

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |                     |   |  |  |  |
|--|---|--|---------------------|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING  |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE                 |  |
| W 0000<br><br>Bldg. 00   | <p>This visit was for the investigation of complaint #IN00370933.</p> <p>Complaint #IN00370933: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W157, W158 and W186.</p> <p>Unrelated deficiency cited.</p> <p>This visit was in conjunction with the PCR (post certification revisit) to the investigation of complaints #IN00366881 and #IN00368229 completed on 12/16/21.</p> <p>Survey Dates: February 14, 15, 16 and 17, 2022.</p> <p>Facility Number: 012632<br/>Provider Number: 15G807<br/>AIMS Number: 201065000</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.<br/>Quality Review of this report completed by #15068 on 2/28/22.</p> |  | W 0000              |   |  |  |  |
| W 0102<br><br>Bldg. 00   | <p>483.410<br/>GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview for 2 of 2 clients in the sample (A and B) and 2 additional clients (C and D), the governing body failed to meet the Condition of Participation: Governing Body and Management. The governing body failed to exercise operating</p>   |  | W 0102              | <p><b>CORRECTION:</b><br/><i>The facility must ensure that specific governing body and management requirements are met. Specifically:<br/>All facility investigations will be</i></p> |  | 03/18/2022                                 |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

|  |   |  |  |  |   |  |                            |
|--|---|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |   | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>direction over the facility by failing to implement its written policy and procedures to prevent neglect of clients A, B and C in regard to four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The governing body failed to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A; one incident of elopement for client B and one incident of elopement for client C. The governing body failed to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests. The governing body failed to ensure there was sufficient staff present in the home to implement plans and to prevent four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The governing body failed to ensure the Extensive Support Needs Reimbursement Guidelines were followed at a minimum for clients A, B, C and D.</p> <p>Findings include:</p> <p>1. Please refer to W104. For 2 of 2 clients in the sample (A and B) and 2 additional clients (C and D), the governing body failed to exercise operating direction over the facility by failing to implement its written policy and procedures to prevent neglect of clients A, B and C in regard to four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The governing body failed to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A; one incident of</p> |  |  |  | <p>completed by trained investigators. Additionally, a new investigator has been trained to assist with investigations at this facility. When incidents requiring investigation occur, the QA manager or designee will assign the investigation to a specific investigator. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes. Specifically, investigators will save electronic files of all components of investigations into a shared investigation folder to provide access and monitoring capability throughout the investigation process and to allow investigations to be reproduced and provided to regulatory entities as required. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes.</p> <p>In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The QIDP Manager will provide</p> |  |                            |

|  |   |  |   |  |  |  |  |
|--|---|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>elopement for client B and one incident of elopement for client C. The governing body failed to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests. The governing body failed to ensure there was sufficient staff present in the home to implement plans and to prevent four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The governing body failed to ensure the Extensive Support Needs Reimbursement Guidelines were followed at a minimum for clients A, B, C and D.</p> <p>2. Please refer to W122. For 2 of 2 clients in the sample (A and B) and 1 additional client (C), governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to implement its written policy and procedures to prevent neglect of clients A, B and C in regard to four incidents of elopement with police involvement, including two arrests, for client A; one elopement for client B and one elopement for client C. The governing body failed to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A; one incident of elopement for client B and one incident of elopement for client C. The governing body failed to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests.</p> <p>3. Please refer to W158. For 2 of 2 clients in the sample (A and B) and 2 additional clients (C and D), the governing body failed to meet the Condition of Participation: Facility Staffing. The governing body failed to ensure there was</p> |  | <p>weekly follow-up to the QA Manager regarding progress and additional training needs. The facility's new behavioral clinician has updated client A's Behavior Support Plan to provide amended strategies to address and prevent elopement. All staff have received documented training on implementing the revised plan included client A's one to one supervision procedures. Additionally, the facility has enlisted the services of an external behavior specialist to provide supplemental therapeutic interaction with client A, to help address the underlying issues that have contributed to her aggression and elopement. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and three staff on duty between 6:00 AM and 11:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. During the current acute staffing shortage Area Supervisors from outside of Wayne County are covering direct support shifts in the facility and will continue to do so until such time as vacancies are filled with trained direct support staff. Additionally, staff from other agency facilities, including from</p> |  |  |  |  |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>sufficient staff present in the home to implement plans and to prevent four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The governing body failed to ensure the Extensive Support Needs Reimbursement Guidelines were followed at a minimum for clients A, B, C and D.</p> <p>This federal tag relates to complaint #IN00370933.</p> <p>9-3-1(a)</p> |  |  |  | <p>facilities outside of Wayne County, are being utilized as needed. All fill-in staff, including supervisors, will receive client specific training prior to working in the facility.</p> <p><b>PREVENTION:</b><br/>The QIDP Manager will maintain 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, comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager. The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will</p> |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|  |  |  |  |  | <p>review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs.</p> <p>The Quality Assurance Team 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. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members.</p> <p>When significant incidents occur, including but not elopement and incidents resulting in police involvement, the QIDP will contact front line team members, behavioral clinicians, and administrative staff as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences.</p> <p>The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met.</p> <p>The Program Manager and Program Director/Operations Manager will assist with procuring staff from outside of the facility as needed.</p> |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |                     |   |  |  |  |
|--|--|--|---------------------|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING  |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE                 |  |
|  |  |  |                     | <p>An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring required staffing levels are in place, and that staff implement behavior support strategies as written. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, until all Conditions of Participation are found to be in compliance. After ongoing certification of the facility is confirmed, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows:</p> <p>The role of the</p> |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |                     |  |  |  |  |
|--|--|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING   |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE                 |  |
| W 0104<br><br>Bldg. 00   | 483.410(a)(1)<br>GOVERNING BODY<br>The governing body must exercise general<br>policy, budget, and operating direction over<br>the facility.<br><br>Based on observation, record review and<br>interview for 2 of 2 clients in the sample (A and<br>B) and 2 additional clients (C and D), the |  | W 0104              | administrative monitor is not<br>simply to observe & Report.<br>· When opportunities for<br>training are observed, the monitor<br>must step in and provide the<br>training and document it.<br>· If gaps in active treatment<br>are observed the monitor is<br>expected to step in, and model the<br>appropriate provision of supports.<br>· Assuring the health and<br>safety of individuals receiving<br>supports at the time of the<br>observation is the top priority.<br>· Review all relevant<br>documentation, providing<br>documented coaching and<br>training as needed<br>Administrative support at the home<br>will include but not be limited to:<br>· Assuring corrective<br>measures are in place, developed<br>through a collaborative<br>interdisciplinary process.<br>· Assuring required staffing<br>levels are in place.<br><b>RESPONSIBLE PARTIES:</b> QIDP,<br>Area Supervisor, Residential<br>Manager, Direct Support Staff,<br>Operations Team, Regional<br>Director<br><br><b>CORRECTION:</b><br><i>The governing body must<br/>exercise general policy, budget,</i> |  | 03/18/2022                                 |  |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>governing body failed to exercise operating direction over the facility by failing to implement its written policy and procedures to prevent neglect of clients A, B and C in regard to four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The governing body failed to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A; one incident of elopement for client B and one incident of elopement for client C. The governing body failed to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests. The governing body failed to ensure there was sufficient staff present in the home to implement plans and to prevent four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The governing body failed to ensure the Extensive Support Needs Reimbursement Guidelines were followed at a minimum for clients A, B, C and D.</p> <p>Findings include:</p> <p>1. Please refer to W149. For 2 of 2 clients in the sample (A and B) and 1 additional client (C), the governing body neglected to implement its written policy and procedures to prevent neglect of clients A, B and C in regard to four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The governing body neglected to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A; one incident of elopement for client B</p> |  |  |  | <p><i>and operating direction over the facility. Specifically:</i><br/>All facility investigations will be completed by trained investigators. Additionally, a new investigator has been trained to assist with investigations at this facility. When incidents requiring investigation occur, the QA manager or designee will assign the investigation to a specific investigator. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes. Specifically, investigators will save electronic files of all components of investigations into a shared investigation folder to provide access and monitoring capability throughout the investigation process and to allow investigations to be reproduced and provided to regulatory entities as required. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes.</p> <p>In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time</p> |  |                            |

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>and one incident of elopement for client C. The governing body neglected to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests.</p> <p>2. Please refer to W154. For 2 of 2 clients in the sample (A and B) and 1 additional client (C), the governing body failed to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A and one incident of elopement for clients B and C.</p> <p>3. Please refer to W157. For 4 of 18 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 1 of 3 clients in the sample (A), the governing body failed to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests.</p> <p>4. Please refer to W186. For 2 of 2 clients in the sample (A and B) and 2 additional clients (C and D), the governing body failed to ensure there was sufficient staff present in the home to implement plans and to prevent four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The governing body failed to ensure the Extensive Support Needs Reimbursement Guidelines were followed at a minimum for clients A, B, C and D.</p> <p>This federal tag relates to complaint #IN00370933.</p> <p>9-3-1(a)</p> |  | <p>management skills to facilitate timely completion if investigations. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs.</p> <p>The facility's new behavioral clinician has updated client A's Behavior Support Plan to provide amended strategies to address and prevent elopement. All staff have received documented training on implementing the revised plan included client A's one to one supervision procedures. Additionally, the facility has enlisted the services of an external behavior specialist to provide supplemental therapeutic interaction with client A, to help address the underlying issues that have contributed to her aggression and elopement.</p> <p>The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and three staff on duty between 6:00 AM and 11:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. During the current acute staffing shortage Area Supervisors from outside of Wayne County are covering direct support shifts in the facility and will continue to do so until such time as vacancies are filled</p> |  |  |  |  |

|  |  |  |                     |  |  |  |  |
|--|--|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING   |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE                 |  |
|  |  |  |                     | <p>with trained direct support staff. Additionally, staff from other agency facilities, including from facilities outside of Wayne County, are being utilized as needed. All fill-in staff, including supervisors, will receive client specific training prior to working in the facility.</p> <p><b>PREVENTION:</b><br/>The QIDP Manager will maintain 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, comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager. The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation</p> |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |                     |   |  |  |  |
|--|--|--|---------------------|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING  |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE                 |  |
|  |  |  |                     | <p>for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team 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. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. When significant incidents occur, including but not elopement and incidents resulting in police involvement, the QIDP will contact front line team members, behavioral clinicians, and administrative staff as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager and Program Director/Operations</p> |  |  |  |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|  |  |  |  |  | <p>Manager will assist with procuring staff from outside of the facility as needed.</p> <p>An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring required staffing levels are in place, and that staff implement behavior support strategies as written. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, until all Conditions of Participation are found to be in compliance. After ongoing certification of the facility is confirmed, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is</p> |  |                            |

|  |   |  |                     |   |  |  |  |
|--|---|--|---------------------|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING  |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                      |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE                 |  |
| W 0122<br><br>Bldg. 00   | 483.420(a)<br>CLIENT PROTECTIONS<br>The facility must ensure the rights of all<br>clients. Therefore the facility must<br>Based on observation, record review and |  | W 0122              | <p>defined as follows:</p> <ul style="list-style-type: none"> <li>The role of the administrative monitor is not simply to observe &amp; Report.</li> <li>When opportunities for training are observed, the monitor must step in and provide the training and document it.</li> <li>If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports.</li> <li>Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority.</li> <li>Review all relevant documentation, providing documented coaching and training as needed</li> </ul> <p>Administrative support at the home will include but not be limited to:</p> <ul style="list-style-type: none"> <li>Assuring corrective measures are in place, developed through a collaborative interdisciplinary process.</li> <li>Assuring required staffing levels are in place.</li> </ul> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> <p><b>CORRECTION:</b></p> |  | 03/18/2022                                 |  |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>interview for 2 of 2 clients in the sample (A and B) and 1 additional client (C), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its written policy and procedures to prevent neglect of clients A, B and C in regard to four incidents of elopement with police involvement, including two arrests, for client A; one elopement for client B and one elopement for client C. The facility failed to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A; one incident of elopement for client B and one incident of elopement for client C. The facility failed to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests.</p> <p>Findings include:</p> <p>1. Please refer to W149. For 2 of 2 clients in the sample (A and B) and 1 additional client (C), the facility neglected to implement its written policy and procedures to prevent neglect of clients A, B and C in regard to four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The facility neglected to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A; one incident of elopement for client B and one incident of elopement for client C. The facility neglected to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests.</p> <p>2. Please refer to W154. For 2 of 2 clients in the sample (A and B) and 1 additional client (C),</p> |  |  |  | <p><i>The facility must ensure that specific client protections requirements are met.</i></p> <p>Specifically, the governing body facilitated the following:<br/>All facility investigations will be completed by trained investigators. Additionally, a new investigator has been trained to assist with investigations at this facility. When incidents requiring investigation occur, the QA manager or designee will assign the investigation to a specific investigator. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes. Specifically, investigators will save electronic files of all components of investigations into a shared investigation folder to provide access and monitoring capability throughout the investigation process and to allow investigations to be reproduced and provided to regulatory entities as required. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes.</p> <p>In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this</p> |  |                            |

|  |   |  |                     |   |  |  |  |
|--|---|--|---------------------|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING  |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE                 |  |
|  | <p>the facility failed to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A and one incident of elopement for clients B and C.</p> <p>3. Please refer to W157. For 4 of 18 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 1 of 3 clients in the sample (A), the facility failed to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests.</p> <p>This federal tag relates to complaint #IN00370933.</p> <p>9-3-2(a)</p> |  |                     | <p>mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. The facility's new behavioral clinician has updated client A's Behavior Support Plan to provide amended strategies to address and prevent elopement. All staff have received documented training on implementing the revised plan included client A's one to one supervision procedures. Additionally, the facility has enlisted the services of an external behavior specialist to provide supplemental therapeutic interaction with client A, to help address the underlying issues that have contributed to her aggression and elopement. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and three staff on duty between 6:00 AM and 11:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. During the current acute staffing shortage Area Supervisors from outside of Wayne County are covering</p> |  |  |  |

|  |  |  |                     |  |  |  |  |
|--|--|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING   |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE                 |  |
|  |  |  |                     | <p>direct support shifts in the facility and will continue to do so until such time as vacancies are filled with trained direct support staff. Additionally, staff from other agency facilities, including from facilities outside of Wayne County, are being utilized as needed. All fill-in staff, including supervisors, will receive client specific training prior to working in the facility.</p> <p><b>PREVENTION:</b><br/>The QIDP Manager will maintain 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, comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager. The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations</p> |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |   |  |                            |
|--|--|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |   | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|  |  |  |  |  | <p>with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs.</p> <p>The Quality Assurance Team 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. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members.</p> <p>When significant incidents occur, including but not elopement and incidents resulting in police involvement, the QIDP will contact front line team members, behavioral clinicians, and administrative staff as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences.</p> <p>The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure</p> |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |                     |  |  |  |  |
|--|--|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING   |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE                 |  |
|  |  |  |                     | <p>required staffing levels are met. The Program Manager and Program Director/Operations Manager will assist with procuring staff from outside of the facility as needed.</p> <p>An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring required staffing levels are in place, and that staff implement behavior support strategies as written. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, until all Conditions of Participation are found to be in compliance. After ongoing certification of the facility is confirmed, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will</p> |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |                     |  |  |  |  |
|--|--|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING   |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE                 |  |
| W 0149<br><br>Bldg. 00   | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement                                       |  |                     | <p>determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows:</p> <ul style="list-style-type: none"> <li>The role of the administrative monitor is not simply to observe &amp; Report.</li> <li>When opportunities for training are observed, the monitor must step in and provide the training and document it.</li> <li>If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports.</li> <li>Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority.</li> <li>Review all relevant documentation, providing documented coaching and training as needed</li> </ul> <p>Administrative support at the home will include but not be limited to:</p> <ul style="list-style-type: none"> <li>Assuring corrective measures are in place, developed through a collaborative interdisciplinary process.</li> <li>Assuring required staffing levels are in place.</li> </ul> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director</p> |  |  |  |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 2 clients in the sample (A and B) and 1 additional client (C), the facility neglected to implement its written policy and procedures to prevent neglect of clients A, B and C in regard to four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The facility neglected to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A; one incident of elopement for client B and one incident of elopement for client C. The facility neglected to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 2/14/22 from 1:25 PM to 1:55 PM and from 3:45 PM to 4:30 PM. Throughout the observation periods, client A had 1:1 staffing. Client A's bedroom had one window and the window did not have a screen in it. The window had an alarm on the inside and outside of the window which sounded when the window was opened.</p> <p>On 2/14/22 at 12:00 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, ResCare incident reports and investigations were reviewed and indicated the following:</p> <p>1a. A 1/4/22 BDDS report indicated, "On 1/3/22 beginning at 8:30 AM; [Client A] became</p> |  |  | W 0149   | <p><b>CORRECTION:</b></p> <p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client. Specific corrections include:</i></p> <p>All facility investigations will be completed by trained investigators. Additionally, a new investigator has been trained to assist with investigations at this facility. When incidents requiring investigation occur, the QA manager or designee will assign the investigation to a specific investigator. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes. Specifically, investigators will save electronic files of all components of investigations into a shared investigation folder to provide access and monitoring capability throughout the investigation process and to allow investigations to be reproduced and provided to regulatory entities as required. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes.</p> <p>In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP</p> |  | 03/18/2022                 |

