PRINTED: 02/08/2023
FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465			(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/21/2022	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
W 0000						
Bldg. 00	#IN00393849 and Complaint #IN003 and State deficience were cited at: W14 Complaint #IN003 and State deficience were cited at: W14	93849: Substantiated, Federal cies related to the allegation(s) 9 and W186.  95040: Substantiated, Federal cies related to the allegation(s) 9 and W186.	W 0000			
W 0149 Bldg. 00	Facility Number: (Provider Number: AIMs Number: 10  These deficiencies accordance with 44  483.420(d)(1)  STAFF TREATM The facility must written policies a mistreatment, ne Based on record resampled clients (Atheir policies and pelopements and SI incidents involving Findings include:  The facility's BDE Disabilities Service	also reflect state findings in 60 IAC 9.  ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client. View and interview for 1 of 3 ), the facility failed to implement procedures to prevent B (Self-Injurious Behavior) as client A.  S (Bureau of Developmental less) reports and investigations 12/15/22 at 11:50 AM and	W 0149	CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abust the client. Specifically, direct support staff have been retrained on client A's behavior support including but not limited to one-to-one supervision protocoprevention:	se of ned s,	

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

TITLE (X6) DATE

Bob Morris QIDP Manager 01/23/2023

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G465	B. W	ING		12/21/	2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			UCKSKIN CT		
COMMU	JNITY ALTERNATIV	/ES-ADEPT	INDIANAPOLIS, IN 46250				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDENS NAMES CORRES		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE.	DATE
					A management staff will be		
	1. A BDDS report	dated 10/31/22 indicated, "On			present, supervising active		
	1	30/22, [client A] told staff he			treatment during no less than	five	
	needed to go to the hospital, walked to out of the				active treatment sessions per		
	_	11 from his personal phone.			week, on varied shifts to assu	re	
		lost line of sight and staff			staff implement clients' Behav		
		or to assist with searching for			Support Plans, as written. For		
	•	or located [client A] with police			next 30 days, members of the		
	•	ction of [name of road] and			Operations Team (comprised		
		d police transported [client A]			the Executive Director, Opera		
	to the [name of hospital] Emergency Department,				Managers, Program Managers		
	_	ed by ResCare staff. Before			Quality Assurance Manager, (		
	1	lient A] ran from the ER			Manager, QIDPs, Quality	~. <b>-</b> .	
		). Staff followed but lost line of			Assurance Coordinators, Area	a	
		r, [client A] was located at the			Supervisors, and Nurse Mana		
	_	Heart Emergency Department.			will conduct twice weekly	J/	
		ed to leave the Heart Hospital			administrative monitoring during	na	
		rted him to the [name of			varied shifts/times, to assure	9	
		al Health Unit for a psychiatric			interaction with multiple staff,		
		n assessment, the crisis team			involved in a full range of activ	/e	
		to ResCare staff with a safety			treatment scenarios. After 30	-	
		ation changes. Upon returning			days, administrative monitorin	α	
	_	illed 911 again and ran from the			will occur no less than weekly	•	
		red but lost line of sight and			until all staff demonstrate		
		Client A] was located talking to			competence. After this period	of	
		orted him the the [name of			enhanced administrative	•	
		it for evaluation. The			monitoring and support, the		
	^ -	sed [client A] with Suicidal			Executive Director and Region	nal	
	1	sed him to ResCare staff with			Director will determine the leve		
		on returning home, [client A]			ongoing support needed at the		
	_	called 911 and walked out of the			facility. Current Operations Te		
	_	red, lost line of sight briefly and			members received training fro		
		in the neighborhood. [Client A]			the QIDP Manager to assure a		
		to be seen at the [name of			clear understanding of	-	
		cy Department. Prior to police			administrative monitoring as		
		orted [client A] to the ER per			defined below.		
	_	t A] does not have approved			• The role of the		
	_	s away from staff line of sight			administrative monitor is not		
		1 hour. Elopement and frivolous			simply to observe & report.		
	Tot approximately	i nour. Diopenient and nivolous	- 1		I simply to observe a report.		

