STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 00 B. WING	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	6025 BUCKSKIN CT INDIANAPOLIS, IN 46250

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00276809. This visit was in conjunction with a post-certification revisit (PCR) to the full recertification and state licensure survey and the investigation of complaint #IN00272821 completed on 9/21/18. Complaint #IN00276809: Substantiated, Federal and state deficiencies related to the allegation are cited at W127 and W157. Dates of Survey: October 25, 26, 29 and 31, 2018. Facility Number: 000979 Provider Number: 15G465 AIMS Number: 100244860 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/7/18.	W 0000		
W 0127 Bldg. 00	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to prevent the continuous bruising and self-injury to client A. Findings include:	W 0127	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or*	11/30/2018

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

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	An observation was conducted at the group home on 10/25/18 from 6:13 AM through 8:00 AM. Client A was observed throughout the observation period. At 6:13 AM, staff #1 answered the door and let the surveyor into the group home. Staff #1 was the only staff on duty from 6:13 AM through 6:49 AM. At 6:26 AM client A was observed in the dining room of the group home. Client A was observed to have 2 bruises on her face and neck. Client A had a bruise 5 inches in diameter from her upper right cheek down to the base of her neck. The bruise was dark purple and had an irregular pattern at the top of the bruise. Client A had a bruise 2-3 inches in diameter on her left cheek. The bruise was a light purple. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/25/18 at 1:24 PM. A BDDS report dated 10/13/18 indicated on 10/12/18, "... On 10/12/18, [Client A] was observed by staff to have red areas on both of her cheeks. The areas are approximately 3 inch (by) 1.4 inch on her left cheek and 3 (by) 1 inches on right cheek. The [Agency] supervisor and nurse were made aware of this incident. As a precaution, [client A] was transported to [Name] Hospital Emergency Room for evaluation. Head, Macfacial and Spine CT (Computerized Tomography scans produced negative results. The RR (sic) physician diagnosed [client A] with contusion of the face and released her to [Agency] staff with no new orders...". A review of the BDDS report dated 10/13/18 indicated staff discovered 2 bruises to client A's right and left cheeks on 10/12/18. The review		*punishment.* Specifically, all facility staff will be retrained toward appropriate implantation of client A's behavior supports including proactive and reactive strategies to prevent and intervene with self-injurious behavior. Additionally, staff will complete daily body assessments to identify emerging patterns of injuries to facilitate prompt implementation of enhanced supervision to prevent further occurrences. **PREVENTION:** When incidents occur, The QIDP Manager will coordinate with the trained investigator through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager) The Residential Manager 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 including but not limited to assuring medications are administered as prescribed. Members of the Operations Team	

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	indicated client A was taken to the ER for evaluation and client A was diagnosed with contusions to her face. An IS (Investigative Summary) form dated 10/13/18 through 10/17/18 indicated, "... Summary of Interviews: ...". -"[Staff #3] I (staff #3) work 4 PM-12 AM. I haven't seen anyone hit [client A]. I (staff #3) would never hit her. Sometimes she (client A) hits herself. Usually she grabs her arms when she (client A) SIB's (Self-Injurious Behavior). I (staff #3) know what happened. We thought it was a rash. When we saw it, we called the nurse and [PM (Program Manager #1]." -"[Staff #2] I (staff #2) work 8 AM-8 PM. Lately I have been 1:1 (one to one) with [client B]. I've been at the hospital with him (client B) since he went in (to the hospital). I (staff #2) don't know what happened to [client A]. I haven't been at the house. She (client A) does hit herself and grab herself sometimes but I have been with [client B]." -"[Staff #4] The last few days I worked 8 AM-12 AM. I don't know what happened to [client A]. I (staff #4) haven't seen anybody hit her. She (client A) hits other people but not lately. I (staff #4) haven't seen her (client A) hit herself in the last few days but she has done that before. When we took her to the ER (Emergency Room), we thought she had a rash...". -"[Staff #1] I work 8 PM-8 AM. [Client A] has been sleeping. I (staff #1) don't know what happened to her face. [Staff #3] told me it was a rash. I haven't seen anyone hit her (client A). Of course I (staff #1) haven't hit her. Sometimes she (client A)gets upset in the morning. I (staff #1)		(comprised of the Executive Director, Operations Directors, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will review facility support documents and perform visual assessments of the facility no less than weekly until all staff demonstrate competence. After of 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. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot	