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>agitated following conversation related to wanting her guardian to purchase earrings for her and not wanting to spend her weekly money on buying her own. [Client A] self-isolated in her room refusing active treatment, most of her meals, and daily hygiene goals. Staff offered supportive conversation, coping skills and PRN (as needed medication) that was recently added to her Behavior Support Plan for increased agitation. [Client A] refused all prompts. Staff completed 15-minute checks as directed by the Area Supervisor, per her plan. Staff offered [client A] snack and reminded her that following snack she would need to take a shower to complete daily hygiene. [Client A] agreed and walked to her room and started removing all items on her shelves throwing (sic) to the floor, breaking picture frames and other personal items. Staff verbally redirected [client A] and attempted to throw items at staff. Staff blocked. [Client A] defecated in her pants, and threw at staff and smeared it on the furniture. [Client A] removed her window alarm while staff was placing on personal protective gear and climbed out of her window. Staff followed while [client A] was walking towards the neighbor's yard in line of sight. [Client A] picked up items from the neighbor's yard and threw them at staff without success. Staff verbally redirected [client A] to leave the neighbor's yard and return to the residence with [client A] refusing. [Client A] entered the neighbor's porch area throwing items from the porch at staff. Staff offered supportive conversation, coping skills and PRN. [Client A] entered the neighbor's vehicle and threw items from the car outside. Redirection and blocking was (sic) ineffective, and staff called 911 for assistance. [Client A] was physically aggressive toward police officers, hitting and spitting. Police officer on scene tased [client A] and</p> |  | <p>Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. The facility's new behavioral clinician has updated client A's Behavior Support Plan to provide amended strategies to address and prevent elopement. All staff have received documented training on implementing the revised plan included client A's one to one supervision procedures. Additionally, the facility has enlisted the services of an external behavior specialist to provide supplemental therapeutic interaction with client A, to help address the underlying issues that have contributed to her aggression and elopement. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and three staff on duty between 6:00 AM and 11:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak</p> |  |  |  |  |

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>placed her in hand cuffs. EMTs (emergency medical technicians) transported [client A] to the [name of emergency department] for medical evaluation from being tased. [Client A] was transported by police to the [county] Jail. Area supervisor and nurse notified.</p> <p>Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Resisting Law Enforcement.... [Client A] is scheduled to be released without bond on 1/5/21 (sic/2022).... The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are (sic) indicated, and the team will resume efforts to pursue acute in-patient psychiatric treatment due to her intractable aggression".</p> <p>A 1/21/22 Incident Follow-Up Report indicated, "[Client A] remains on 1:1 supervision since her return home from acute inpatient psychiatric care, at [name of hospital], as outlined in her Behavior Support Plan and was discussed during [client A's] IDT (interdisciplinary team) meeting 01/11/2022."</p> <p>A 1/8/22 Investigative Summary indicated the following:</p> <p>"Factual Findings:<br/>-[Area Supervisor/AS #1], [AS #2], [former staff #9] and [staff #1] were present when the incident occurred.<br/>-[Client A] had refused to participate in tasks and stayed in bed through the morning and early afternoon, coming out to eat 25% (percent) of her lunch and a snack.<br/>-[Client A] escalated and began throwing first objects and later fecal material.</p> |  | <p>activity. During the current acute staffing shortage Area Supervisors from outside of Wayne County are covering direct support shifts in the facility and will continue to do so until such time as vacancies are filled with trained direct support staff. Additionally, staff from other agency facilities, including from facilities outside of Wayne County, are being utilized as needed. All fill-in staff, including supervisors, will receive client specific training prior to working in the facility.</p> <p><b>PREVENTION:</b><br/>The QIDP Manager will maintain 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, comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager. The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members</p> |  |  |  |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>-While staff were putting on personal protective equipment, to avoid contact with feces, [client A] climbed out her window.</p> <p>-The window alarm functioned properly and staff followed, maintaining line of sight.</p> <p>-When [client A] got into a neighbor's car, [AS #2] called the police. [Client A] dd (sic) not cooperate with police, was tased, handcuffed, taken to the ER (emergency room), and then incarcerated.</p> <p>-[Client A] was never out of staff 's line of sight.</p> <p>-[Client A's] Behavior Support Plan addresses Verbal Aggression, Physical Aggression, Leaving the Assigned Area, Socially Offensive Behavior and Property Disruption/Destruction.</p> <p>-Testimony indicates staff followed her plan, although a negative outcome occurred.</p> <p>Conclusion:</p> <ol style="list-style-type: none"> <li>1. The evidence substantiates that [client A] engaged in behaviors that led to her being tased and arrested on 1/3/22.</li> <li>2. The evidence does not substantiate that [client A's] Behavior Support Plan failed to address the behaviors leading to her arrest.</li> <li>3. The evidence does not substantiate that staff failed to implement [client A's] Behavior Support Plan appropriately.</li> </ol> <p>Recommendations:</p> <ol style="list-style-type: none"> <li>1. Continue to explore acute inpatient psychiatric treatment options for [client A], limiting discussion on the topic that will lead to [client A] perseverating about it.</li> <li>2. Continue to encourage the use of [client A's] agitation PRN (as needed) before her behavior escalates beyond severe resistance to support.</li> <li>3. Continue to implement [client A's] current behavior support strategies".</li> </ol> |  | <p>will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs.</p> <p>The Quality Assurance Team 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. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members.</p> <p>When significant incidents occur, including but not elopement and incidents resulting in police involvement, the QIDP will contact front line team members, behavioral clinicians, and administrative staff as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences.</p> <p>The Area Supervisor will submit schedule revisions to Program</p> |  |  |  |  |

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>A review of the 1/4/22 BDDS report and the 1/8/22 Investigative Summary indicated client A was agitated throughout the day and later in the day, client A displayed behaviors of property destruction then defecated in her pants and threw it at staff. As staff went to obtain personal protective equipment (leaving client A unsupervised), client A removed the alarm from her bedroom window and eloped through the window. Staff followed her to the neighbor's house where she destroyed property on the neighbor's porch and in their vehicle. Police were called and client A was tased due to resisting arrest. Client A was transported to the hospital for an evaluation due to being tased then she was transported to jail. There was no documentation indicating effective corrective measures were initiated to prevent reoccurrence.</p> <p>On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following: The staff schedule indicated on 1/3/22 former staff #9 worked from 8:00 AM to 8:00 PM and staff #1 worked from 10:00 AM to 10:00 PM. The visitor log and monthly support tracking form indicated former staff #9 worked from 8:09 AM to 8:10 PM, Area Supervisor (AS) #1 worked from 8:03 AM to 5:30 PM and staff #1 signed in at 10:13 AM. The review indicated two staff and a supervisor were working at the time of the incident.</p> <p>On 2/16/22 at 9:28 AM, the QAM (Quality Assurance Manager), QIDPM (Qualified Intellectual Disabilities Professional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The QIDPM indicated staff #1, former staff #9 and Area</p> |  | <p>Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager and Program Director/Operations Manager will assist with procuring staff from outside of the facility as needed.</p> <p>An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring required staffing levels are in place, and that staff implement behavior support strategies as written. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, until all Conditions of Participation are found to be in compliance. After ongoing certification of the facility is confirmed, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After</p> |  |  |  |  |

|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>Supervisor #1 were working during the incident and AS #2 arrived later. The QIDPM indicated client A's supervision level was 1:1 at the time of the incident.</p> <p>1b. A 1/8/22 BDDS report indicated, "On 01/07/22 beginning at 4:20 PM; [client A] was in her room while staff was completing 15-minute checks. Following a 15-minute check [client A] left her room after defecating on the floor. Staff verbally redirected [client A] to clean up after herself. [Client A] refused. Staff sanitized [client A's] room, with [client A] laying on her bed. Staff left the room to throw soiled items away and returned to [client A's] room and observed her window being opened, with the alarm broken and [client A] no longer in her room. Staff notified Area Supervisor and [city] Police Dispatch that [client A] was no longer at the residence, and initiated a search of the area. Multiple staff, Area Supervisor, staff from other homes, and police attempted to locate [client A]. [Client A] was out of line of sight from 4:44 PM until 8:34 PM when [client A] was located, at the intersection of [name of street] and [name of road], 0.3 miles from her home. [Client A] was handcuffed. [Client A] was physically aggressive with Police Officers resulting in a windshield being kicked out of a police car. EMTs transported [client A] to the [name of hospital] Emergency Department for medical evaluation. [Client A] was then transported by police to the [county] Jail. The Area Supervisor and nurse (sic) notified. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery against a public safety official, Resisting Law Enforcement, and Criminal Mischief-Pecuniary Loss of at least</p> |  | <p>this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows:</p> <ul style="list-style-type: none"> <li>· The role of the administrative monitor is not simply to observe &amp; Report.</li> <li>· When opportunities for training are observed, the monitor must step in and provide the training and document it.</li> <li>· If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports.</li> <li>· Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority.</li> <li>· Review all relevant documentation, providing documented coaching and training as needed</li> </ul> <p>Administrative support at the home will include but not be limited to:</p> <ul style="list-style-type: none"> <li>· Assuring corrective measures are in place, developed through a collaborative interdisciplinary process.</li> <li>· Assuring required staffing levels are in place.</li> </ul> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director</p> |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>\$750.00.... She does not have plan approved alone time, and she was away from staff supervision for three hours and 50 minutes. The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are (sic) indicated, and the team will work with [client A's] attending psychiatrist to pursue acute in-patient psychiatric treatment due to her intractable aggression".</p> <p>A 1/21/22 Incident Follow-Up Report indicated, "[Client A] remains on 1:1 supervision since her return home from acute inpatient psychiatric care, at [name of hospital], as outlined in her Behavior Support Plan and was discussed during [client A's] IDT meeting 01/11/2022."</p> <p>A review of the 1/8/22 BDDS report indicated client A eloped from the group home and was without staff supervision for 3 hours and 50 minutes. When client A was located, she was handcuffed due to being physically aggressive with police. Client A kicked out the windshield of the police car. Client A was arrested and transported to the hospital for evaluation then to jail. She was charged with battery against a public safety official, resisting law enforcement and criminal mischief. There was no documentation indicating an investigation was completed or effective corrective measures were initiated to prevent reoccurrence.</p> <p>A ResCare incident report pertaining to the 1/7/22 incident was not provided.</p> <p>On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following:<br/>The staff schedule indicated on 1/7/22 former</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>staff #9 worked from 8:00 AM to 8:00 PM and staff #1 worked from 10:00 AM to 10:00 PM. The visitor log and monthly support tracking form indicated former staff #9 worked from 8:06 AM to 8:20 PM and staff #1 worked from 10:40 AM to 10:00 PM. The review indicated two staff were working at the time of the incident.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated two staff were working at the time of the incident and there should've been three. The QIDPM indicated client A's supervision level was 1:1 at the time of the incident. The QIDPM indicated this incident wasn't investigated and it should have been. The QIDPM stated, "I just didn't get to it. We know that is not an excuse".</p> <p>1c. A 2/5/22 BDDS report indicated, "On the evening of 2/5/2022 (6:00 PM), [client A] and staff were sitting at the dining table while she colored and without any apparent precedent [client A] got up and headed for the door, staff redirected her, but she pushed past staff and ran out of the door. Staff followed [client A] while redirecting her to come back to the house and offering coping skills, but she continued to escalate. [Client A] entered a [name of] convenience store where staff continued to redirect while offering coping skills. An individual at the store called 911. When police arrived, [client A] told them she was suicidal, and the Police transported her to the [name of hospital] Emergency Department.... [Client A] was diagnosed with agitation.... [Client A] was released to ResCare staff to be taken home.... Plan to Resolve: [Client A] was not injured during the incident and continues to receive</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022