911 calls will be included in [client A's] initial

0PXO11

When opportunities for

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	ETED
		15G465	B. W	ING		12/21/2	2022
				CTREET	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
00040411		EO ADEDT			UCKSKIN CT		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Behavior Support P	lan".			training are observed, the mor	nitor	
					must step in and provide the		
	An IS (Investigation Summary) dated 11/4/22 indicated the following:				training and document it.		
					If gaps in active treatme	nt	
					are observed the monitor is		
	-"Introduction				expected to step in and model	the	
	On 10/30/22 Individ	dual [client A] told staff he			appropriate provision of suppo	orts.	
	_	hospital, walked to out of the			· Assuring the health and		
		1 from his personal phone.			safety of individuals receiving		
		lost line of sight and staff			supports at the time of the		
	-	or to assist with searching for			observation is the top priority.		
	-	r located [client A] with police			· Review all relevant		
	in the at the intersection of [name of street] and				documentation, providing		
	-	d police transported [client A]			documented coaching and tra	ining	
	-	pital] Emergency Department,			as needed		
	-	d by ResCare staff. Before			Administrative oversight will		
	-	ient A] ran from the ER. Staff			include assuring staff impleme	ent	
		ne of sight. Minutes later,			behavior supports as written.		
		ed at the [name of hospital]			RESPONSIBLE PARTIES: QI		
		ment. He (client A) refused to			Area Supervisor, Direct Suppo		
		ospital and police transported			Staff, Operations Team, Region	onal	
	_	hospital] Behavioral Health			Director		
		ic evaluation. After an					
		is team released [client A] to					
	ResCare staff with						
		. Upon returning home, [client and ran from the house. Staff					
	, ,	and ran from the nouse. Staff ne of sight and initiated a					
		vas located talking to police,					
		n to [name of hospital] Crisis					
	-	The psychiatrist diagnosed					
		idal Ideations and released him					
		th no new orders. Upon					
		ient A] remained agitated called					
		of the house. Staff followed,					
		efly and found him walking in					
		Client A] insisted he needed					
		me of hospital] Emergency					
	_	o police arrival, staff					
	transported [client A	-					
		1) to the Die per into					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		15G465	B. W	ING		12/21	/2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
COMMU		VEC ADEDT			JCKSKIN CT		
COMMO	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	requestThe ER Pl	hysician diagnosed [client A]					
	with Auditory Hall	ucinations, Foley Catheter in					
	Place, and Acute C	ystitis without Hematuria					
	(sudden inflammati	on of the urinary bladder) and					
	released him to Res	Care staff with a prescription					
	for Keflex (infectio	n). Upon returning home, [client					
	I -	the yard, called 911 and					
		ving a seizure (he was not).					
		transported [client A] to the					
		Emergency Department. After					
		nt, [client A] was admitted for					
	psychiatric observa	tion.					
	Scope of Investigat						
		Initial Behavior Support Plan					
	fail to address Elop						
		Initial Behavior Support Plan					
	fail to address Frive						
		elient A] without staff					
	supervision?						
		follow ResCare's Policies and					
	Procedures?						
	FG. 00.1107						
	[Staff #2]						
	1 2 2 1	ned the front door and left.					
		unning, I (staff #2) was trying					
	to follow him (clier						
		ny car; I was looking for him					
	(client A).	1					
	_ `	client A] at [name of street].					
		ng to verbally redirect [client					
	A] and calm him.	1 1 1					
		up and an ambulance. took [client A] to the hospital.					