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	have seen her (client A) hit herself but not in the past 2 days...". -"Conclusion:" -"1. The evidence does not substantiate that a housemate caused the contusions on [client A's] face, discovered on 10/12/18." -"2. The evidence does not substantiate that a staff person is responsible for supporting [client A] caused the contusion on [client A's] face, discovered on 10/12/18." -"3. The evidence substantiated that the contusions discovered on [client A's] face on 10/12/18 most likely from self-injurious behavior." A review of the IS dated 10/13/18 through 10/17/18 indicated staff stated they had observed client A having had self-injurious behavior in the past. The review indicated the facility concluded the contusions/bruises to client A's face were most likely caused by client A's self-injurious behavior. A ROV (Record Of Visit) form dated 10/12/18 and completed by the ER Physician indicated, "Reason For Visit: Discoloration on both sides of face. Results/Findings of examination: no fractures or displacements. Diagnosis: Contusion of face...". Client A's record was reviewed on 10/25/18 at 1:17 PM. Client A's BSP (Behavior Support Plan) dated 8/27/18 indicated, "... On 9/1/2018, the IDT (Interdisciplinary Team) decided that [client A] will be placed on Enhanced Supervision 1:1 staff		checks later in the evening toward bed time. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring Behavior interventions are implemented as written and protective measures are developed and implemented as needed. **RESPONSIBLE PARTIES:** QIDP,	

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	anytime she (client A) begins to target or show aggression toward any of her peers...". -"Target Behaviors and Goals:" -"Self-Injurious Behaviors (SIB): any time [client A] causes an injury to herself that results in an injury, first aid, or and medical treatment...". A review of client A's BSP dated 8/27/18 indicated client A had a target behavior for SIB. The review indicated client A was to be placed on enhanced one to one supervision whenever she became physically aggressive towards her peers. Client A's ABC (Antecedent Behavior Consequence) forms were reviewed. Client A's ABC tracked client A's Target Behaviors. Client A's ABC form dated 10/8/18 to 10/14/18 listed no instances of self-injurious behaviors. Client A's ABC form dated 10/15/18 to 10/21/18 listed no instances of self-injurious behaviors. Client A's DPN (Daily Progress Note) form dated 10/11/18 indicated, "... [Client A] arrived safely from day service, ate well, had her medication. Staff ensured she had her bath. There was no issue observed." Client A's DPN form dated 10/12/18 indicated, "... [Client A] had a great day. Staff ensured she (client A) had her personal hygiene, medications taken, ate dinner very well, no issue observed." A review of the DPN dated 10/12/18 did not indicate documentation client A had bruises on her face and was taken to the ER for a medical evaluation. Client A's DPN form dated 10/13/18 indicated, "...		Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	

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	[Client A] was coming out her (sic) when I (staff) got here. She (client A) took her afternoon med, ate dinner and was later taken out with staff and one other staff and individual." Client A's DPN form dated 10/24/18 indicated, "... [Client A] was in the house when staff arrived at site (group home). She (client A) didn't attend day service today. Staff was told when arrived from another staff that [client A] was sent back home because she (client A) pee (sic). She (client A) ate well, had her medications, bath before going to bed." A review of the DPN dated 10/24/18 did not indicate documentation regarding bruises/contusions to client A's face. Client A was interviewed on 10/25/18 at 6:28 AM. Client A was asked how she received the bruises to her face. Client A stated, "She hit me, [client D]. I'm going to bust (hit) her in her [expletive] face." Staff #1 was interviewed on 10/25/18 at 6:20 AM. Staff #1 was asked if had noticed the bruises on client A's face. Staff #1 stated, "No, not recently. I just returned to work on Tuesday (10/22/18) night. I never noticed anything on her (client A)." Staff #2 was interviewed on 10/25/18 at 6:51 AM. Staff #2 was asked when he noticed bruises on client A's face. Staff #2 stated, "That would have been last week. All this on her (client A's) face. I (staff #2) don't know what happened." Staff #2 was asked if he had reported client A's bruises to anyone. Staff #2 stated, "Yes we reported. We (staff) called the on-call nurse. I believe we did an incident report. I (staff #2) noticed some changes here, her face. I noticed it when she (client A) got back from day services. It (bruising) was little			