FORM APPROVED

OMB NO. 0938-0391

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>ongoing emotional support.... She does not have plan approved alone time. It should be noted that staff did not lose sight of [client A] at any time during the entire incident. Staff will continue to follow the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences. The administrative team is aware of the incident".</p> <p>A review of the 2/5/22 BDDS report indicated client A eloped from the group home with staff following. Client A was then transported to the hospital due to reporting she was suicidal to the police. There was no documentation indicating an investigation was completed. There was no documentation indicating effective corrective measures were initiated to prevent reoccurrence.</p> <p>A 2/5/22 ResCare incident report indicated staff #1 and staff #3 were present during the incident. Staff #1 followed client A on foot to the gas station and staff #3 loaded the other three clients into the agency van and went to look for client A and staff #1. They were unable to locate them so they returned to the group home. Dispatch called and reported they were at the gas station. Staff #3 and the other three clients went to the gas station to pick staff #1 and client A up. Client A reported to police she was suicidal so she was transported by police to the emergency room.</p> <p>On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following. The staff schedule indicated on 2/5/22 staff #1 and staff #3 worked from 8:00 AM to 8:00 PM. The visitor log and monthly support tracking form indicated staff #1 signed in at 8:45 AM, but did not indicate when staff #1 signed out or when</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>staff #3 signed in or out. The review indicated two staff were working at the time of the incident.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated two staff were working when the incident started, but the overnight staff came in early. The QIDPM indicated there should've been three staff working. The QIDPM stated, "She was in line of sight. It wasn't an elopement per se. She never evaded staff supervision". The QIDPM indicated this incident wasn't investigated and it should have been. The QIDPM indicated client A's supervision level at the time of the incident was 1:1.</p> <p>1d. A 2/11/22 BDDS report indicated, "On 2.10.22, [client A] (8:10 PM) and other housemates were talking about running, staff verbally redirected [client A] and had supportive conversation in an attempt to aid in calming. [Client A] refused to use coping skills (sic), and refused her evening medications. [Client A] continued being verbally aggressive towards staff. [Client A] attempted to go out the front door. Staff blocked, successfully. Staff continued to offer supportive conversation and coping skills, unsuccessfully, and [client A] spit on staff. [Client A] charged at staff and the front door, staff attempted to block and tripped, falling over a chair and [client A] eloped out the front door, and staff lost line of sight. Staff contacted [city] police department, and began searching. The police located [client A] and brought her back to the home 15 minutes later. Staff offered supportive conversation and coping skills, but [client A] remained agitated and aggressive and the police officer informed staff he would remain in the home until he assessed that the</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>environment was safe. Staff contacted the Behavior Clinician (BC) to assist in providing supportive conversation. [Client A] was verbally aggressive with the BC on the phone, and made threats to harm the police and take his gun to use. [Client A] attempted to elope from home, staff and police officer blocked the door successfully. [Client A] became verbally aggressive towards housemates. Staff verbally redirected [client A]. [Client A] attempted to move towards housemates, staff blocked successfully. [Client A] attempting (sic) to hit and kick staff, to get past them, without making contact. [Client A] was placed in a 2 -person You're Safe, I'm Safe hold. Staff had supportive conversation with [client A]. [Client A] stated she was just frustrated and upset. [Client A] started calming and using coping skills, after about 15 minutes and hold was released. [Client A] agreed to take her PRN (as needed medication) (Haldol 5 mg/milligrams) and evening medications. [Client A] continued calming in the dining room and then went to bed and remained on 1:1 staff supervision. Area supervisor was on site and Nurse notified. The police officer left without taking further action.</p> <p>Plan to Resolve: [Client A] was not injured and received emotional support from her team. [Client A] has a history of physical aggression, verbal aggression, and elopement behaviors addressed in her Behavior Support Plan, which staff followed. [Client A] was unsupervised by staff for approximately 15 minutes. [Client A] does not have approved alone time.... Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences...."</p> <p>A 2/10/22 ResCare incident report indicated the incident occurred right at shift change at 8:00</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>PM. Staff #1 and staff #3 were getting ready to leave their shift and staff #6 and staff #8 were just arriving for their shift. Staff #6 completed the incident report and indicated, "At about 8:10 PM, [client A] and other housemate (client C) were talking about running away.... [Client A] then started walking towards the front door and one staff blocked while the other continued trying to calm [client A].... [Client A] tried going for the door, staff blocked. [Client A] then spit on one staff. Staff backed away. Other staff then tried blocking the door. [Client A] pushed staff. Staff tripped over chair (sic) fell on floor. [Client A] then ran out the front door. Staff had to stay with other clients. Police were called...."</p> <p>On 2/15/22 at 11:30 AM, the [name of county] Emergency Communications Command Log (dispatch report) dated 2/10/22 was reviewed. The log indicated the following: 2/10/22 at 20:34 (8:34 PM): "[Client A] took off".... Took off about 3 minutes ago.... STAFF UNABLE TO LEAVE.... [Client A] detained (20:44/8:44 PM)...."</p> <p>A review of the 2/11/22 BDDS report, the 2/10/22 ResCare incident report and the 2/10/22 Emergency Communication Command Log indicated only two staff were on duty when client A eloped from the group home and staff were unable to leave to assist with locating client A. There was no documentation indicating an investigation was completed. There was no documentation indicating effective corrective measures were initiated to prevent reoccurrence.</p> <p>On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following:</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>The staff schedule indicated on 2/10/22 staff #1 and staff #3 worked from 8:00 AM to 8:00 PM and staff #6 and staff #8 worked from 8:00 PM to 8:00 AM. The visitor log and monthly support tracking form indicated staff #1 signed in at 8:30 AM, staff #3 signed in at 4:00 PM, staff #6 signed in at 8:00 PM and staff #8 signed in at 8:00 PM. The form did not indicate when the staff signed out. The review indicated 2 staff were scheduled from 8:00 AM to 8:00 PM and 2 staff were scheduled from 8:00 PM to 8:00 AM.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated two staff were working at the time of the incident. The QIDPM indicated client A's supervision level at the time of the incident was 1:1. The QIDPM stated, "It has not been investigated". The QIDPM indicated the investigation wasn't due until Thursday, 2/17/22. The QAM stated, "It will be investigated and started".</p> <p>On 2/15/22 at 12:50 PM, client A's record was reviewed and indicated the following:</p> <p>A 1/5/22 [County] Circuit and Superior Courts Appearance Form indicated client A was booked into jail on 1/3/22 and she was released on 1/5/22 with a charge of resisting law enforcement.</p> <p>A 1/7/22 [County] Circuit and Superior Courts Appearance Form indicated client A was booked into jail on 1/7/22 and she was released on 1/9/22 with charges of criminal mischief, resisting law enforcement and Batt (6) (battery-level 6 felony).</p> <p>Client A's 1/8/21 (revised 4/29/21) BSP</p> |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>(Behavior Support Plan) indicated client A had target behaviors of self injury behavior, disruptive behavior, task refusal, physical aggression, verbal aggression, emotional manipulation, false allegations/lying, elopement, and property destruction/disruption.</p> <p>"Elopement... Operational Definition: Any occurrence of [client A] leaving an assigned area including including areas within the home or where the group is located without staff acknowledgement and/or permission. Displays of Elopement include occurrences of [client A] climbing out (attempts included) windows (at the residence or elsewhere), walking out of the residence into the front and/or back yard, the garage, across the road to the mailbox, exiting the back gate without having received the explicit permission of a member of staff (residential). Elopement/Leaving Assigned Area also includes occurrences when [client A] enters the personal spaces/areas of the housemates without having received express permission from the individual housemate and/or from a staff member".</p> <p>"Rights restrictions.... Enhanced Supervision (1:1)- elopement (to prevent). To protect [client A] from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff".</p> <p>Notes from an Interdisciplinary Team Meeting dated 1/10/22 indicated, "[Former Behavior Clinical] notified and requested 1:1 supervision remain in place and explained that due to increased elopements [client A] will remain in sight of and with staff at all times".</p> <p>Notes from an Interdisciplinary Team Meeting dated 2/7/22 indicated, "[Client A] states that when she was at the gas station (2/5/22 incident)</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>she talked with staff in the store to get warm and then was still irritated so she got into a male strangers car and asked them to call the police...."</p> <p>Discharge records from client A's inpatient psychiatric stay dated 1/11/22-1/19/22 indicated the following. "...psychiatric (sic) history of ADHD (attention deficit hyperactivity disorder), anxiety, bipolar affective, depression and insomnia.... active with outpatient mental health treatment through [name of provider].... recent legal problems due to running away from group home and becoming assaultive with law enforcement. She was brought to [name of emergency department] due to suicidal ideation. The patient reports her depression has been getting progressively worse over the last month and she has been arrested numerous times for behaviors. She endorsed suicidal ideations with a plan to hang herself.... a psychiatric triage was ordered and the patient was admitted to Adult Psychiatry with a diagnosis of depression with suicidal ideation....</p> <p>The patient (sic) seen today face-to-face during inpatient rounds. During my assessment, the patient was laying in bed in medical restraints. Per nursing staff, the patient did not sleep at all last evening. The patient defecated on her floor, then flung feces on to the door window of the unit and smeared feces on the walls, door, windows, handle and herself. The patient also proceeded to put feces in her mouth. It required several staff members and [name of hospital] police to assist with getting the patient into the shower and clean. The patient was aggressive, resistive and spitting at staff during this time and ended up in medical restraints.... The patient yelled profanities at the staff stating when she got out of the hospital she was going to get a</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>bomb to blow up with this place and kill everyone in the hospital. The patient was removed from restraints early in the morning. Shortly after she was removed from restraints and conversing with staff, staff noticed to (sic) outlet covers off the wall into (sic) missing screws. The covers were found underneath the patient bed and the patient stated she swallowed the 2 screws. Patient vomited up 1 of the screws and the other screw was not found. The patient was initially placed in the seclusion room to prevent the patient from harming herself and the patient immediately started self-harming by biting herself. The patient was placed back in four-point locking restraints. She received a 1 time dose of IM (intramuscularly) Ativan, Haldol and Benadryl (for behavior). The patient was completely removed from restraints at 11:10 a.m.... patient did swallowed (sic) a screw and hospitalist is consulting GI (gastrointestinal).... The patient initially stated she had the behaviors because 'I just want to die.' However, when provider spoke with the patient longer asking her to talk with staff about what was really going on, the patient stated, 'I am the kind of person that wants attention. It does not matter if it is negative or positive.' When provider asked the patient if she attempted to speak with staff before acting out the patient stated she did not know how to get positive attention.... Provider spent over 15 minutes speaking with the patient about her past, current behaviors and how negative behaviors healed (sic) negative results and positive behaviors yelled (sic) positive results. The patient verbalized understanding and requested to be removed from the restraints. Provider informed the patient she had to no longer endorse thoughts of harming herself, exhibit the behaviors that caused her to be in restraints, and act appropriately. The patient verbalized</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>understanding. The patient continues to endorse anxiety and depression. She denies suicidal and homicidal ideations. The patient states she 'just wants to go back to the group home.' Provider explained to the patient that she needed to act appropriately and have a good night before this could occur. The patient verbalized understanding. Mood lability (sic) noted. The patient has very poor insight and judgment. Her behaviors actually appeared to worsen the longer she is on the unit. She would benefit more from her outpatient therapy. The behaviors the patient has been exhibiting the past 2 days are behaviors the group home verbalized she exhibits at her baseline.... Medication changes at this point are not going to provide much benefit to the patient. She would benefit more from behavioral therapy...."</p> <p>On 2/15/22 at 9:54 AM, the COP (Chief of Police) was interviewed. The COP indicated client A had criminal charges including 3 felony battery charges for spitting at police officers, criminal mischief for kicking out the windshield of a police car and some resisting arrest charges. The COP stated, "I'm going to be frankly honest with you. We have no other course but to arrest her. She needs more of a secure detention (facility). This home isn't secure enough for her". The COP stated, "I don't know what is going on there. It was quiet there for a really long time then in October/November (2021) we started getting regular calls about [client A]".</p> <p>On 2/15/22 at 3:50 PM, staff #1 was interviewed. When asked about client A's behavior, staff #1 stated, "It's a mess. We have done so much listening. If she doesn't like what she hears, she doesn't like it and you'll pay for it. Once she cools down and wants to talk she's ok.</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>She's been to jail several times and she has pending charges. She wants any kind of attention she can get, positive or negative. It doesn't matter what attention she gets. Nothing is fair, she gets upset when other clients have family come visit. She gets mad at everyone then apologizes. Just last week she went out the front door again. I was behind her. I was outside walking without a phone or a coat. It was below zero outside. She didn't have a coat on, only pajama pants and a long sleeved shirt. It doesn't matter what we do, it doesn't work. She plots to get out. She gets off on that". Staff #1 indicated client A required 1:1 supervision. Staff #1 indicated the incidents with client A on 1/3/22, 1/7/22 and on 2/5/22 only two staff were working when the incidents occurred.</p> <p>On 2/15/22 at 5:00 PM, staff #3 was interviewed. Staff #3 indicated she just returned to work on 1/22/22 so she hasn't been involved with many of client A's behaviors. When asked to describe client A's behavior, staff #3 stated, "She is very emotional and manipulative, more verbal than anything. Physically aggressive at times. She can be very violent (towards staff)". Staff #3 stated, "I don't feel like 2 or 3 people can effectively deal with behaviors and help her. If she doesn't listen there is only so much we can do".</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM and the QIDP indicated client A had pending criminal charges for criminal mischief, battery with a bodily fluid (felony) and resisting arrest. The QIDP indicated there was a preliminary court hearing scheduled for 2/23/22. The QIDPM stated, "We have had continuing problems but there has also been overall improvement in her</p> |  |  |  |  |  |  |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>(client A) ability to control herself. She (client A) has agreed to take her PRN. [QIDP] is nodding her head in agreement". The QIDPM indicated the new BC was in the process of rewriting client A's BSP. The QIDPM stated, "The new plan will hopefully be more effective. We are confident that we are in the process of turning the corner on this". The QIDP and QIDPM indicated client A was 1:1 and client D was 1:1 when she's outside of her bedroom. The QIDPM indicated the staffing level for the ESN (extensive support needs) was 3 staff on first shift, 3 staff on second shift and 2 staff on third shift. When asked if they were aware of any shifts which didn't have the correct number of staff, the QIDPM stated, "Yes, we are". The QIDPM and the QIDP indicated it wasn't possible to implement the plans as written with only two staff working when the clients are awake. The QIDPM stated, "The Program Manager is responsible for ensuring the correct number of staff are scheduled. However, [QAM] and I monitor as well. When we discover insufficiencies, we point them out".</p> <p>2. On 2/14/22 at 12:00 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, ResCare incident reports and investigations were reviewed and indicated the following:</p> <p>A 1/24/22 BDDS report indicated, "On the morning of 01/23/2022, at 7:35 AM, [client B] exited the house through the alarmed back door and staff could not maintain line of sight. Staff initiated a search and notified the supervisor. At 7:5</p> <p>1 AM, [city] Police Dispatch contacted the [name of group home] reporting [client B] was on [name of street] telling people</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>she was suicidal. Staff got into their vehicle and met with police, EMTs, and [client B] at 7:58 AM on [address]. [Client B] reported to staff that her chest hurt and that she was suicidal. EMS transported [client B] to [name of hospital] to be examined.... Staff had a supportive conversation with [client B]. [Client B] reported she was angry and suicidal. [Client B] and staff waited for Psych (psychiatric services) to complete and (sic) evaluation. [Client B] used her coping skills and watched TV (television) to calm. ER nurse came in to speak with [client B] and when the nurse left to speak to the Dr. (doctor) assigned to [client B], [client B] got up and went into the hallway and was yelling she did not want to return home. [Client B] refused to go back into her room when asked by hospital staff and security. [Client B] became physically aggressive with security staff, trying to hit and kick unsuccessfully. Nursing staff administered Haldol IM, and [client B] was (sic) admitted, [client B] for acute inpatient psychiatric treatment.... Plan to Resolve: [Client B] was not injured prior to her hospitalization. [Client B] has a history of Elopement and Suicidal Ideation addressed in her Behavior Support Plan. [Client B] does not have plan approved alone time and was away from staff supervision for the twenty three minutes. The interdisciplinary team will meet to review the circumstances of the</p> |  |  |  |  |  |                            |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>incident to determine if additional supports are indicated. ResCare nursing will remain in contact with the hospital to assure continuity of care...."A review of the 1/24/22 BDDS report indicated client B eloped from the group home and was without staff supervision for 23 minutes. Client B was transported to the hospital and was admitted for a psychiatric evaluation. There was no investigation completed. On 2/15/22 at 11:15 AM, client B's record was reviewed and indicated the following. Client B's 8/31/21 BSP indicated client B had target behaviors of self injury behavior, physical aggression, verbal aggression, property disruption/destruction, elopement/leaving assigned areas, socially offensive behaviors (invading personal space of others), task refusal, suicidal/homicidal threats. "Elopement/Leaving assigned area... Operational Definition: Any occurrence of [client B] walking away from or leaving an assigned area without having received the express and direct permission from a member of staff providing supervision, at that time. Occurrences of Elopement/Leaving Assigned Area includes but is not limited to [client B] leaving areas in the home or if out within the community, leaving areas where the group has congregated (defined as the staff that are with her on a community outing) without staff acknowledgement and/or permission.</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>Elopement/Leaving Assigned Areas also includes occurrences of [client B] climbing out the alarmed window (in her bedroom), as well as, occurrences of [client B] walking/running out of the house and into the front and/or the back yard areas of the home, to the garage, or the field north of the residence (directly outside of the front door and across [name of street] without staff acknowledgement and/or permission; Elopement/Leaving Assigned Area also included occurrences of [client B] entering the bedroom(s) of housemate(s) without permission. Includes Attempts....""...If [client B] attempts to exit the home through one of the exit doors with an egress directly to the street (front door or garage door), staff will attempt to block the front and garage exits, while physically redirecting [client B's] movements away from the door. If [client B] persists in attempting to exit the residence, staff will continue to block the door(s), while verbally redirecting [client B] to exit through the back door to the back yard (a space that is fenced and does not provide a direct egress to the main road)...."On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following. The staff schedule indicated on 1/23/22 staff #6 and staff #8 were scheduled to work from 8:00 PM to 8:00 AM. The</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>visitor log and monthly support tracking form indicated staff #6 signed in at 8:20 PM and signed out at 8:37 AM. Staff #8 did not sign in or out. According to the schedule, two staff were working at the time of the incident. On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated client B did not have alone time in the community. When asked how many staff were working when the incident took place, the QIDPM stated, "Most likely two". The QIDPM indicated the elopement was not investigated and it should have been. 3. On 2/14/22 at 12:00 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, ResCare incident reports and investigations were reviewed and indicated the following: A 1/12/22 BDDS report indicated, "On the evening of 01/11/2022 (8:00 PM), [client C] was prompted to take evening medications. [Client C] was standing in the dining room area when she refused her evening medications. [Client C] immediately ran out the frontdoor and started running down [name of street] towards [name of road] and the park. Staff followed, but lost sight of [client C]. Staff informed the supervisor and completed a police report. Several staff and Area Supervisors continued searching for [client C]. [Client C] remained out of line of sight from 8:00 PM until 10:30 PM, when staff located</p> |  |  |  |  |  |                            |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>[client C] at [hospital] waiting room. A[city] police officer stated that he would remain with [client C] until she was admitted. The ResCare Area Supervisor was not permitted to remain at the hospital while [client C] wait (sic) the ER with the police due to COVID visitation restrictions. The police officer arrived at [client C's] home at 12:20 AM, to inform staff that [client C] was admitted to the [hospital] Psychological Unit for suicidal ideation.... Plan to Resolve: [Client C] was not injured during this incident. She was released from the hospital to ResCare staff on 01/12/2022, at 11:50 AM. [Client C] has a history of Elopement and Suicidal Ideation addressed in her Behavior Support Plan. [Client C] does not have plan approved alone time and was away from staff supervision for two hours and thirty minutes. The interdisciplinary team will meet to review the circumstances of the incident to determine if additional supports are indicated...." A review of the 1/12/22 BDDS report indicated client C eloped from the group home and was without staff supervision for two hours and thirty minutes. Client C was located by the local police department and was transported to the ER for a psychiatric evaluation. There was no investigation completed. On 2/15/22 at 11:50 AM, client C's record was reviewed and indicated the following. Client C's</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>11/29/21 BSP indicated client C had target behaviors of self injury behavior, socially offensive behavior, task refusal, physical aggression/physical intimidation, verbal aggression/verbal intimidation, emotional manipulation, withdrawn/isolating behavior and elopement/leaving assigned area. "Elopement/Leaving assigned area... Operational Definition: Any occurrence of [client C] leaving an assigned area (area where she has been directed to remain or is expected to remain) including areas within the home or where the (sic) [client C] accesses without having obtained staff acknowledgement and/or permission. Displays of Elopement or Leaving Assigned Area include occurrences of [client C] climbing or attempting to climb out of windows (at the residence or elsewhere), exiting of the residence and accessing the front and/or back yard(s), accessing the garage, exiting the back gate without having received the explicit permission of a member of staff (residential). Elopement or Leaving Assigned Area also includes occurrences of [client C] entering the personal spaces/areas of the housemates without having received express permission from the individual housemate and permission from a staff member. Includes Attempts". "Rights restrictions.... 24-Hour Supervision/Freedom of Movement and Unrestricted Access to Community-</p> |  |  |  |  |  |                            |