	But [client A] run f						
	Dui [cheni A] run f	rom me nospitai.					
	[Staff #3]						
		I (staff #3) arrived at the					
		as sitting on the couch.					
		ne he didn't want to be here					
	The (cheffit A) told h	ne ne ulun i wani to de nere					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15G465	B. W	ING		12/21	/2022
NAME OF T	DROLUDER OF GUREY TO		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		6025 BI	UCKSKIN CT		
COMMU	NITY ALTERNATIV	'ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	anymore.	R LSC IDENTIFYING INFORMATION		TAG	bei telever,		DATE
	1 -	tside to talk to the other					
	consumers.	iside to talk to the other					
	[Client A] came storming out of the house.						
	[Client A] walked to the street, I was verbally						
	redirecting [client A	A].					
	[Client A] was on the phone; he was calling 911						
	and just kept walking.						
		ff #2) followed [client A], but					
	she couldn't keep up	-					
	[client A].	got in her car and followed					
	[chefit A].						
	[Staff #4]						
	1	1, he then run out of the house.					
	I (staff #4) went aft						
	He (client A) kept s	saying he wanted to go to the					
	hospital.						
		ient A] to the hospital (after					
	_	neighbor during his last					
	elopement) in the v	an.					
	[Staff #5]						
	[Client A] called 91						
	[Client A] then left						
	[Staff #4] followed	= -					
		l up in at the hospital.					
	_	ived at the home, but [client A]					
	and already left.  [Staff #4] was with	him and took [client A] to the					
	emergency room.	mm and took [chefit A] to the					
	in the same of the						
	Factual Findings						
	[Staff #2] states [cl	ient A] just left through the					
		pement on 10/30/22). I (staff					
	#2) followed him.						
		en I (staff #3) arrived [client A]					
		ant to be here anymore and he					
	ran out the door.	iont Al colled 011 44					
	Staff #4   states   cli	ient A] called 911 and then run	- 1		I		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/21/2022	
	PROVIDER OR SUPPLIEF NITY ALTERNATIV		6025 BI	ADDRESS, CITY, STATE, ZIP COE UCKSKIN CT IAPOLIS, IN 46250	)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE COMPLETION
	I (staff #4) followed hospital.  [Staff #5] states [cli (second elopement followed him.  [Client A] has 0 (no was without staff stone hour.  [Client A] returned later.  [Client A's] initial Hourselly in development, in development, in development, due to the state of the state	iated that [client A's] Initial Plan faiedl (sic) to address the plan not being in place liated that [client A's] Initial Plan failed to address Frivolous te plan not yet being in place ted that [client A] was without tr approximately one hour. liated that staff failed to follow and Procedures.			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		15G465	B. WI	NG		12/21/	2022
NAME OF P	DOMNED OF CLIPPLIES		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<b>C</b>		6025 BL	JCKSKIN CT		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIATE		TE.	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Client A's record in	diamental and IDT					
		eam) Meeting form dated					
		form dated 10/31/22 indicated					
	the following:	iorni dated 10/31/22 indicated					
	the following.						
	-"Meeting Agenda/	Topics Discussed/Plan					
	Changes						
	[CI: 4 A ] 1	1 11 1011 10/20/20 : 1					
	[Client A] eloped an taken to the hospital	nd called 911 on 10/30/22 to be					
	-	eleased and when he returned					
		second time and was taken to a					
	-	ere he was admitted for					
	psychiatric observat						
	Action Steps:						
	- ,	laster Level Behavioral					
		ssistance with assessment and					
	development of init						
	_	as Target Behavior in BSP					
	(Behavioral Suppor	t Plan)."					
	2. A BDDS report of	lated 11/2/22 indicated, "On the					