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	then." QAM (Quality Assurance Manager) #1 was interviewed on 10/26/18 at 12:15 PM. QAM #1 was asked if the facility's investigation regarding bruises to both sides of client A's face ,which were reported on 10/13/18, substantiated the bruises were most likely caused by self-injury. QAM #1 stated, "Yes." QAM #1 was asked if client A still had a 5 inch bruise on her right cheek/neck and a 2-3 inch bruise on her left cheek/neck. QAM #1 stated, "She will be assessed by a nurse today." QIDPM (Qualified Intellectual Disabilities Professional) #1 was interviewed on 10/26/18 at 12:30 PM. QIDPM #1 was asked if group home staff had documented the bruises to client A's face from 10/12/18 through 10/25/18. QIDPM #1 stated, "There should have been an injury flow chart." QIDPM #1 was asked if staff had observed client A hitting herself in the face. QIDPM #1 stated, "They (staff) have. They hadn't noticed it at the time the bruises appeared. My concern is that they (staff) have been de-sensitized to observing it, observing self-injurious behavior day in and day out. That's why we (Facility) need to re-open the investigation." This federal tag relates to complaint #IN00276809. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 1 of 9 allegations of abuse, neglect and mistreatment reviewed, the facility failed to	W 0157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must*	11/30/2018

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	implement effective corrective measures to prevent bruising to client A's face. Findings include: An observation was conducted at the group home on 10/25/18 from 6:13 AM through 8:00 AM. Client A was observed throughout the observation period. At 6:13 AM, staff #1 answered the door and let the surveyor into the group home. Staff #1 was the only staff on duty from 6:13 AM through 6:49 AM. At 6:26 AM client A was observed in the dining room of the group home. Client A was observed to have 2 bruises on her face and neck. Client A had a bruise 5 inches in diameter from her upper right cheek down to the base of her neck. The bruise was dark purple and had an irregular pattern at the top of the bruise. Client A had a bruise 2-3 inches in diameter on her left cheek. The bruise was a light purple. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/25/18 at 1:24 PM. A BDDS report dated 10/13/18 indicated on 10/12/18, "... On 10/12/18, [Client A] was observed by staff to have red areas on both of her cheeks. The areas are approximately 3 inch (by) 1.4 inch on her left cheek and 3 (by) 1 inches on right cheek. The [Agency] supervisor and nurse were made aware of this incident. As a precaution, [client A] was transported to [Name] Hospital Emergency Room for evaluation. Head, Macfacial and Spine CT (Computerized Tomography scans produced negative results. The RR (sic) physician diagnosed [client A] with contusion of the face and released her to [Agency] staff with no new orders...".		*be taken.* Specifically, all facility staff will be retrained toward appropriate implantation of client A's behavior supports including proactive and reactive strategies to prevent and intervene with self-injurious behavior. Additionally, staff will complete daily body assessments to identify emerging patterns of injuries to facilitate prompt implementation of enhanced supervision to prevent further occurrences. **PREVENTION:** When incidents occur, The QIDP Manager will coordinate with the trained investigator through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager) The Residential Manager 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 including but not limited to assuring medications are administered as prescribed. Members of the Operations Team	

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	A review of the BDDS report dated 10/13/18 indicated staff discovered 2 bruises to client A's right and left cheeks on 10/12/18. The review indicated client A was taken to the ER for evaluation and client A was diagnosed with contusions to her face. An IS (Investigative Summary) form dated 10/13/18 through 10/17/18 indicated, "... Summary of Interviews: ...". -"[Staff #3] I (staff #3) work 4 PM-12 AM. I haven't seen anyone hit [client A]. I (staff #3) would never hit her. Sometimes she (client A) hits herself. Usually she grabs her arms when she (client A) SIB's (Self-Injurious Behavior). I (staff #3) know what happened. We thought it was a rash. When we saw it, we called the nurse and [PM (Program Manager #1]." -"[Staff #2] I (staff #2) work 8 AM-8 PM. Lately I have been 1:1 (one to one) with [client B]. I've been at the hospital with him (client B) since he went in (to the hospital). I (staff #2) don't know what happened to [client A]. I haven't been at the house. She (client A) does hit herself and grab herself sometimes but I have been with [client B]." -"[Staff #4] The last few days I worked 8 AM-12 AM. I don't know what happened to [client A]. I (staff #4) haven't seen anybody hit her. She (client A) hits other people but not lately. I (staff #4) haven't seen her (client A) hit herself in the last few days but she has done that before. When we took her to the ER (Emergency Room), we thought she had a rash...". -"[Staff #1] I work 8 PM-8 AM. [Client A] has been sleeping. I (staff #1) don't know what		(comprised of the Executive Director, Operations Directors, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) will review facility support documents and perform visual assessments of the facility no less than weekly until all staff demonstrate competence. After of 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. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot	