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>especially following displays of high intensity behaviors attributed to Self-Injury Behavior; Elopement/Leaving Assigned Area; Physical Aggression or Physical Intimidation (or other novel maladaptive behaviors not included herein). Without continuous supervision and direct oversight of [client C] across environments, there is an increased risk of injury to [client C] or others within the environment or setting due to displays of high intensity and duration behavioral episodes and behaviors. [Client C's] lack of understanding of safe community members or those who may wish to bring him (sic) harm may also increase risks to [client C's] safety and that of others resulting in accidents, injury, or exploitation...."On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following: The staff schedule indicated on 1/11/22 staff #5 was scheduled to work from 8:00 PM to 8:00 AM. The visitor log and monthly support tracking form indicated staff #7 signed in at 8:20 AM and signed out at 12:00 AM, staff #2 signed in at 8:23 AM and did not sign out, staff #4 signed in at 8:40 PM and signed out at 8:53 AM, former staff #9 signed in at 8:44 AM, AS #1 signed in at 8:00 AM and did not sign out and staff # 5 signed in at 9:13 PM and did not sign out. The</p> |  |  |  |  |  |  |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>review indicated when the incident occurred at 8:00 PM staff #7 was working. It cannot be determined if anyone else was working at the time of the incident due to staff not signing out. On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated client C did not have alone time in the community. When asked if two staff were working when the incident took place, the QIDPM stated, "I believe that is accurate. We are double checking. We had additional people responding". On 2/15/22 at 3:50 PM, staff #1 was interviewed. Staff #1 indicated client A and client D both required 1:1 supervision, but client D was only 1:1 when she is out of her bedroom. Staff #1 indicated she works with one other staff. Staff #1 stated, "Since they took the med (medical) coach away and we don't have a manager, we have been short staffed lately. I don't think we are ever all the way staffed. It's only me and [staff #3] from 8a-8p now. Unless a manager is here. [AS #2] and [AS #1] both come in. Usually during the day at least one of them is here at some point". Staff #1 indicated the incidents with client A on 1/3/22, 1/7/22 and on 2/5/22 only two staff were working when the incidents occurred. On 2/15/22 at 5:00 PM, staff #3 was interviewed. Staff #3 indicated staffing was short and she only worked with one other staff from 8:00 AM to 8:00</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>PM. Staff #3 indicated AS #1 and AS #3 were usually at the home at some point throughout her shift. When asked about staffing after 5:00 PM, staff #3 stated, "It's not very often there are more than 2 staff". Staff #3 indicated there have been times where she had to be both 1:1 staff due to lack of staffing. Staff #3 stated, "We just kind of stay with them both. [Client D] spends a lot of time in her room". On 2/15/22 at 5:45 PM, AS #1 was interviewed. AS #1 indicated she worked off and on between 8:00 AM and 4:00 PM. AS #1 stated, "Staffing has been bad. Sickness, calling in, open positions. There's been multiple times where only 2 staff were working". AS #1 indicated client A was 1:1 at all times and client D was 1:1 when she's out of her room. AS #1 indicated two staff working would not be able to implement the plans as written. On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDP and QIDPM indicated client A was 1:1 and client D was 1:1 when she's outside of her bedroom. The QIDPM indicated the staffing level for the ESN (extensive support needs) was 3 staff on first shift, 3 staff on second shift and 2 staff on third shift. When asked if they were aware of any shifts which didn't have the correct number of staff, the QIDPM stated, "Yes, we are". The QIDPM and the QIDP indicated it wasn't possible to implement the plans as written</p> |  |  |  |  |  |                            |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
| W 0154   | <p>with only two staff working when the clients are awake. The QIDPM stated, "The Program Manager is responsible for ensuring the correct number of staff are scheduled. However, [QAM] and I monitor as well. When we discover insufficiencies, we point them out". The QIDPM indicated the elopement was not investigated and it should have been. The QIDPM indicated the agency had an abuse/neglect policy and a policy requiring investigations to be completed for allegations of neglect and the policies should be implemented as written. The agency's "Abuse, Neglect, Exploitation, Mistreatment" Operating Standard dated 2/26/18 was reviewed on 2/17/22 at 9:30 AM and indicated the agency strictly prohibited abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights. "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of RESCARE, Rescare, and local, state and federal guidelines."This federal tag relates to complaint #IN00370933.9-3-2(a) 483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> |  |  |  |  |  |                            |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
| Bldg. 00   | <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review and interview for 2 of 2 clients in the sample (A and B) and 1 additional client (C), the facility failed to conduct thorough investigations for three incidents of elopement with police involvement including an arrest for client A and one incident of elopement for clients B and C.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 2/14/22 from 1:25 PM to 1:55 PM and from 3:45 PM to 4:30 PM. Throughout the observation periods, client A had 1:1 staffing. Client A's bedroom had one window and the window did not have a screen in it. The window had an alarm on the inside and outside of the window which sounded when the window was opened.</p> <p>On 2/14/22 at 12:00 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, ResCare incident reports and investigations were reviewed and indicated the following:</p> <p>1a. A 1/8/22 BDDS report indicated, "On 01/07/22 beginning at 4:20 PM; [client A] was in her room while staff was completing 15-minute checks. Following a 15-minute check [client A] left her room after defecating on the floor. Staff verbally redirected [client A] to clean up after herself. [Client A] refused. Staff sanitized [client A's] room, with [client A] laying on her bed. Staff left the room to throw soiled items away and returned to [client A's] room and observed her window being opened, with the alarm broken and</p> |  |  | W 0154   | <p><b>CORRECTION:</b></p> <p><i>The facility must have evidence that all alleged violations are thoroughly investigated. Specifically: All facility investigations will be completed by trained investigators. The facility must have evidence that all alleged violations are thoroughly investigated. Specifically: All facility investigations will be completed by trained investigators. Additionally, a new investigator has been trained to assist with investigations at this facility. When incidents requiring investigation occur, the QA manager or designee will assign the investigation to a specific investigator. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes. Specifically, investigators will save electronic files of all components of investigations into a shared investigation folder to provide access and monitoring capability throughout the investigation process and to allow investigations to be reproduced and provided to regulatory entities as required. The QIDP manager will conduct follow-up with the investigator to assure completion within required timeframes. In addition to weekly face to face training and follow-up with the</i></p> |  | 03/18/2022                 |

|  |   |  |  |  |   |  |                            |
|--|---|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |   | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>[client A] no longer in her room. Staff notified Area Supervisor and [city] Police Dispatch that [client A] was no longer at the residence, and initiated a search of the area. Multiple staff, Area Supervisor, staff from other homes, and police attempted to locate [client A]. [Client A] was out of line of sight from 4:44 PM until 8:34 PM when [client A] was located, at the intersection of [name of street] and [name of road], 0.3 miles from her home. [Client A] was handcuffed. [Client A] was physically aggressive with Police Officers resulting in a windshield being kicked out of a police car. EMTs transported [client A] to the [name of hospital] Emergency Department for medical evaluation. [Client A] was then transported by police to the [county] Jail. The Area Supervisor and nurse (sic) notified. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery against a public safety official, Resisting Law Enforcement, and Criminal Mischief-Pecuniary Loss of at least \$750.00.... She does not have plan approved alone time, and she was away from staff supervision for three hours and 50 minutes. The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are (sic) indicated, and the team will work with [client A's] attending psychiatrist to pursue acute in-patient psychiatric treatment due to her intractable aggression".</p> <p>A 1/21/22 Incident Follow-Up Report indicated, "[Client A] remains on 1:1 supervision since her return home from acute inpatient psychiatric care, at [name of hospital], as outlined in her Behavior Support Plan and was discussed during [client A's] IDT meeting 01/11/2022."</p> |  |  |  | <p>Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs.</p> <p><b>PREVENTION:</b><br/>The QIDP Manager will maintain 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, comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager. The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members</p> |  |                            |

|  |  |  |  |  |   |  |                            |
|--|--|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |   | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>A review of the 1/8/22 BDDS report indicated client A eloped from the group home and was without staff supervision for 3 hours and 50 minutes. When client A was located, she was handcuffed due to being physically aggressive with police. Client A kicked out the windshield of the police car. Client A was arrested and transported to the hospital for evaluation then to jail. She was charged with battery against a public safety official, resisting law enforcement and criminal mischief. There was no documentation indicating an investigation was completed.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated this incident wasn't investigated and it should have been. The QIDPM stated, "I just didn't get to it. We know that is not an excuse".</p> <p>1b. A 2/5/22 BDDS report indicated, "On the evening of 2/5/2022 (6:00 PM), [client A] and staff were sitting at the dining table while she colored and without any apparent precedent [client A] got up and headed for the door, staff redirected her, but she pushed past staff and ran out of the door. Staff followed [client A] while redirecting her to come back to the house and offering coping skills, but she continued to escalate. [Client A] entered a [name of] convenience store where staff continued to redirect while offering coping skills. An individual at the store called 911. When police arrived, [client A] told them she was suicidal, and the Police transported her to the [name of hospital] Emergency Department.... [Client A] was diagnosed with agitation.... [Client A] was released to ResCare staff to be taken home.... Plan to Resolve: [Client A] was not injured during the incident and continues to receive</p> |  |  |  | <p>will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs.</p> <p>The Quality Assurance Team 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. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>ongoing emotional support.... She does not have plan approved alone time. It should be noted that staff did not lose sight of [client A] at any time during the entire incident. Staff will continue to follow the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences. The administrative team is aware of the incident".</p> <p>A review of the 2/5/22 BDDS report indicated client A eloped from the group home with staff following. Client A was then transported to the hospital due to reporting she was suicidal to the police. There was no documentation indicating an investigation was completed.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated this incident wasn't investigated and it should have been.</p> <p>1c. A 2/11/22 BDDS report indicated, "On 2.10.22, [client A] (8:10 PM) and other housemates were talking about running, staff verbally redirected [client A] and had supportive conversation in an attempt to aid in calming. [Client A] refused to use coping skillsm (sic), and refused her evening medications. [Client A] continued being verbally aggressive towards staff. [Client A] attempted to go out the front door. Staff blocked, successfully. Staff continued to offer supportive conversation and coping skills, unsuccessfully, and [client A] spit on staff. [Client A] charged at staff and the front door, staff attempted to block and tripped, falling over a chair and [client A] eloped out the front door, and staff lost line of sight. Staff contacted [city] police department, and began searching. The police located [client A] and brought her back to the home 15 minutes later. Staff offered</p> |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>supportive conversation and coping skills, but [client A] remained agitated and aggressive and the police officer informed staff he would remain in the home until he assessed that the environment was safe. Staff contacted the Behavior Clinician (BC) to assist in providing supportive conversation. [Client A] was verbally aggressive with the BC on the phone, and made threats to harm the police and take his gun to use. [Client A] attempted to elope from home, staff and police officer blocked the door successfully. [Client A] became verbally aggressive towards housemates. Staff verbally redirected [client A]. [Client A] attempted to move towards housemates, staff blocked successfully. [Client A] attempting (sic) to hit and kick staff, to get past them, without making contact. [Client A] was placed in a 2 -person You're Safe, I'm Safe hold. Staff had supportive conversation with [client A]. [Client A] stated she was just frustrated and upset. [Client A] started calming and using coping skills, after about 15 minutes and hold was released. [Client A] agreed to take her PRN (as needed medication) (Haldol 5 mg/milligrams) and evening medications. [Client A] continued calming in the dining room and then went to bed and remained on 1:1 staff supervision. Area supervisor was on site and Nurse notified. The police officer left without taking further action.</p> <p>Plan to Resolve: [Client A] was not injured and received emotional support from her team. [Client A] has a history of physical aggression, verbal aggression, and elopement behaviors addressed in her Behavior Support Plan, which staff followed. [Client A] was unsupervised by staff for approximately 15 minutes. [Client A] does not have approved alone time.... Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>prevent further occurrences...."</p> <p>A review of the 2/11/22 BDDS report, the 2/10/22 ResCare incident report and the 2/10/22 Emergency Communication Command Log indicated only two staff were on duty when client A eloped from the group home and staff were unable to leave to assist with locating client A. There was no documentation indicating an investigation was completed.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM stated, "It has not been investigated". The QIDPM indicated the investigation wasn't due until Thursday, 2/17/22. The QAM stated, "It will be investigated and started".</p> <p>2. On 2/14/22 at 12:00 PM, the facility's BDDS reports, ResCare incident reports and investigations were reviewed and indicated the following:</p> <p>A 1/24/22 BDDS report indicated, "On the morning of 01/23/2022, at 7:35 AM, [client B] exited the house through the alarmed back door and staff could not maintain line of sight. Staff initiated a search and notified the supervisor. At 7:51 AM, [city] Police Dispatch contacted the [name of group home] reporting [client B] was on [name of street] telling people she was suicidal. Staff got into their vehicle and met with police, EMTs, and [client B] at 7:58 AM on [address]. [Client B] reported to staff that her chest hurt and that she was suicidal. EMS transported [client B] to [name of hospital] to be examined.... Staff had a supportive conversation with [client B]. [Client B] reported she was angry and suicidal. [Client B] and staff waited for Psych (psychiatric services) to complete and (sic) evaluation. [Client B] used</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>her coping skills and watched TV (television) to calm. ER nurse came in to speak with [client B] and when the nurse left to speak to the Dr. (doctor) assigned to [client B], [client B] got up and went into the hallway and was yelling she did not want to return home. [Client B] refused to go back into her room when asked by hospital staff and security. [Client B] became physically aggressive with security staff, trying to hit and kick unsuccessfully. Nursing staff administered Haldol IM, and [client B] was (sic) admitted, [client B] for acute inpatient psychiatric treatment.... Plan to Resolve: [Client B] was not injured prior to her hospitalization. [Client B] has a history of Elopement and Suicidal Ideation addressed in her Behavior Support Plan. [Client B] does not have plan approved alone time and was away from staff supervision for the twenty three minutes. The interdisciplinary team will meet to review the circumstances of the incident to determine if additional supports are indicated. ResCare nursing will remain in contact with the hospital to assure continuity of care...."</p> <p>A review of the 1/24/22 BDDS report indicated client B eloped from the group home and was without staff supervision for 23 minutes. Client B was transported to the hospital and was admitted for a psychiatric evaluation. There was no investigation completed.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated the elopement was not investigated and it should have been.</p> <p>3. On 2/14/22 at 12:00 PM, the facility's BDDS reports, ResCare incident reports and investigations were reviewed and indicated the following:</p> |  |  |  |  |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>A 1/12/22 BDDS report indicated, "On the evening of 01/11/2022 (8:00 PM), [client C] was prompted to take evening medications. [Client C] was standing in the dining room area when she refused her evening medications. [Client C] immediately ran out the front door and started running down [name of street] towards [name of road] and the park. Staff followed, but lost sight of [client C]. Staff informed the supervisor and completed a police report. Several staff and Area Supervisors continued searching for [client C]. [Client C] remained out of line of sight from 8:00 PM until 10:30 PM, when staff located [client C] at [hospital] waiting room. A [city] police officer stated that he would remain with [client C] until she was admitted. The ResCare Area Supervisor was not permitted to remain at the hospital while [client C] wait (sic) the ER with the police due to COVID visitation restrictions. The police officer arrived at [client C's] home at 12:20 AM, to inform staff that [client C] was admitted to the [hospital] Psychological Unit for suicidal ideation.... Plan to Resolve: [Client C] was not injured during this incident. She was released from the hospital to ResCare staff on 01/12/2022, at 11:50 AM. [Client C] has a history of Elopement and Suicidal Ideation addressed in her Behavior Support Plan. [Client C] does not have plan approved alone time and was away from staff supervision for two hours and thirty minutes. The interdisciplinary team will meet to review the circumstances of the incident to determine if additional supports are indicated...."</p> <p>A review of the 1/12/22 BDDS report indicated client C eloped from the group home and was</p> |  |  |  |  |  |  |