	•	2 (sic) (11/1/22), [client A] ran					
	out of the home's fr	ont door and staff were not					
	able to maintain line	e of sight. Staff and					
	supervisors initiated	d a search of the					
	neighborhood. Prior	r to locating him, a neighbor					
	observed						
		he road and called 911. Police					
		A] to [name of hospital]					
		ment for a psychiatric					
		e staff went to the hospital to					
		A] is scheduled to initiate					
		rough his psychiatric provider					
		ranged for a Master's level to assess [client A] and assist					
		propriate behavior supports.					
		ain on line of sight supervision					
	Loucht 11 will tellic	an on the of sight supervision					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 12/21/2022	
	ROVIDER OR SUPPLIER		6025	T ADDRESS, CITY, STATE, ZIP COD BUCKSKIN CT NAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
		i-minute checks while sleeping Il be installed pending Human approval".			
	11/2/22, [name of It residential supervision being discharged for detention. Before Reloped from the hosearch and filed a molice, who informereceiving an addition [name of hospital]. permitted to provide during the assessment ResCare staff were ready for discharge hospital] personnel would be released, and a fork, and wout to attempt to remove scheduled to initiate psychiatric provide initial assessment in documentation to a clinician to assess [developing appropring thave document non-food objects procurrent home on 10 [client A] will remay while awake and 15 and door alarms will have document will have document will and door alarms will have document will have a subject will have	dated 11/3/22 indicated, "On pospital] staff called the or and said [client A] was ome emergency psychiatric person responsively. [client A] spital. ResCare initiated a phissing person report with the ed staff that [client A] was onal psychiatric evaluation at ResCare staff were not be supervision or support ent. Later in the evening, informed that [client A] was a whole when the content of the supervision and the supervision of the supervisio			
	_	or and said [client A] was			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G465	B. W	ING		12/21/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			JCKSKIN CT		
COMMUI	NITY ALTERNATIV	'FS-ADFPT		1	APOLIS, IN 46250		
	ı			<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		om emergency psychiatric					
		ResCare staff arrived, [client A]					
	eloped from the hospital. ResCare initiated a search and filed a missing person report with the						
	1 ~	ed staff that [client A] was onal psychiatric evaluation at					
	_	ResCare staff were not					
		e supervision or support					
		ent. Later in the evening,					
	_	informed that [client A] was					
		. When staff arrived, [name of					
		reported that when told he					
		[client A] swallowed a spoon					
	and a fork, and would be receiving an endoscope						
	to attempt to remove the objects.						
	_						
	[Staff #6]						
	[Individual's name]	from [name of hospital] called					
	saying [client A] wa	as getting discharged.					
	_	ospital] also stated [client A]					
	left the hospital.						
		ook for [client A] and called					
	the police.						
	1	nd about any hour later at					
	[name of hospital].						
		(sic) a fork and spoon while					
	there (at the hospita	al) and he was admitted.					
	[Stoff #7]						
	[Staff #7]	Lagrina Caliant Alvuga baina					
		l saying [client A] was being ame of hospital] and that he					
	(client A) left.	ame of nospital and that he					
		ook for him, and called the					
	police.	took for min, and cance the					
	_	nd at [name of hospital].					
		t go back with [client A].					
	` ′	getting ready to leave and he					
	swollen (sic) a spoo						
	Spot						
	Factual Findings						
			1				