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	happened to her face. [Staff #3] told me it was a rash. I haven't seen anyone hit her (client A). Of course I (staff #1) haven't hit her. Sometimes she (client A)gets upset in the morning. I (staff #1) have seen her (client A) hit herself but not in the past 2 days...". -"Conclusion:" -"1. The evidence does not substantiate that a housemate caused the contusions on [client A's] face, discovered on 10/12/18." -"2. The evidence does not substantiate that a staff person is responsible for supporting [client A] caused the contusion on [client A's] face, discovered on 10/12/18." -"3. The evidence substantiated that the contusions discovered on [client A's] face on 10/12/18 most likely from self-injurious behavior." A review of the IS dated 10/13/18 through 10/17/18 indicated staff stated they had observed client A having self-injurious behavior in the past. The review indicated the facility concluded the contusions/bruises to client A's face were most likely caused by client A's self-injurious behavior. Client A's DPN (Daily Progress Note) form dated 10/11/18 indicated, "... [Client A] arrived safely from day service, ate well, had her medication. Staff ensured she had her bath. There was no issue observed." Client A's DPN form dated 10/12/18 indicated, "... [Client A] had a great day. Staff ensured she (client A) had her personal hygiene, medications taken, ate dinner very well, no issue observed."		checks later in the evening toward bed time. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: ·The role of the administrative monitor is not simply to observe & Report. ·When opportunities for training are observed, the monitor must step in and provide the training and document it. ·If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. ·Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. ·Review all relevant documentation, providing documented coaching and training as needed. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring Behavior interventions are implemented as written and protective measures are developed and implemented as needed. **RESPONSIBLE PARTIES:** QIDP,	

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	A review of the DPN dated 10/12/18 did not indicate documentation client A had bruises on her face and was taken to the ER for a medical evaluation. Client A's DPN form dated 10/13/18 indicated, "... [Client A] was coming out her (sic) when I (staff) got here. She (client A) took her afternoon med, ate dinner and was later taken out with staff and one other staff and individual." Client A's DPN form dated 10/24/18 indicated, "... [Client A] was in the house when staff arrived at site (group home). She (client A) didn't attend day service today. Staff was told when arrived from another staff that [client A] was sent back home because she (client A) pee (sic). She (client A) ate well, had her medications, bath before going to bed." A review of the DPN dated 10/24/18 did not indicate documentation regarding bruises/contusions to client A's face. Staff #1 was interviewed on 10/25/18 at 6:20 AM. Staff #1 was asked if had noticed the bruises on client A's face. Staff #1 stated, "No, not recently. I just returned to work on Tuesday (10/22/18) night. I never noticed anything on her (client A)." Staff #2 was interviewed on 10/25/18 at 6:51 AM. Staff #2 was asked when he noticed bruises on client A's face. Staff #2 stated, "That would have been last week. All this on her (client A's) face. I (staff #2) don't know what happened." Staff #2 was asked if he had reported client A's bruises to anyone. Staff #2 stated, "Yes we reported. We (staff) called the on-call nurse. I believe we did an incident report. I (staff #2) noticed some changes here, her face. I noticed it when she (client A) got		Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 00 B. WING	10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	back from day services. It (bruising) was little then." QIDPM (Qualified Intellectual Disabilities Professional) #1 was interviewed on 10/26/18 at 12:30 PM. QIDPM #1 was asked if group home staff had documented the bruises to client A's face from 10/12/18 through 10/25/18. QIDPM #1 stated, "There should have been an injury flow chart." QIDPM #1 was asked if staff had observed client A hitting herself in the face. QIDPM #1 stated, "They (staff) have. They hadn't noticed it at the time the bruises appeared. My concern is that they (staff) have been de-sensitized to observing it, observing self-injurious behavior day in and day out. That's why we (Facility) need to re-open the investigation." QIDPM #1 indicated the facility would develop corrective measures based on recommendations from the IDT and the new investigation regarding the significant bruising to both sides of client A's face. This federal tag relates to complaint #IN00276809. 9-3-2(a)			