|  |   |  |                     |  |  |  |  |
|--|---|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING   |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE                 |  |
| W 0157<br><br>Bldg. 00   | <p>without staff supervision for two hours and thirty minutes. Client C was located by the local police department and was transported to the ER for a psychiatric evaluation. There was no investigation completed.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated the elopement was not investigated and it should have been.</p> <p>This federal tag relates to complaint #IN00370933.</p> <p>9-3-2(a)</p> <p>483.420(d)(4)</p> <p><b>STAFF TREATMENT OF CLIENTS</b></p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review and interview for 4 of 18 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 1 of 3 clients in the sample (A), the facility failed to initiate effective corrective measures to address client A's continued episodes of elopement with police involvement and arrests.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/14/22 from 1:25 PM to 1:55 PM and from 3:45 PM to 4:30 PM. Throughout the observation periods, client A had 1:1 staffing. Client A's bedroom had one window and the window did not have a screen in it. The window had an alarm on the inside and outside of the window which sounded when the window was opened.</p> |  | W 0157              | <p><b>CORRECTION:</b></p> <p><i>If the alleged violation is verified, appropriate corrective action must be taken.</i> Through observation and a review of assessment data, the governing body has determined that this deficient practice could affect all clients who reside in the facility. Specific corrections include: The facility's new behavioral clinician has updated client A's Behavior Support Plan to provide amended strategies to address and prevent elopement. All staff have received documented training on implementing the revised plan included client A's one to one supervision procedures. Additionally, the</p> |  | 03/18/2022                                 |  |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>On 2/14/22 at 12:00 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, ResCare incident reports and investigations were reviewed and indicated the following:</p> <p>1. A 1/4/22 BDDS report indicated, "On 1/3/22 beginning at 8:30 AM; [Client A] became agitated following conversation related to wanting her guardian to purchase earrings for her and not wanting to spend her weekly money on buying her own. [Client A] self-isolated in her room refusing active treatment, most of her meals, and daily hygiene goals. Staff offered supportive conversation, coping skills and PRN (as needed medication) that was recently added to her Behavior Support Plan for increased agitation. [Client A] refused all prompts. Staff completed 15-minute checks as directed by the Area Supervisor, per her plan. Staff offered [client A] snack and reminded her that following snack she would need to take a shower to complete daily hygiene. [Client A] agreed and walked to her room and started removing all items on her shelves throwing (sic) to the floor, breaking picture frames and other personal items. Staff verbally redirected [client A] and attempted to throw items at staff. Staff blocked. [Client A] defecated in her pants, and threw at staff and smeared it on the furniture. [Client A] removed her window alarm while staff was placing on personal protective gear and climbed out of her window. Staff followed while [client A] was walking towards the neighbor's yard in line of sight. [Client A] picked up items from the neighbor's yard and threw them at staff without success. Staff verbally redirected [client A] to leave the neighbor's yard and return to the residence with [client A] refusing. [Client A]</p> |  |  |  | <p>facility has enlisted the services of an external behavior specialist to provide supplemental therapeutic interaction with client A, to help address the underlying issues that have contributed to her aggression and elopement. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and three staff on duty between 6:00 AM and 11:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. During the current acute staffing shortage Area Supervisors from outside of Wayne County are covering direct support shifts in the facility and will continue to do so until such time as vacancies are filled with trained direct support staff. Additionally, staff from other agency facilities, including from facilities outside of Wayne County, are being utilized as needed. All fill-in staff, including supervisors, will receive client specific training prior to working in the facility.</p> <p><b>PREVENTION:</b><br/>When significant incidents occur, including but not elopement and incidents resulting in police involvement, the QIDP will contact front line team members, behavioral clinicians, and</p> |  |                            |

|  |   |  |   |  |  |  |  |
|--|---|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>entered the neighbor's porch area throwing items from the porch at staff. Staff offered supportive conversation, coping skills and PRN. [Client A] entered the neighbor's vehicle and threw items from the car outside. Redirection and blocking was (sic) ineffective, and staff called 911 for assistance. [Client A] was physically aggressive toward police officers, hitting and spitting. Police officer on scene tased [client A] and placed her in hand cuffs. EMTs (emergency medical technicians) transported [client A] to the [name of emergency department] for medical evaluation from being tased. [Client A] was transported by police to the [county] Jail. Area supervisor and nurse notified.</p> <p>Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Resisting Law Enforcement.... [Client A] is scheduled to be released without bond on 1/5/22.... The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are (sic) indicated, and the team will resume efforts to pursue acute in-patient psychiatric treatment due to her intractable aggression".</p> <p>A 1/21/22 Incident Follow-Up Report indicated, "[Client A] remains on 1:1 supervision since her return home from acute inpatient psychiatric care, at [name of hospital], as outlined in her Behavior Support Plan and was discussed during [client A's] IDT (interdisciplinary team) meeting 01/11/2022."</p> <p>A 1/8/22 Investigative Summary indicated the following:</p> <p>"Factual Findings:<br/>-[Area Supervisor/AS #1], [AS #2], [former staff</p> |  | <p>administrative staff as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring required staffing levels are in place, and that staff implement behavior support strategies as written. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, until all Conditions of Participation are found to be in compliance. After ongoing certification of the facility is confirmed, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing</p> |  |  |  |  |

|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>#9] and [staff #1] were present when the incident occurred.</p> <p>-[Client A] had refused to participate in tasks and stayed in bed through the morning and early afternoon, coming out to eat 25% (percent) of her lunch and a snack.</p> <p>-[Client A] escalated and began throwing first objects and later fecal material.</p> <p>-While staff were putting on personal protective equipment, to avoid contact with feces, [client A] climbed out her window.</p> <p>-The window alarm functioned properly and staff followed, maintaining line of sight.</p> <p>-When [client A] got into a neighbor's car, [AS #2] called the police. [Client A] dd (sic) not cooperate with police, was tased, handcuffed, taken to the ER (emergency room), and then incarcerated.</p> <p>-[Client A] was never out of staff 's line of sight.</p> <p>-[Client A's] Behavior Support Plan addresses Verbal Aggression, Physical Aggression, Leaving the Assigned Area, Socially Offensive Behavior and Property Disruption/Destruction.</p> <p>-Testimony indicates staff followed her plan, although a negative outcome occurred.</p> <p>Conclusion:</p> <ol style="list-style-type: none"> <li>1. The evidence substantiates that [client A] engaged in behaviors that led to her being tased and arrested on 1/3/22.</li> <li>2. The evidence does not substantiate that [client A's] Behavior Support Plan failed to address the behaviors leading to her arrest.</li> <li>3. The evidence does not substantiate that staff failed to implement [client A's] Behavior Support Plan appropriately.</li> </ol> <p>Recommendations:</p> <ol style="list-style-type: none"> <li>1. Continue to explore acute inpatient psychiatric treatment options for [client A], limiting</li> </ol> |  | <p>support needed at the facility. Administrative Monitoring is defined as follows:</p> <ul style="list-style-type: none"> <li>· The role of the administrative monitor is not simply to observe &amp; Report.</li> <li>· When opportunities for training are observed, the monitor must step in and provide the training and document it.</li> <li>· If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports.</li> <li>· Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority.</li> <li>· Review all relevant documentation, providing documented coaching and training as needed</li> </ul> <p>Administrative support at the home will include but not be limited to assuring corrective measures are in place, developed through a collaborative interdisciplinary process.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director</p> |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>discussion on the topic that will lead to [client A] perseverating about it.</p> <p>2. Continue to encourage the use of [client A's] agitation PRN (as needed) before her behavior escalates beyond severe resistance to support.</p> <p>3. Continue to implement [client A's] current behavior support strategies".</p> <p>A review of the 1/4/22 BDDS report and the 1/8/22 Investigative Summary indicated client A was agitated throughout the day and later in the day, client A displayed behaviors of property destruction then defecated in her pants and threw it at staff. As staff went to obtain personal protective equipment (leaving client A unsupervised), client A removed the alarm from her bedroom window and eloped through the window. Staff followed her to the neighbor's house where she destroyed property on the neighbor's porch and in their vehicle. Police were called and client A was tased due to resisting arrest. Client A was transported to the hospital for an evaluation due to being tased then she was transported to jail. There was no documentation indicating effective corrective measures were initiated to prevent reoccurrence.</p> <p>2. A 1/8/22 BDDS report indicated, "On 01/07/22 beginning at 4:20 PM; [client A] was in her room while staff was completing 15-minute checks. Following a 15-minute check [client A] left her room after defecating on the floor. Staff verbally redirected [client A] to clean up after herself. [Client A] refused. Staff sanitized [client A's] room, with [client A] laying on her bed. Staff left the room to throw soiled items away and returned to [client A's] room and observed her window being opened, with the alarm broken and [client A] no longer in her room. Staff notified</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>Area Supervisor and [city] Police Dispatch that [client A] was no longer at the residence, and initiated a search of the area. Multiple staff, Area Supervisor, staff from other homes, and police attempted to locate [client A]. [Client A] was out of line of sight from 4:44 PM until 8:34 PM when [client A] was located, at the intersection of [name of street] and [name of road], 0.3 miles from her home. [Client A] was handcuffed. [Client A] was physically aggressive with Police Officers resulting in a windshield being kicked out of a police car. EMTs transported [client A] to the [name of hospital] Emergency Department for medical evaluation. [Client A] was then transported by police to the [county] Jail. The Area Supervisor and nurse (sic) notified. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery against a public safety official, Resisting Law Enforcement, and Criminal Mischief-Pecuniary Loss of at least \$750.00.... She does not have plan approved alone time, and she was away from staff supervision for three hours and 50 minutes. The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are (sic) indicated, and the team will work with [client A's] attending psychiatrist to pursue acute in-patient psychiatric treatment due to her intractable aggression".</p> <p>A 1/21/22 Incident Follow-Up Report indicated, "[Client A] remains on 1:1 supervision since her return home from acute inpatient psychiatric care, at [name of hospital], as outlined in her Behavior Support Plan and was discussed during [client A's] IDT meeting 01/11/2022."</p> <p>A review of the 1/8/22 BDDS report indicated</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>client A eloped from the group home and was without staff supervision for 3 hours and 50 minutes. When client A was located, she was handcuffed due to being physically aggressive with police. Client A kicked out the windshield of the police car. Client A was arrested and transported to the hospital for evaluation then to jail. She was charged with battery against a public safety official, resisting law enforcement and criminal mischief. There was no documentation indicating effective corrective measures were initiated to prevent reoccurrence.</p> <p>3. A 2/5/22 BDDS report indicated, "On the evening of 2/5/2022 (6:00 PM), [client A] and staff were sitting at the dining table while she colored and without any apparent precedent [client A] got up and headed for the door, staff redirected her, but she pushed past staff and ran out of the door. Staff followed [client A] while redirecting her to come back to the house and offering coping skills, but she continued to escalate. [Client A] entered a [name of] convenience store where staff continued to redirect while offering coping skills. An individual at the store called 911. When police arrived, [client A] told them she was suicidal, and the Police transported her to the [name of hospital] Emergency Department.... [Client A] was diagnosed with agitation.... [Client A] was released to ResCare staff to be taken home.... Plan to Resolve: [Client A] was not injured during the incident and continues to receive ongoing emotional support.... She does not have plan approved alone time. It should be noted that staff did not lose sight of [client A] at any time during the entire incident. Staff will continue to follow the proactive and reactive strategies in [client A's] plan to help reduce and prevent</p> |  |  |  |  |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>further occurrences. The administrative team is aware of the incident".</p> <p>A review of the 2/5/22 BDDS report indicated client A eloped from the group home with staff following. Client A was then transported to the hospital due to reporting she was suicidal to the police. There was no documentation indicating effective corrective measures were initiated to prevent reoccurrence.</p> <p>4. A 2/11/22 BDDS report indicated, "On 2.10.22, [client A] (8:10 PM) and other housemates were talking about running, staff verbally redirected [client A] and had supportive conversation in an attempt to aid in calming. [Client A] refused to use coping skillsm (sic), and refused her evening medications. [Client A] continued being verbally aggressive towards staff. [Client A] attempted to go out the front door. Staff blocked, successfully. Staff continued to offer supportive conversation and coping skills, unsuccessfully, and [client A] spit on staff. [Client A] charged at staff and the front door, staff attempted to block and tripped, falling over a chair and [client A] eloped out the front door, and staff lost line of sight. Staff contacted [city] police department, and began searching. The police located [client A] and brought her back to the home 15 minutes later. Staff offered supportive conversation and coping skills, but [client A] remained agitated and aggressive and the police officer informed staff he would remain in the home until he assessed that the environment was safe. Staff contacted the Behavior Clinician (BC) to assist in providing supportive conversation. [Client A] was verbally aggressive with the BC on the phone, and made threats to harm the police and take his gun to use. [Client A] attempted to elope from home, staff</p> |  |  |  |  |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>and police officer blocked the door successfully. [Client A] became verbally aggressive towards housemates. Staff verbally redirected [client A]. [Client A] attempted to move towards housemates, staff blocked successfully. [Client A] attempting (sic) to hit and kick staff, to get past them, without making contact. [Client A] was placed in a 2 -person You're Safe, I'm Safe hold. Staff had supportive conversation with [client A]. [Client A] stated she was just frustrated and upset. [Client A] started calming and using coping skills, after about 15 minutes and hold was released. [Client A] agreed to take her PRN (as needed medication) (Haldol 5 mg/milligrams) and evening medications. [Client A] continued calming in the dining room and then went to bed and remained on 1:1 staff supervision. Area supervisor was on site and Nurse notified. The police officer left without taking further action.</p> <p>Plan to Resolve: [Client A] was not injured and received emotional support from her team. [Client A] has a history of physical aggression, verbal aggression, and elopement behaviors addressed in her Behavior Support Plan, which staff followed. [Client A] was unsupervised by staff for approximately 15 minutes. [Client A] does not have approved alone time.... Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences...."</p> <p>A 2/10/22 ResCare incident report indicated the incident occurred right at shift change at 8:00 PM. Staff #1 and staff #3 were getting ready to leave their shift and staff #6 and staff #8 were just arriving for their shift. Staff #6 completed the incident report and indicated, "At about 8:10 PM, [client A] and other housemate (client C) were talking about running away.... [Client A]</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |                            |  |  |
|--|---|--|--|--|----------------------------|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |                            | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |  |  |
|  | <p>then started walking towards the front door and one staff blocked while the other continued trying to calm [client A].... [Client A] tried going for the door, staff blocked. [Client A] then spit on one staff. Staff backed away. Other staff then tried blocking the door. [Client A] pushed staff. Staff tripped over chair (sic) fell on floor. [Client A] then ran out the front door. Staff had to stay with other clients. Police were called...."</p> <p>On 2/15/22 at 11:30 AM, the [name of county] Emergency Communications Command Log (dispatch report) dated 2/10/22 was reviewed. The log indicated the following: 2/10/22 at 20:34 (8:34 PM): "[Client A] took off".... Took off about 3 minutes ago.... STAFF UNABLE TO LEAVE.... [Client A] detained (20:44/8:44 PM)...."</p> <p>A review of the 2/11/22 BDDS report, the 2/10/22 ResCare incident report and the 2/10/22 Emergency Communication Command Log indicated only two staff were on duty when client A eloped from the group home and staff were unable to leave to assist with locating client A. There was no documentation indicating effective corrective measures were initiated to prevent reoccurrence.</p> <p>On 2/15/22 at 12:50 PM, client A's record was reviewed and indicated the following:</p> <p>A 1/5/22 [County] Circuit and Superior Courts Appearance Form indicated client A was booked into jail on 1/3/22 and she was released on 1/5/22 with a charge of resisting law enforcement.</p> <p>A 1/7/22 [County] Circuit and Superior Courts Appearance Form indicated client A was booked</p> |  |  |  |                            |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>into jail on 1/7/22 and she was released on 1/9/22 with charges of criminal mischief, resisting law enforcement and Batt (6) (battery-level 6 felony).</p> <p>Client A's 1/8/21 (revised 4/29/21) BSP (Behavior Support Plan) indicated client A had target behaviors of self injury behavior, disruptive behavior, task refusal, physical aggression, verbal aggression, emotional manipulation, false allegations/lying, elopement, and property destruction/disruption.</p> <p>"Elopement... Operational Definition: Any occurrence of [client A] leaving an assigned area including including areas within the home or where the group is located without staff acknowledgement and/or permission. Displays of Elopement include occurrences of [client A] climbing out (attempts included) windows (at the residence or elsewhere), walking out of the residence into the front and/or back yard, the garage, across the road to the mailbox, exiting the back gate without having received the explicit permission of a member of staff (residential). Elopement/Leaving Assigned Area also includes occurrences when [client A] enters the personal spaces/areas of the housemates without having received express permission from the individual housemate and/or from a staff member".</p> <p>"Rights restrictions.... Enhanced Supervision (1:1)- elopement (to prevent). To protect [client A] from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff".</p> <p>Notes from an Interdisciplinary Team Meeting dated 1/10/22 indicated, "[Former Behavior Clinical] notified and requested 1:1 supervision remain in place and explained that due to</p> |  |  |  |  |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>increased elopements [client A] will remain in sight of and with staff at all times".</p> <p>Notes from an Interdisciplinary Team Meeting dated 2/7/22 indicated, "[Client A] states that when she was at the gas station (2/5/22 incident) she talked with staff in the store to get warm and then was still irritated so she got into a male strangers car and asked them to call the police...."</p> <p>On 2/15/22 at 9:54 AM, the COP (Chief of Police) was interviewed. The COP indicated client A had criminal charges including 3 felony battery charges for spitting at police officers, criminal mischief for kicking out the windshield of a police car and some resisting arrest charges. The COP stated, "I'm going to be frankly honest with you. We have no other course but to arrest her. She needs more of a secure detention (facility). This home isn't secure enough for her". The COP stated, "I don't know what is going on there. It was quiet there for a really long time then in October/November (2021) we started getting regular calls about [client A]".</p> <p>On 2/15/22 at 3:50 PM, staff #1 was interviewed. When asked about client A's behavior, staff #1 stated, "It's a mess. We have done so much listening. If she doesn't like what she hears, she doesn't like it and you'll pay for it. Once she cools down and wants to talk she's ok. She's been to jail several times and she has pending charges. She wants any kind of attention she can get, positive or negative. It doesn't matter what attention she gets. Nothing is fair, she gets upset when other clients have family come visit. She gets mad at everyone then apologizes. Just last week she went out the front door again. I was behind her. I was outside walking without a phone or a coat. It was below zero outside. She</p> |  |  |  |  |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>didn't have a coat on, only pajama pants and a long sleeved shirt. It doesn't matter what we do, it doesn't work. She plots to get out. She gets off on that". Staff #1 indicated client A required 1:1 supervision. Staff #1 indicated the incidents with client A on 1/3/22, 1/7/22 and on 2/5/22 only two staff were working when the incidents occurred.</p> <p>On 2/15/22 at 5:00 PM, staff #3 was interviewed. Staff #3 indicated she just returned to work on 1/22/22 so she hasn't been involved with many of client A's behaviors. When asked to describe client A's behavior, staff #3 stated, "She is very emotional and manipulative, more verbal than anything. Physically aggressive at times. She can be very violent (towards staff)". Staff #3 stated, "I don't feel like 2 or 3 people can effectively deal with behaviors and help her. If she doesn't listen there is only so much we can do".</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM and the QIDP indicated client A had pending criminal charges for criminal mischief, battery with a bodily fluid (felony) and resisting arrest. The QIDP indicated there was a preliminary court hearing scheduled for 2/23/22. The QIDPM stated, "We have had continuing problems but there has also been overall improvement in her (client A) ability to control herself. She (client A) has agreed to take her PRN. [QIDP] is nodding her head in agreement". The QIDPM indicated the new BC was in the process of rewriting client A's BSP. The QIDPM stated, "The new plan will hopefully be more effective. We are confident that we are in the process of turning the corner on this".</p> |  |  |  |  |  |  |