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

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMPLE	(X3) DATE SURVEY COMPLETED 12/21/2022	
	PROVIDER OR SUPPLIE		6025 B	ADDRESS, CITY, STATE, ZIP COD UCKSKIN CT IAPOLIS, IN 46250	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
		ame of hospital] called and said				
		g discharged and that he had				
	left the hospital.					
		lient A] swollen (sic) a spoon				
		dmitted to [name of hospital]. receiving ResCare supports at				
	the time of the inci					
		e [client A's] initial Behavior				
	_	been hindered due his frequent				
	inpatient hospitaliz	rations.				
	Conclusion					
		riated that [client A's] Initial				
		Plan failed to address				
	elopement, due to the plan still being in development.					
	_	iated that [client A's] Initial				
		Plan failed to address				
		od items, due to the plan still				
	being in developme	_				
	3. It is not substant	iated that staff failed to follow				
	ResCare's Policies	and Procedures.				
	Recommendations					
	Provide [MLBC #1					
	documentation.					
	_	non-food items as Target				
	Behavior in BSP.					
		e checks upon return from				
	hospital."					
	Client A's record in	ndicated an IDT Meeting Form				
		IDT form dated 11/3/22				
	indicated the follow					
	113.6	/m ' D' 1/21				
		Topics Discussed/Plan				
	Changes					
		and made a frivolous 911 call on				
	11/1/22 and was re	-hospitalized.		1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/21/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	He eloped from the he would be discha	hospital on 11/2/22 when told rged and ran to another ER d additional non-food items.						
	Behavior in BSP. Obtain HRC (Humato secure silverward Continue 15-minute hospital".  4. A BDDS report of the evening of 11/1 and out of the group swallowed a toothborun down the street maintain line of sig supervisors initiated neighborhood. App [client A] was local road] and [name of and paramedics. EM Services) transported hospital] Emergence evaluation. ResCarmeet him. [Client A with a diagnosis of the will be receiving remove the object initiate behavior the provider and his teat assessment informat documentation to a clinician to assess [developing approprime returns home, [c	non-food items as Target  an Rights Committee) approval e and small objects. e checks upon return from  dated 11/12/22 indicated, "On 1/22, [client A] was pacing in p home stating he had rush. [Client A] then began to and staff were not able to ht. Staff and d a search of the roximately 20 minutes later, ted at the corner of [name of road], along with the police MS (Emergency Medical ed [client A] to [name of ry Department for an e staff went to the hospital es Swallowing a Foreign Object. g an endoscope to attempt to .[Client A] is scheduled to erapy through his psychiatric um has provided initial attion and incident master's level behavioral client A] and assist with riate behavior supports. When lient A] will remain in						
	ine-of-sight superv	rision at all times, and door						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G465		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY  MPLETED  21/2022	
	PROVIDER OR SUPPLIEF NITY ALTERNATIV		6025 B	ADDRESS, CITY, STATE, ZIP CO UCKSKIN CT JAPOLIS, IN 46250	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	An IS dated 11/16/2	22 indicated the following:				
	the group home start toothbrush. [Client the street, and staff of sight. Staff and state neighborhood. A later, [client A] was of street] and [name police and paramed to the [name of hos for an evaluation. R hospital to meet him the hospital with a G Foreign Object. He	t A] was pacing in and out of cing he had swallowed a A] then began to run down were not able to maintain line upervisors initiated a search of Approximately 20 minutes a located at the corner of [name to of street], along with the ics. EMS transported [client A] pital] Emergency Department tesCare staff went to the in. [Client A] was admitted to diagnosis of: Swallowing a (client A) will be receiving an put to remove the object.				
	[Client A] started p He (client A) then s toothbrush.	ollow [client A]. medics found him.				
	[Client A] then said toothbrush.  We called the super A] left the home.	arted pacing around.  The had swollen (sic) a  rvisor and that is when [client e was found by the police and				

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Event ID:

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Facility ID: 000979

If continuation sheet

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15G465	A. BUILDING B. WING	00	COMPLETED 12/21/2022
		1.5.00		ADDRESS CITY STATE ZID COD	,_,_,,_
NAME OF P	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD UCKSKIN CT	
COMMUI	NITY ALTERNATIV	'ES-ADEPT		APOLIS, IN 46250	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	paramedics.	ok him to the hospital.			
	-	gone for about 20 minutes			
	before he was found				
	octore ne was round	<b>u.</b>			
	Factual Findings				
		(client A) said he (client A)			
	had swollen (sic) a toothbrush. [Client A] then left the home.  [Staff #9] states [client A] just started pacing around the house, he (client A) then said he (client A) had swollen (sic) a toothbrush and left				
	the home.	.)1			
		b) plan approved alone time and upervision for approximately 20			
	minutes.	apervision for approximately 20			
		al], [client A] was diagnosed			
	with Swallowed Fo				
		-			
	Conclusion				
		iated that [client A's] Initial			
		Plan failed to address			
	-	he plan being in development.			
		iated that [client A's] Initial			
		Plan failed to ingest non-food			
	-	an being in development.  I that [client A] was without			
		r approximately 20 minutes.			
	-	iated that staff failed to follow			
	ResCare's Policies				
	Recommendations:				
	Provide [MLBC #1	] with all incident			
	documentation.				
		one observation, while plan as			
	a whole is in develo	-			
		nplementation of 1:1			
	supervision.				
	Discuss Waiver nla	cement to arrange for safer	I	I	

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environment."

