Indicated she had not addressed the dietician's recommendations with client #1's physician. 9-3-6(a)			
W 460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the facility failed to ensure client #2 was provided with the recommended diet texture. Findings include: Observations were conducted at the group home on 3/31/15 between 4 PM and 7 PM. During this observation period client #2 was observed eating her evening meal of a pasta bake, a salad and pudding. The salad consisted of lettuce and tomatoes and was cut into small pieces and provided to client #2 one bite at a time. Client #2's record was reviewed on	W 460	**CORRECTION:** *Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.* Specifically, all staff have been retrained regarding proper implementation of Client #2's Mechanical soft food, ground meat…small bites diet. **PREVENTION:** The QIDP will be present, supervising and participating in active treatment during no less than five active treatment sessions per week on varied shifts to assure diet orders are	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	4/7/15 at 1 PM and 4/8/15 at 2:30 PM. Client #2's physician's orders for 2015 indicated client #2 was to receive a "Dysphagia (difficulty swallowing) diet - Mechanical soft food, ground meat... small bites...." Review of the 1/28/14 Dysphagia Diet - Level IV guidelines on 4/7/15 at 1 PM indicated foods to avoid, not all inclusive: salad and tomatoes. During interview with staff #3 on 3/31/15 at 6:15 PM, staff #3 indicated client #2 had a history of choking and had a tendency to eat too fast and to take large bites. When asked what type of diet client #2 was to have, staff #3 stated, "She is on a mechanical soft diet." When asked is it ok for client #2 to have lettuce and tomatoes, staff #3 stated, "Yes, we just cut them up in small pieces for her." Interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 4/7/15 at 2 PM indicated the staff were to provide the clients with their prescribed diets at every meal. 9-3-4(a)		followed as written, providing coaching and hands on training to staff as needed. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct active treatment observations no less than twice weekly for the next 30 days and weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility and the Director of Operations/Regional Manager no less than monthly for the next 60 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			Administrative support at the home will include but not be limited to assuring correct implementation of diet orders. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team	
W 488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 1 of 2 sampled clients (#2), the facility failed to ensure the staff provided training in meal preparation and family style dining when formal and informal training opportunities existed. Findings include: Observations were conducted at the group home on 3/31/15 between 4 PM and 7 PM. During this observation period: __Client #2 was observed eating her evening meal of a pasta bake, a salad and pudding. __Client #2's food was prepared by the	W 488	**CORRECTION:** *The facility must assure that each client eats in a manner consistent with his or her developmental level.* Specifically, staff will be retrained regarding the need to assure Client #2 is encouraged to participate in meal preparation and family style dining. Administrative Team observation of active treatment determined that this deficient practice did not affect additional clients. **PREVENTION:** The QIDP will be present,	05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
	staff in the kitchen and brought to the table for client #2 who was sitting in her wheel chair at the dining room table. __Client #2 was provided an empty plate and an empty cup. __Staff #3 sat down beside client #2. __Staff #3 pre filled a spoon with food and placed the spoon of food on client #2's empty plate. __Client #2 picked up the spoon with food, placed the spoon in her mouth and then returned the empty spoon to the empty plate in front of her. __Staff #3 then poured a small amount of liquid into the empty cup in front of client #2. __Client #2 picked up the cup, drank the liquid and sat the cup down for the staff to refill. __The process of one bite, one sip, one bite and one sip continued throughout the meal until client #2 finished her evening meal. Interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 4/9/15 at 2 PM, the QIDPD: __Indicated the clients had assigned days to be in the kitchen and to assist with meal preparation. __"Stated, "It must not have been her night." __Indicated client #2 could not prepare a		supervising and participating in active treatment during no less than five active treatment sessions per week on varied shifts to assure meal preparation training and family style dining occurs, providing coaching and hands on training to staff as needed. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will conduct active treatment observations no less than twice weekly for the next 30 days and weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/13/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330	

(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
	meal by herself and required assistance and training. __Stated client #2 "should assist" in meal preparation and/or setting the table. 9-3-8(a)		active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G807		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(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
			Director will participate directly in administrative monitoring of the facility and the Director of Operations/Regional Manager no less than monthly for the next 60 days. Administrative support at the home will include but not be limited to assuring meal preparation training occurs and family style dining is supported with all clients. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team	