|  |   |  |                     |  |  |  |  |
|--|---|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING   |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE                 |  |
| W 0158<br><br>Bldg. 00   | <p>This federal tag relates to complaint #IN00370933.</p> <p>9-3-2(a)</p> <p>483.430<br/>FACILITY STAFFING</p> <p>The facility must ensure that specific facility staffing requirements are met.</p> <p>Based on observation, record review and interview for 2 of 2 clients in the sample (A and B) and 2 additional clients (C and D), the facility failed to meet the Condition of Participation: Facility Staffing. The facility failed to ensure there was sufficient staff present in the home to implement plans and to prevent four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The facility failed to ensure the Extensive Support Needs Reimbursement Guidelines were followed at a minimum for clients A, B, C and D.</p> <p>Findings include:</p> <p>Please refer to W186. For 2 of 2 clients in the sample (A and B) and 1 additional client (C), the facility failed to ensure there was sufficient staff present in the home to implement plans and to prevent four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The facility failed to ensure the Extensive Support Needs Reimbursement Guidelines were followed at a minimum for clients A, B, C and D.</p> <p>This federal tag relates to complaint #IN00370933.</p> |  | W 0158              | <p><b>CORRECTION:</b></p> <p><i>The facility must ensure that specific facility staffing requirements are met.</i></p> <p>Specifically, Specific corrections include:</p> <p>Specifically, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and three staff on duty between 6:00 AM and 11:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. During the current acute staffing shortage Area Supervisors from outside of Wayne County are covering direct support shifts in the facility and will continue to do so until such time as vacancies are filled with trained direct support staff. Additionally, staff from other agency facilities, including from facilities outside of Wayne County, are being utilized as needed. All fill-in staff, including supervisors, will receive client specific training prior to working</p> |  | 03/18/2022                                 |  |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE |
|  | 9-3-3(a)   |  |  |  | <p>in the facility.</p> <p><b>PREVENTION:</b></p> <p>The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager and Program Director/Operations Manager will assist with procuring staff from outside of the facility as needed.</p> <p>An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring required staffing levels are in place. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, until all Conditions of Participation are found to be in compliance. After ongoing certification of the facility is confirmed, administrative monitoring will occur no less than</p> |  |                            |

|  |  |  |  |  |   |  |                            |
|--|--|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |   | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|  |  |  |  |  | <p>three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows:</p> <ul style="list-style-type: none"> <li>· The role of the administrative monitor is not simply to observe &amp; Report.</li> <li>· When opportunities for training are observed, the monitor must step in and provide the training and document it.</li> <li>· If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports.</li> <li>· Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority.</li> <li>· Review all relevant documentation, providing documented coaching and training as needed</li> </ul> <p>Administrative support at the home will include but not be limited to assuring required staffing levels are in place.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> |  |                            |

|  |   |  |  |  |   |  |                            |
|--|---|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |   | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
| W 0186<br><br>Bldg. 00   | <p>483.430(d)(1-2)<br/>DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 2 of 2 clients in the sample (A and B) and 2 additional clients (C and D), the facility failed to ensure there was sufficient staff present in the home to implement plans and to prevent four incidents of elopement with police involvement including two arrests for client A; one elopement for client B and one elopement for client C. The facility failed to ensure the Extensive Support Needs Reimbursement Guidelines were followed at a minimum for clients A, B, C and D.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 2/14/22 from 1:25 PM to 1:55 PM and from 3:45 PM to 4:30 PM. Throughout the observation periods, client A had 1:1 staffing. Client A's bedroom had one window and the window did not have a screen in it. The window had an alarm on the inside and outside of the window which sounded when the window was opened.</p> <p>On 2/14/22 at 12:00 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, ResCare incident reports and investigations were reviewed and indicated the</p> |  |  | W 0186   | <p><b>CORRECTION:</b></p> <p><i>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Specifically, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and three staff on duty between 6:00 AM and 11:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. During the current acute staffing shortage Area Supervisors from outside of Wayne County are covering direct support shifts in the facility and will continue to do so until such time as vacancies are filled with trained direct support staff. Additionally, staff from other agency facilities, including from facilities outside of Wayne County, are being utilized as needed. All fill-in staff, including</i></p> |  | 03/18/2022                 |

|  |  |  |  |  |   |  |                            |
|--|--|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |   | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>following:</p> <p>1a. A 1/4/22 BDDS report indicated, "On 1/3/22 beginning at 8:30 AM; [Client A] became agitated following conversation related to wanting her guardian to purchase earrings for her and not wanting to spend her weekly money on buying her own. [Client A] self-isolated in her room refusing active treatment, most of her meals, and daily hygiene goals. Staff offered supportive conversation, coping skills and PRN (as needed medication) that was recently added to her Behavior Support Plan for increased agitation. [Client A] refused all prompts. Staff completed 15-minute checks as directed by the Area Supervisor, per her plan. Staff offered [client A] snack and reminded her that following snack she would need to take a shower to complete daily hygiene. [Client A] agreed and walked to her room and started removing all items on her shelves throwing (sic) to the floor, breaking picture frames and other personal items. Staff verbally redirected [client A] and attempted to throw items at staff. Staff blocked. [Client A] defecated in her pants, and threw at staff and smeared it on the furniture. [Client A] removed her window alarm while staff was placing on personal protective gear and climbed out of her window. Staff followed while [client A] was walking towards the neighbor's yard in line of sight. [Client A] picked up items from the neighbor's yard and threw them at staff without success. Staff verbally redirected [client A] to leave the neighbor's yard and return to the residence with [client A] refusing. [Client A] entered the neighbor's porch area throwing items from the porch at staff. Staff offered supportive conversation, coping skills and PRN. [Client A] entered the neighbor's vehicle and threw items from the car outside. Redirection and blocking</p> |  |  |  | <p>supervisors, will receive client specific training prior to working in the facility.</p> <p><b>PREVENTION:</b></p> <p>The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager and Program Director/Operations Manager will assist with procuring staff from outside of the facility as needed.</p> <p>An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring required staffing levels are in place. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, until all Conditions of Participation are found to be in compliance. After ongoing certification of the facility is</p> |  |                            |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>was (sic) ineffective, and staff called 911 for assistance. [Client A] was physically aggressive toward police officers, hitting and spitting. Police officer on scene tased [client A] and placed her in hand cuffs. EMTs (emergency medical technicians) transported [client A] to the [name of emergency department] for medical evaluation from being tased. [Client A] was transported by police to the [county] Jail. Area supervisor and nurse notified.</p> <p>Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Resisting Law Enforcement.... [Client A] is scheduled to be released without bond on 1/5/22.... The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are (sic) indicated, and the team will resume efforts to pursue acute in-patient psychiatric treatment due to her intractable aggression".</p> <p>A 1/21/22 Incident Follow-Up Report indicated, "[Client A] remains on 1:1 supervision since her return home from acute inpatient psychiatric care, at [name of hospital], as outlined in her Behavior Support Plan and was discussed during [client A's] IDT (interdisciplinary team) meeting 01/11/2022."</p> <p>A 1/8/22 Investigative Summary indicated the following:</p> <p>"Factual Findings:<br/>-[Area Supervisor/AS #1], [AS #2], [former staff #9] and [staff #1] were present when the incident occurred.<br/>-[Client A] had refused to participate in tasks and stayed in bed through the morning and early afternoon, coming out to eat 25% (percent) of</p> |  | <p>confirmed, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows:</p> <ul style="list-style-type: none"> <li>· The role of the administrative monitor is not simply to observe &amp; Report.</li> <li>· When opportunities for training are observed, the monitor must step in and provide the training and document it.</li> <li>· If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports.</li> <li>· Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority.</li> <li>· Review all relevant documentation, providing documented coaching and training as needed</li> </ul> <p>Administrative support at the home will include but not be limited to assuring required staffing levels are in place.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>her lunch and a snack.</p> <p>-[Client A] escalated and began throwing first objects and later fecal material.</p> <p>-While staff were putting on personal protective equipment, to avoid contact with feces, [client A] climbed out her window.</p> <p>-The window alarm functioned properly and staff followed, maintaining line of sight.</p> <p>-When [client A] got into a neighbor's car, [AS #2] called the police. [Client A] dd (sic) not cooperate with police, was tased, handcuffed, taken to the ER (emergency room), and then incarcerated.</p> <p>-[Client A] was never out of staff 's line of sight.</p> <p>-[Client A's] Behavior Support Plan addresses Verbal Aggression, Physical Aggression, Leaving the Assigned Area, Socially Offensive Behavior and Property Disruption/Destruction.</p> <p>-Testimony indicates staff followed her plan, although a negative outcome occurred.</p> <p>Conclusion:</p> <ol style="list-style-type: none"> <li>1. The evidence substantiates that [client A] engaged in behaviors that led to her being tased and arrested on 1/3/22.</li> <li>2. The evidence does not substantiate that [client A's] Behavior Support Plan failed to address the behaviors leading to her arrest.</li> <li>3. The evidence does not substantiate that staff failed to implement [client A's] Behavior Support Plan appropriately.</li> </ol> <p>Recommendations:</p> <ol style="list-style-type: none"> <li>1. Continue to explore acute inpatient psychiatric treatment options for [client A], limiting discussion on the topic that will lead to [client A] perseverating about it.</li> <li>2. Continue to encourage the use of [client A's] agitation PRN (as needed) before her behavior escalates beyond severe resistance to support.</li> </ol> |  |  |  |  |  |  |

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>3. Continue to implement [client A's] current behavior support strategies".</p> <p>A review of the 1/4/22 BDDS report and the 1/8/22 Investigative Summary indicated client A was agitated throughout the day and later in the day, client A displayed behaviors of property destruction then defecated in her pants and threw it at staff. As staff went to obtain personal protective equipment (leaving client A unsupervised), client A removed the alarm from her bedroom window and eloped through the window. Staff followed her to the neighbor's house where she destroyed property on the neighbor's porch and in their vehicle. Police were called and client A was tased due to resisting arrest. Client A was transported to the hospital for an evaluation due to being tased then she was transported to jail.</p> <p>On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following:<br/>The staff schedule indicated on 1/3/22 former staff #9 worked from 8:00 AM to 8:00 PM and staff #1 worked from 10:00 AM to 10:00 PM. The visitor log and monthly support tracking form indicated former staff #9 worked from 8:09 AM to 8:10 PM, Area Supervisor (AS) #1 worked from 8:03 AM to 5:30 PM and staff #1 signed in at 10:13 AM. The review indicated two staff and a supervisor were working at the time of the incident.</p> <p>On 2/16/22 at 9:28 AM, the QAM (Quality Assurance Manager), QIDPM (Qualified Intellectual Disabilities Professional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The QIDPM</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022