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	COMPLETED	
		15G465	B. W	ING		12/21/	2022	
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD			
00141411		EO ADEDT			JCKSKIN CT			
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	Client A's record in	dicated hospital discharge						
		d 11/11/22. The after visit						
	summary form dated 11/11/22 indicated the following:  -"Reason for Hospitalization Your (client A's) primary diagnosis was							
		Body Initial Encounter						
	8							
	Swallowed Foreign Body Based on your (client A's) evaluation, no							
		at this time. The swallowed						
		o move through your digestive						
		ne body in the stool with no						
	problems".	ie dody in the stoot with ho						
	proorems							
	Client A's record in	dicated an IDT Meeting Form						
		e IDT form dated 11/12/22						
	indicated the follow							
	marcarea and remen							
	-"Meeting Agenda/	Topics Discussed/Plan						
	Changes							
	_	nour and a half after returning						
		italization on 11/11/22, [client						
	• •	lowed a toothbrush and						
	eloped.							
		as taken to [name of hospital]						
	by EMS and Admit							
	-	he hospital, his BC (Behavioral						
		een able to complete a						
	face-to-face assessn	-						
	1400 10 1400 45505511	110110.						
	Action Steps:							
	Provide [MLBC #1]	l with all incident						
	documentation.	, un mordent						
	Install door alarms.							
		urs a day/7 days per week) one						
	to one observation.	ars a day / days per week) one						
		unlamantation of 1.1						
	Train all staff on im	ipiementation of 1:1						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/21/2022	
	PROVIDER OR SUPPLIER		6025 BI	ADDRESS, CITY, STATE, ZIP CO UCKSKIN CT APOLIS, IN 46250	DD .
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
	supervision. Discuss Waiver pla environment".	cement to arrange for safer			
	the morning 11/22/home's front door a contacted the reside [client A] three blowillingly rode back with the supervisor elopement addresse Plan. He does not hand was away from approximately five one-to-one supervisor prevent further occurrained toward propenhanced supervision	[Client A] has a history of ed in his Behavior Support ave plan approved alone time a staff supervision for minutes. [Client A] will receive sion to help reduce and urrences, and all staff will be per implementation of the on protocols".			
	-"Introduction On the morning 11/home's front door a contacted the reside [client A] three blowillingly rode back supervisor.  [Staff #10] I (staff #10) was ge medications ready in [Client A] sneaked I (staff #10) didn't If At first, he (client A) with me. He (client A) went That is when he (cl	know he (client A) left.  A) was in the medication room			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPI	
		15G465	B. WI	NG		12/21	/2022
NAME OF I	PROVIDER OR SUPPLIE	D	•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					UCKSKIN CT		
COMMU	NITY ALTERNATI\	/ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 1	im a couple of blocks away.					
	[Client A] returned	home with me.					
	Factual Findings						
	_	[Staff #10] states [client A] was in the medication					
	room with me, he (client A) said he (client A) was going to the bathroom, and he (client A) left.  [Staff #10] did not follow [client A] to the bathroom, per the plan (BSP).						
	Conclusion						
	<ol> <li>It is not substantiated that [client A's] Behavior</li> <li>Support Plan failed to address Elopement.</li> <li>It is substantiated that [client A] was without</li> </ol>						
	staff supervision.	d that [chefit A] was without					
	_	d that [client A] was without					
		or approximately 5 minutes.					
	^	d that staff failed to follow					
	[client A's] Behavi						
		iated that staff failed to follow					
	ResCare's Policies	and Procedures.					
	Recommendations						
		[client A's] Behavior Support					
	Plan.	[enem 713] Behavior Support					
		eive 24/7 one to one staffing.					
		on the one to one protocols".					
	( ) DDD2	1 . 111/00/02					
	_	dated 11/29/22 indicated, "On					
	_	] was at home with his					
		he other staff on duty was  A's] housemates to their day					
		A's] nousemates to their day A's] one-to-one staff used the					
	_	finished [client A]					
		rallowed a toothbrush. Staff					
		isor and nurse and transported					
	_	f hospital] Emergency					
		rse instructions. After an initial					
		ending physician admitted					
		[client A] to the hospital for observation[Client					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE C A. BUILDING	onstruction 00	(X3) DATE SURVEY COMPLETED	
		15G465	B. WING		12/21/2022
NAME OF P	ROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COD	
COMMUI	NITY ALTERNATIV	'ES-ADEPT		NAPOLIS, IN 46250	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		swallowing non-food items			
		havior Support Plan. ResCare ill assure sufficient staff are			
		[client A's] one-to-one			
	supervision when staff take care of personal needs".  Client A's record indicated an IDT Meeting Form				
		e IDT form dated 11/29/22			
	indicated the follow	ving:			
	-"Meeting Agenda/Topics Discussed/Plan Changes				
	=	at A] was home alone with his			
	1:1 staff.	used the bathroom, [client A]			
	swallowed a toothb				
		pitalized and the toothbrush			
		essfully via endoscope.			
	was removed succe	ssrany via endoscope.			
	Action Steps:				
	Provide [MLBC #1	] with all incident			
	documentation.				
	Assure two staff are	e present wherever [client A] is			
		supervision can be supported			
	when staff must tak	te care of personal needs".			
	7 A DDDG (	dated 12/0/22 indicated " On			
	•	dated 12/8/22 indicated, "On			
		complained to staff of I staff contacted the nurse and			
	•	ER, [client A] disclosed that he			
	_	zor which was confirmed by an			
		nputerized topography) scan.			
	· ·	admitted [client A] to the			
		for removal of the object and			
		ed to the facility's behavioral			
		unclear how [client A]			
		cause they are not currently			
	used in his home[	[Client A] has a history of			
	swallowing non-foo	od items addressed in his			
			I	I	1