FORM APPROVED

OMB NO. 0938-0391

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>indicated staff #1, former staff #9 and Area Supervisor #1 were working during the incident and AS #2 arrived later. The QIDPM indicated client A's supervision level was 1:1 at the time of the incident.</p> <p>1b. A 1/8/22 BDDS report indicated, "On 01/07/22 beginning at 4:20 PM; [client A] was in her room while staff was completing 15-minute checks. Following a 15-minute check [client A] left her room after defecating on the floor. Staff verbally redirected [client A] to clean up after herself. [Client A] refused. Staff sanitized [client A's] room, with [client A] laying on her bed. Staff left the room to throw soiled items away and returned to [client A's] room and observed her window being opened, with the alarm broken and [client A] no longer in her room. Staff notified Area Supervisor and [city] Police Dispatch that [client A] was no longer at the residence, and initiated a search of the area. Multiple staff, Area Supervisor, staff from other homes, and police attempted to locate [client A]. [Client A] was out of line of sight from 4:44 PM until 8:34 PM when [client A] was located, at the intersection of [name of street] and [name of road], 0.3 miles from her home. [Client A] was handcuffed. [Client A] was physically aggressive with Police Officers resulting in a windshield being kicked out of a police car. EMTs transported [client A] to the [name of hospital] Emergency Department for medical evaluation. [Client A] was then transported by police to the [county] Jail. The Area Supervisor and nurse (sic) notified. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery against a public safety official, Resisting Law Enforcement, and</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>Criminal Mischief-Pecuniary Loss of at least \$750.00.... She does not have plan approved alone time, and she was away from staff supervision for three hours and 50 minutes. The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are (sic) indicated, and the team will work with [client A's] attending psychiatrist to pursue acute in-patient psychiatric treatment due to her intractable aggression".</p> <p>A 1/21/22 Incident Follow-Up Report indicated, "[Client A] remains on 1:1 supervision since her return home from acute inpatient psychiatric care, at [name of hospital], as outlined in her Behavior Support Plan and was discussed during [client A's] IDT meeting 01/11/2022."</p> <p>A review of the 1/8/22 BDDS report indicated client A eloped from the group home and was without staff supervision for 3 hours and 50 minutes. When client A was located, she was handcuffed due to being physically aggressive with police. Client A kicked out the windshield of the police car. Client A was arrested and transported to the hospital for evaluation then to jail. She was charged with battery against a public safety official, resisting law enforcement and criminal mischief.</p> <p>A ResCare incident report pertaining to the 1/7/22 incident was not provided.</p> <p>On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following:<br/>The staff schedule indicated on 1/7/22 former staff #9 worked from 8:00 AM to 8:00 PM and staff #1 worked from 10:00 AM to 10:00 PM.</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>The visitor log and monthly support tracking form indicated former staff #9 worked from 8:06 AM to 8:20 PM and staff #1 worked from 10:40 AM to 10:00 PM. The review indicated two staff were working at the time of the incident.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated two staff were working at the time of the incident and there should've been three. The QIDPM indicated client A's supervision level was 1:1 at the time of the incident.</p> <p>1c. A 2/5/22 BDDS report indicated, "On the evening of 2/5/2022 (6:00 PM), [client A] and staff were sitting at the dining table while she colored and without any apparent precedent [client A] got up and headed for the door, staff redirected her, but she pushed past staff and ran out of the door. Staff followed [client A] while redirecting her to come back to the house and offering coping skills, but she continued to escalate. [Client A] entered a [name of] convenience store where staff continued to redirect while offering coping skills. An individual at the store called 911. When police arrived, [client A] told them she was suicidal, and the Police transported her to the [name of] hospital] Emergency Department.... [Client A] was diagnosed with agitation.... [Client A] was released to ResCare staff to be taken home.... Plan to Resolve: [Client A] was not injured during the incident and continues to receive ongoing emotional support.... She does not have plan approved alone time. It should be noted that staff did not lose sight of [client A] at any time during the entire incident. Staff will continue to follow the proactive and reactive strategies in [client A's] plan to help reduce and prevent</p> |  |  |  |  |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>further occurrences. The administrative team is aware of the incident".</p> <p>A review of the 2/5/22 BDDS report indicated client A eloped from the group home with staff following. Client A was then transported to the hospital due to reporting she was suicidal to the police.</p> <p>A 2/5/22 ResCare incident report indicated staff #1 and staff #3 were present during the incident. Staff #1 followed client A on foot to the gas station and staff #3 loaded the other three clients into the agency van and went to look for client A and staff #1. They were unable to locate them so they returned to the group home. Dispatch called and reported they were at the gas station. Staff #3 and the other three clients went to the gas station to pick staff #1 and client A up. Client A reported to police she was suicidal so she was transported by police to the emergency room.</p> <p>On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following:<br/>The staff schedule indicated on 2/5/22 staff #1 and staff #3 worked from 8:00 AM to 8:00 PM. The visitor log and monthly support tracking form indicated staff #1 signed in at 8:45 AM, but did not indicate when staff #1 signed out or when staff #3 signed in or out. The review indicated two staff were working at the time of the incident.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated two staff were working when the incident started, but the overnight staff came in early. The QIDPM indicated there should've</p> |  |  |  |  |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |                            |  |  |
|--|---|--|--|--|----------------------------|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |                            | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |  |  |
|  | <p>been three staff working. The QIDPM stated, "She was in line of sight. It wasn't an elopement per se. She never evaded staff supervision". The QIDPM indicated client A's supervision level at the time of the incident was 1:1.</p> <p>1d. A 2/11/22 BDDS report indicated, "On 2.10.22, [client A] (8:10 PM) and other housemates were talking about running, staff verbally redirected [client A] and had supportive conversation in an attempt to aid in calming. [Client A] refused to use coping skills (sic), and refused her evening medications. [Client A] continued being verbally aggressive towards staff. [Client A] attempted to go out the front door. Staff blocked, successfully. Staff continued to offer supportive conversation and coping skills, unsuccessfully, and [client A] spit on staff. [Client A] charged at staff and the front door, staff attempted to block and tripped, falling over a chair and [client A] eloped out the front door, and staff lost line of sight. Staff contacted [city] police department, and began searching. The police located [client A] and brought her back to the home 15 minutes later. Staff offered supportive conversation and coping skills, but [client A] remained agitated and aggressive and the police officer informed staff he would remain in the home until he assessed that the environment was safe. Staff contacted the Behavior Clinician (BC) to assist in providing supportive conversation. [Client A] was verbally aggressive with the BC on the phone, and made threats to harm the police and take his gun to use. [Client A] attempted to elope from home, staff and police officer blocked the door successfully. [Client A] became verbally aggressive towards housemates. Staff verbally redirected [client A]. [Client A] attempted to move towards housemates, staff blocked successfully. [Client</p> |  |  |  |                            |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>A] attempting (sic) to hit and kick staff, to get past them, without making contact. [Client A] was placed in a 2 -person You're Safe, I'm Safe hold. Staff had supportive conversation with [client A]. [Client A] stated she was just frustrated and upset. [Client A] started calming and using coping skills, after about 15 minutes and hold was released. [Client A] agreed to take her PRN (as needed medication) (Haldol 5 mg/milligrams) and evening medications. [Client A] continued calming in the dining room and then went to bed and remained on 1:1 staff supervision. Area supervisor was on site and Nurse notified. The police officer left without taking further action.</p> <p>Plan to Resolve: [Client A] was not injured and received emotional support from her team. [Client A] has a history of physical aggression, verbal aggression, and elopement behaviors addressed in her Behavior Support Plan, which staff followed. [Client A] was unsupervised by staff for approximately 15 minutes. [Client A] does not have approved alone time.... Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences...."</p> <p>A 2/10/22 ResCare incident report indicated the incident occurred right at shift change at 8:00 PM. Staff #1 and staff #3 were getting ready to leave their shift and staff #6 and staff #8 were just arriving for their shift. Staff #6 completed the incident report and indicated, "At about 8:10 PM, [client A] and other housemate (client C) were talking about running away.... [Client A] then started walking towards the front door and one staff blocked while the other continued trying to calm [client A].... [Client A] tried going for the door, staff blocked. [Client A] then spit on one staff. Staff backed away. Other staff then</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |                            |  |  |
|--|--|--|--|--|----------------------------|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |                            | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |  |  |
|  | <p>tried blocking the door. [Client A] pushed staff. Staff tripped over chair (sic) fell on floor. [Client A] then ran out the front door. Staff had to stay with other clients. Police were called...."</p> <p>On 2/15/22 at 11:30 AM, the [name of county] Emergency Communications Command Log (dispatch report) dated 2/10/22 was reviewed. The log indicated the following: 2/10/22 at 20:34 (8:34 PM): "[Client A] took off".... Took off about 3 minutes ago.... STAFF UNABLE TO LEAVE.... [Client A] detained (20:44/8:44 PM)...."</p> <p>A review of the 2/11/22 BDDS report, the 2/10/22 ResCare incident report and the 2/10/22 Emergency Communication Command Log indicated only two staff were on duty when client A eloped from the group home and staff were unable to leave to assist with locating client A.</p> <p>On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following: The staff schedule indicated on 2/10/22 staff #1 and staff #3 worked from 8:00 AM to 8:00 PM and staff #6 and staff #8 worked from 8:00 PM to 8:00 AM. The visitor log and monthly support tracking form indicated staff #1 signed in at 8:30 AM, staff #3 signed in at 4:00 PM, staff #6 signed in at 8:00 PM and staff #8 signed in at 8:00 PM. The form did not indicate when the staff signed out. The review indicated 2 staff were scheduled from 8:00 AM to 8:00 PM and 2 staff were scheduled from 8:00 PM to 8:00 AM.</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated two staff were working at the time of</p> |  |  |  |                            |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>the incident. The QIDPM indicated client A's supervision level at the time of the incident was 1:1.</p> <p>On 2/15/22 at 12:50 PM, client A's record was reviewed and indicated the following.</p> <p>A 1/5/22 [County] Circuit and Superior Courts Appearance Form indicated client A was booked into jail on 1/3/22 and she was released on 1/5/22 with a charge of resisting law enforcement.</p> <p>A 1/7/22 [County] Circuit and Superior Courts Appearance Form indicated client A was booked into jail on 1/7/22 and she was released on 1/9/22 with charges of criminal mischief, resisting law enforcement and Batt (6) (battery-level 6 felony).</p> <p>Client A's 1/8/21 (revised 4/29/21) BSP (Behavior Support Plan) indicated client A had target behaviors of self injury behavior, disruptive behavior, task refusal, physical aggression, verbal aggression, emotional manipulation, false allegations/lying, elopement, and property destruction/disruption.</p> <p>"Elopement... Operational Definition: Any occurrence of [client A] leaving an assigned area including including areas within the home or where the group is located without staff acknowledgement and/or permission. Displays of Elopement include occurrences of [client A] climbing out (attempts included) windows (at the residence or elsewhere), walking out of the residence into the front and/or back yard, the garage, across the road to the mailbox, exiting the back gate without having received the explicit permission of a member of staff (residential). Elopement/Leaving Assigned Area also includes</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>occurrences when [client A] enters the personal spaces/areas of the housemates without having received express permission from the individual housemate and/or from a staff member".</p> <p>"Rights restrictions.... Enhanced Supervision (1:1)- elopement (to prevent). To protect [client A] from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff".</p> <p>Notes from an Interdisciplinary Team Meeting dated 1/10/22 indicated, "[Former Behavior Clinical] notified and requested 1:1 supervision remain in place and explained that due to increased elopements [client A] will remain in sight of and with staff at all times".</p> <p>Notes from an Interdisciplinary Team Meeting dated 2/7/22 indicated, "[Client A] states that when she was at the gas station (2/5/22 incident) she talked with staff in the store to get warm and then was still irritated so she got into a male strangers car and asked them to call the police...."</p> <p>Discharge records from client A's inpatient psychiatric stay dated 1/11/22-1/19/22 indicated the following. "...psychiatric (sic) history of ADHD (attention deficit hyperactivity disorder), anxiety, bipolar affective, depression and insomnia.... active with outpatient mental health treatment through [name of provider].... recent legal problems due to running away from group home and becoming assaultive with law enforcement. She was brought to [name of emergency department] due to suicidal ideation. The patient reports her depression has been getting progressively worse over the last month and she has been arrested numerous times for behaviors. She endorsed suicidal ideations with a</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |                     |  |  |  |  |
|--|--|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING   |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                 |  |
|  | <p>plan to hang herself.... a psychiatric triage was ordered and the patient was admitted to Adult Psychiatry with a diagnosis of depression with suicidal ideation....</p> <p>The patient (sic) seen today face-to-face during inpatient rounds. During my assessment, the patient was laying in bed in medical restraints. Per nursing staff, the patient did not sleep at all last evening. The patient defecated on her floor, then flung feces on to the door window of the unit and smeared feces on the walls, door, windows, handle and herself. The patient also proceeded to put feces in her mouth. It required several staff members and [name of hospital] police to assist with getting the patient into the shower and clean. The patient was aggressive, resistive and spitting at staff during this time and ended up in medical restraints.... The patient yelled profanities at the staff stating when she got out of the hospital she was going to get a bomb to blow up with this place and kill everyone in the hospital. The patient was removed from restraints early in the morning. Shortly after she was removed from restraints and conversing with staff, staff noticed to (sic) outlet covers off the wall into (sic) missing screws. The covers were found underneath the patient bed and the patient stated she swallowed the 2 screws. Patient vomited up 1 of the screws and the other screw was not found. The patient was initially placed in the seclusion room to prevent the patient from harming herself and the patient immediately started self-harming by biting herself. The patient was placed back in four-point locking restraints. She received a 1 time dose of IM (intramuscularly) Ativan, Haldol and Benadryl (for behavior). The patient was completely removed from restraints at 11:10 a.m.... patient did swallowed (sic) a screw and hospitalist is</p> |  |                     |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |                     |  |  |  |  |
|--|--|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING   |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                 |  |
|  | <p>consulting GI (gastrointestinal).... The patient initially stated she had the behaviors because 'I just want to die.' However, when provider spoke with the patient longer asking her to talk with staff about what was really going on, the patient stated, 'I am the kind of person that wants attention. It does not matter if it is negative or positive.' When provider asked the patient if she attempted to speak with staff before acting out the patient stated she did not know how to get positive attention.... Provider spent over 15 minutes speaking with the patient about her past, current behaviors and how negative behaviors healed (sic) negative results and positive behaviors yelled (sic) positive results. The patient verbalized understanding and requested to be removed from the restraints. Provider informed the patient she had to no longer endorse thoughts of harming herself, exhibit the behaviors that caused her to be in restraints, and act appropriately. The patient verbalized understanding. The patient continues to endorse anxiety and depression. She denies suicidal and homicidal ideations. The patient states she 'just wants to go back to the group home.' Provider explained to the patient that she needed to act appropriately and have a good night before this could occur. The patient verbalized understanding. Mood lability (sic) noted. The patient has very poor insight and judgment. Her behaviors actually appeared to worsen the longer she is on the unit. She would benefit more from her outpatient therapy. The behaviors the patient has been exhibiting the past 2 days are behaviors the group home verbalized she exhibits at her baseline.... Medication changes at this point are not going to provide much benefit to the patient. She would benefit more from behavioral therapy...."</p> |  |                     |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>On 2/15/22 at 9:54 AM, the COP (Chief of Police) was interviewed. The COP indicated client A had criminal charges including 3 felony battery charges for spitting at police officers, criminal mischief for kicking out the windshield of a police car and some resisting arrest charges. The COP stated, "I'm going to be frankly honest with you. We have no other course but to arrest her. She needs more of a secure detention (facility). This home isn't secure enough for her". The COP stated, "I don't know what is going on there. It was quiet there for a really long time then in October/November (2021) we started getting regular calls about [client A]".</p> <p>On 2/15/22 at 3:50 PM, staff #1 was interviewed. When asked about client A's behavior, staff #1 stated, "It's a mess. We have done so much listening. If she doesn't like what she hears, she doesn't like it and you'll pay for it. Once she cools down and wants to talk she's ok. She's been to jail several times and she has pending charges. She wants any kind of attention she can get, positive or negative. It doesn't matter what attention she gets. Nothing is fair, she gets upset when other clients have family come visit. She gets mad at everyone then apologizes. Just last week she went out the front door again. I was behind her. I was outside walking without a phone or a coat. It was below zero outside. She didn't have a coat on, only pajama pants and a long sleeved shirt. It doesn't matter what we do, it doesn't work. She plots to get out. She gets off on that". Staff #1 indicated client A required 1:1 supervision. Staff #1 indicated the incidents with client A on 1/3/22, 1/7/22 and on 2/5/22 only two staff were working when the incidents occurred.</p> <p>On 2/15/22 at 5:00 PM, staff #3 was</p> |  |  |  |  |  |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>interviewed. Staff #3 indicated she just returned to work on 1/22/22 so she hasn't been involved with many of client A's behaviors. When asked to describe client A's behavior, staff #3 stated, "She is very emotional and manipulative, more verbal than anything. Physically aggressive at times. She can be very violent (towards staff)". Staff #3 stated, "I don't feel like 2 or 3 people can effectively deal with behaviors and help her. If she doesn't listen there is only so much we can do".</p> <p>On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM and the QIDP indicated client A had pending criminal charges for criminal mischief, battery with a bodily fluid (felony) and resisting arrest. The QIDP indicated there was a preliminary court hearing scheduled for 2/23/22. The QIDPM stated, "We have had continuing problems but there has also been overall improvement in her (client A) ability to control herself. She (client A) has agreed to take her PRN. [QIDP] is nodding her head in agreement". The QIDPM indicated the new BC was in the process of rewriting client A's BSP.</p> <p>2. On 2/14/22 at 12:00 PM, the facility's BDDS reports, ResCare incident reports and investigations were reviewed and indicated the following:</p> <p>A 1/24/22 BDDS report indicated, "On the morning of 01/23/2022, at 7:35 AM, [client B] exited the house through the alarmed back door and staff could not maintain line of sight. Staff initiated a search and notified the supervisor. At 7:51 AM, [city] Police Dispatch contacted the [name of group home] reporting [client B] was on [name of street] telling people she was suicidal.</p> |  |  |  |  |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE   |  |  |  |
|  | <p>Staff got into their vehicle and met with police, EMTs, and [client B] at 7:58 AM on [address]. [Client B] reported to staff that her chest hurt and that she was suicidal. EMS transported [client B] to [name of hospital] to be examined.... Staff had a supportive conversation with [client B]. [Client B] reported she was angry and suicidal. [Client B] and staff waited for Psych (psychiatric services) to complete and (sic) evaluation. [Client B] used her coping skills and watched TV (television) to calm. ER nurse came in to speak with [client B] and when the nurse left to speak to the Dr. (doctor) assigned to [client B], [client B] got up and went into the hallway and was yelling she did not want to return home. [Client B] refused to go back into her room when asked by hospital staff and security. [Client B] became physically aggressive with security staff, trying to hit and kick unsuccessfully. Nursing staff administered Haldol IM, and [client B] was (sic) admitted, [client B] for acute inpatient psychiatric treatment.... Plan to Resolve: [Client B] was not injured prior to her hospitalization. [Client B] has a history of Elopement and Suicidal Ideation addressed in her Behavior Support Plan. [Client B] does not have plan approved alone time and was away from staff supervision for the twenty three minutes. The interdisciplinary team will meet to review the circumstances of the incident to determine if additional supports are indicated. ResCare nursing will remain in contact with the hospital to assure continuity of care...."</p> <p>A review of the 1/24/22 BDDS report indicated client B eloped from the group home and was without staff supervision for 23 minutes. Client B was transported to the hospital and was admitted for a psychiatric evaluation.</p> <p>On 2/15/22 at 11:15 AM, client B's record was</p> |  |  |  |  |  |  |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>reviewed and indicated the following.</p> <p>Client B's 8/31/21 BSP indicated client B had target behaviors of self injury behavior, physical aggression, verbal aggression, property disruption/destruction, elopement/leaving assigned areas, socially offensive behaviors (invading personal space of others), task refusal, suicidal/homicidal threats. "Elopement/Leaving assigned area... Operational Definition: Any occurrence of [client B] walking away from or leaving an assigned area without having received the express and direct permission from a member of staff providing supervision, at that time. Occurrences of Elopement/Leaving Assigned Area includes but is not limited to [client B] leaving areas in the home or if out within the community, leaving areas where the group has congregated (defined as the staff that are with her on a community outing) without staff acknowledgement and/or permission. Elopement/Leaving Assigned Areas also includes occurrences of [client B] climbing out the alarmed window (in her bedroom), as well as, occurrences of [client B] walking/running out of the house and into the front and/or the back yard areas of the home, to the garage, or the field north of the residence (directly outside of the front door and across [name of street] without staff acknowledgement and/or permission; Elopement/Leaving Assigned Area also included occurrences of [client B] entering the bedroom(s) of</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>housemate(s) without permission. Includes Attempts....""...If [client B] attempts to exit the home through one of the exit doors with an egress directly to the street (front door or garage door), staff will attempt to block the front and garage exits, while physically redirecting [client B's] movements away from the door. If [client B] persists in attempting to exit the residence, staff will continue to block the door(s), while verbally redirecting [client B] to exit through the back door to the back yard (a space that is fenced and does not provide a direct egress to the main road)...."On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following: The staff schedule indicated on 1/23/22 staff #6 and staff #8 were scheduled to work from 8:00 PM to 8:00 AM. The visitor log and monthly support tracking form indicated staff #6 signed in at 8:20 PM and signed out at 8:37 AM. Staff #8 did not sign in or out. According to the schedule, two staff were working at the time of the incident. On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated client B did not have alone time in the community. When asked how many staff were working when the incident took place, the QIDPM stated, "Most likely two". 3. On 2/14/22 at 12:00 PM, the</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>facility's BDDS reports, ResCare incident reports and investigations were reviewed and indicated the following: A 1/12/22 BDDS report indicated, "On the evening of 01/11/2022 (8:00 PM), [client C] was prompted to take evening medications. [Client C] was standing in the dining room area when she refused her evening medications. [Client C] immediately ran out the frontdoor and started running down [name of street] towards [name of road] and the park. Staff followed, but lost sight of [client C]. Staff informed the supervisor and completed a police report. Several staff and Area Supervisors continued searching for [client C]. [Client C] remained out of line of sight from 8:00 PM until 10:30 PM, when staff located [client C] at [hospital] waiting room. A [city] police officer stated that he would remain with [client C] until she was admitted. The ResCare Area Supervisor was not permitted to remain at the hospital while [client C] wait (sic) the ER with the police due to COVID visitation restrictions. The police officer arrived at [client C's] home at 12:20 AM, to inform staff that [client C] was admitted to the [hospital] Psychological Unit for suicidal ideation.... Plan to Resolve: [Client C] was not injured during this incident. She was released from the hospital to ResCare staff on 01/12/2022, at 11:50 AM. [Client C] has a history of Elopement and Suicidal Ideation addressed in her</p> |  |  |  |  |  |                            |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>Behavior Support Plan. [Client C] does not have plan approved alone time and was away from staff supervision for two hours and thirty minutes. The interdisciplinary team will meet to review the circumstances of the incident to determine if additional supports are indicated...." A review of the 1/12/22 BDDS report indicated client C eloped from the group home and was without staff supervision for two hours and thirty minutes. Client C was located by the local police department and was transported to the ER for a psychiatric evaluation. On 2/15/22 at 11:50 AM, client C's record was reviewed and indicated the following. Client C's 11/29/21 BSP indicated client C had target behaviors of self injury behavior, socially offensive behavior, task refusal, physical aggression/physical intimidation, verbal aggression/verbal intimidation, emotional manipulation, withdrawn/isolating behavior and elopement/leaving assigned area. "Elopement/Leaving assigned area... Operational Definition: Any occurrence of [client C] leaving an assigned area (area where she has been directed to remain or is expected to remain) including areas within the home or where the (sic) [client C] accesses without having obtained staff acknowledgement and/or permission. Displays of Elopement or Leaving Assigned Area include occurrences of</p> |  |  |  |  |  |                            |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>[client C] climbing or attempting to climb out of windows (at the residence or elsewhere), exiting of the residence and accessing the front and/or back yard(s), accessing the garage, exiting the back gate without having received the explicit permission of a member of staff (residential). Elopement or Leaving Assigned Area also includes occurrences of [client C] entering the personal spaces/areas of the housemates without having received express permission from the individual housemate and permission from a staff member. Includes Attempts". "Rights restrictions.... 24-Hour Supervision/Freedom of Movement and Unrestricted Access to Community- especially following displays of high intensity behaviors attributed to Self-Injury Behavior; Elopement/Leaving Assigned Area; Physical Aggression or Physical Intimidation (or other novel maladaptive behaviors not included herein). Without continuous supervision and direct oversight of [client C] across environments, there is an increased risk of injury to [client C] or others within the environment or setting due to displays of high intensity and duration behavioral episodes and behaviors. [Client C's] lack of understanding of safe community members or those who may wish to bring him (sic) harm may also increase risks to [client C's] safety and that of others resulting in accidents, injury, or</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>exploitation...."On 2/15/22 at 12:00 PM, the staff schedule, visitor log and the monthly support tracking forms from 1/1/22 to 2/15/22 for the group home were reviewed and indicated the following: The staff schedule indicated on 1/11/22 staff #5 was scheduled to work from 8:00 PM to 8:00 AM. The visitor log and monthly support tracking form indicated staff #7 signed in at 8:20 AM and signed out at 12:00 AM, staff #2 signed in at 8:23 AM and did not sign out, staff # 4 signed in at 8:40 PM and signed out at 8:53 AM, former staff #9 signed in at 8:44 AM, AS #1 signed in at 8:00 AM and did not sign out and staff # 5 signed in at 9:13 PM and did not sign out. The review indicated when the incident occurred at 8:00 PM staff #7 was working. It cannot be determined if anyone else was working at the time of the incident due to staff not signing out. On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDPM indicated client C did not have alone time in the community. When asked if two staff were working when the incident took place, the QIDPM stated, "I believe that is accurate. We are double checking. We had additional people responding". 4. Observations were conducted at the group home on 2/14/22 from 1:25 PM to 1:55 PM and from 3:45 PM to 4:30 PM. Throughout the observation periods, client D had 1:1</p> |  |  |  |  |  |                            |

|  |  |  |  |  |  |  |                            |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>staffing each time she was out of her bedroom. On 2/15/22 at 12:30 PM, client D's 8/31/21 BSP was reviewed and indicated the following. Client D's target behaviors include self-injury behaviors, physical aggression, property disruption/destruction, verbal aggression, emotional manipulation, socially offensive behavior (invading personal space of others) and task refusal. "...[Client D] will have 1:1 staff as determined by the RM/QIDP/AS and Behaviorist. The purpose of the 1:1 is to provide uninterrupted observation and intervention of [client D] to decrease episodes of displays of behavior which can be harmful to [client D]...." On 2/15/22 at 3:50 PM, staff #1 was interviewed. Staff #1 indicated client A and client D both required 1:1 supervision, but client D was only 1:1 when she is out of her bedroom. Staff #1 indicated she works with one other staff. Staff #1 stated, "Since they took the med (medical) coach away and we don't have a manager, we have been short staffed lately. I don't think we are ever all the way staffed. It's only me and [staff #3] from 8a-8p now. Unless a manager is here. [AS #2] and [AS #1] both come in. Usually during the day at least one of them is here at some point". Staff #1 indicated the incidents with client A on 1/3/22, 1/7/22 and on 2/5/22 only two staff were working when the incidents occurred. On 2/15/22 at 5:00 PM, staff</p> |  |  |  |  |  |                            |

|  |   |  |  |  |  |  |                            |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>#3 was interviewed. Staff #3 indicated staffing was short and she only worked with one other staff from 8:00 AM to 8:00 PM. Staff #3 indicated AS #1 and AS #3 were usually at the home at some point throughout her shift. When asked about staffing after 5:00 PM, staff #3 stated, "It's not very often there are more than 2 staff". Staff #3 indicated there have been times where she had to be both 1:1 staff due to lack of staffing. Staff #3 stated, "We just kind of stay with them both. [Client D] spends a lot of time in her room". On 2/15/22 at 5:45 PM, AS #1 was interviewed. AS #1 indicated she worked off and on between 8:00 AM and 4:00 PM. AS #1 stated, "Staffing has been bad. Sickness, calling in, open positions. There's been multiple times where only 2 staff were working". AS #1 indicated client A was 1:1 at all times and client D was 1:1 when she's out of her room. AS #1 indicated two staff working would not be able to implement the plans as written. On 2/16/22 at 9:28 AM, the QAM, QIDPM and the QIDP were interviewed. The QIDP and QIDPM indicated client A was 1:1 and client D was 1:1 when she's outside of her bedroom. The QIDPM indicated the staffing level for the ESN (extensive support needs) was 3 staff on first shift, 3 staff on second shift and 2 staff on third shift. When asked if they were aware of any shifts which didn't have the correct number of staff, the</p> |  |  |  |  |  |                            |

|  |   |  |                     |   |  |  |  |
|--|---|--|---------------------|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING  |  | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE                 |  |
| W 0312<br><br>Bldg. 00   | <p>QIDPM stated, "Yes, we are". The QIDPM and the QIDP indicated it wasn't possible to implement the plans as written with only two staff working when the clients are awake. The QIDPM stated, "The Program Manager is responsible for ensuring the correct number of staff are scheduled. However, [QAM] and I monitor as well. When we discover insufficiencies, we point them out". The undated Reimbursement Guidelines for the 24 hour Extensive Support Needs/ESN Residences were reviewed on 2/17/22 at 10:00 AM. The guidelines indicated ESN homes "...Individuals living in residences under this category must be supervised at all times and the staffing pattern at full capacity should be a minimum of three (3) staff on the day shift; three (3) staff on the evening shift; and two (2) staff on the night shift." This federal tag relates to complaint #IN00370933.9-3-3(a)</p> <p>483.450(e)(2)<br/>DRUG USAGE</p> <p>be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (A), the facility failed to develop an active treatment program for the use of client A's PRN (as needed) psychotropic medications used for behavior control.</p> <p>Findings include:</p> |  | W 0312              | <p><b>CORRECTION:</b></p> <p><i>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and</i></p> |  | 03/18/2022                                 |  |

|  |  |  |  |  |   |  |                            |
|--|--|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |   | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|  | <p>On 2/15/22 at 12:50 PM, client A's record was reviewed and indicated the following.</p> <p>Discharge records from client A's inpatient psychiatric stay dated 1/11/22-1/19/22 indicated client A was prescribed "Haloperidol 5 mg (milligrams) tablet. Take one tablet (5 mg total) by mouth every 6 hours as needed for agitation".</p> <p>A 1/26/22 Record of Visit form from client A's Psychiatrist indicated the following medication was continued or changed: discontinue haldol 5 mg twice a day and continue haldol 5 mg every 6 hours as needed for severe agitation/anxiety/aggression and hydroxyzine 25 mg TID (three times a day) PRN for mild/moderate anxiety.</p> <p>Client A's 2/10/22 ISP (Individual Support Plan) and/or client A's 1/8/21 BSP (Behavior Support Plan) did not include an active treatment program for the use of haldol or hydroxyzine as PRN medications.</p> <p>On 2/16/22 at 9:28 AM, the QAM (Quality Assurance Manager), QIDPM (Qualified Intellectual Disabilities Professional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The QIDP indicated client A was prescribed haldol as needed for severe agitation and hydroxyzine was prescribed as needed for mild to moderate agitation. The QIDP indicated client A could request the PRN or staff could offer it to her. The QIDPM indicated the PRN medication should be included in client A's BSP.</p> <p>9-3-5(a)</p> |  |  |  | <p><i>eventual elimination of the behaviors for which the drugs are employed.</i> Specifically, the behavioral clinician has incorporated protocols for the use of an agitation PRN (as needed) medication into client A's Behavior Support Plan. A review of facility support plans and current medication orders indicated this deficient practice did not affect additional clients.</p> <p><b>PREVENTION:</b><br/>The behavioral clinician will be trained regarding the need to assure that active treatment programs are in place to support the reduction and eventual elimination of all currently prescribed psychotropic medications and that the use of all behavior controlling medications is incorporated into clients' behavior support plans. This training will include the need to incorporate specific protocols for the use of as needed psychotropic medications into clients' plans. Additionally, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will incorporate audits of support documents into visits to the facility</p> |  |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2022  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |  |   |  |                            |
|--|--|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>15G807 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                           |   | X3) DATE SURVEY<br>COMPLETED<br>02/17/2022 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY ALTERNATIVES ADEPT |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>213 W WATER ST<br>CENTERVILLE, IN 47330 |   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)  |  | (X5)<br>COMPLETION<br>DATE |
|  |  |  |  |  | no less than monthly to assure the plans include active treatment programs designed to reduce and eventually eliminate the use of behavior controlling medications.<br><b>RESPONSIBLE PARTIES:</b> QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director |  |                            |