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i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPLETED	
		15G465	B. WINC	·		12/21/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	ŕ	ΓAG	DEFICIENCY)		DATE
	Behavior Support P	lan. The interdisciplinary team					
		I that in addition to [client A's]					
	-	sion, staff will complete					
	-	e every half-hour to remove					
	-	A] could potentially swallow,					
		omplete a body check each					
		rns from outside of the home.  n members will train all staff on					
	implementation of [						
	protocois".	protocols".					
	Client A's record wa						
	AM. Client A's rec						
		2. The IDT form dated 12/7/22					
	indicated the follow						
	Meeting Agenda/To	opics Discussed/Plan Changes					
	During the overnigh	nt hours of 12/7/22, [client A]					
	-	re abdominal pain and was					
	taken to the ER.						
	1:1 staffing was in p						
	=	a] told staff he swallowed a					
	razor.						
	[Client A] was hosp	oitalized.					
	Action Steps:						
	Provide [MLBC #1]	l with all incident					
	documentation.	1 <del>m</del>					
		hour house sweeps,					
	-	to 1 staff to not draw					
	attention to the task						
	Complete Body che	ecks each time [client A]					
		away from the home.					
		n members to provide all house					
		with retraining on 1:1					
	-	ng on new house sweep					
	protocol".						
		1.10/7/00 : 1:					
		ed 12/7/22 indicated the					
	following:		1				

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

PRINTED: 02/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. H.		A. BU	A. BUILDING 00 C			ETED 2022			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	-"Plan Date: 11/17/	22, revised 12/7/22							
	since Consumer's tr placement are: Phys Intimidation; Verba calls and Elopemen Medication Seeking Additional behavior they have been obse in/displayed by Cor the residence are: S (spoons, forks straw Dietary/Health; and into busy roadways to watch have typic the same time and v target behaviors to	History: s identified and displayed ansition to the residential sical Aggression/Physical l Aggression; Frivolous 911 t/Leaving Assigned Area and g (opiates).							
	swallowing non-foot psychiatric hospital procedures, [client 24/7. This supervisit sight at all times, clup an item to swallot staff will position the with the door crack maintained. If [clien must enter the room up an item to swallow A specific staff will	ern of elopement and od items that has led to ization and inpatient medical A] will receive 1:1 supervision on is defined as within line of ose enough to react if he picks ow. When [client A] is in bed, nemselves outside of the door ed so that line of sight is nt A] gets out of bed, staff n to prevent him from picking							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	re survey ipleted 21/2022
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP C	COD	
СОММО	NITY ALTERNATIV	ES-ADEPT		UCKSKIN CT APOLIS, IN 46250		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION gned staff needs to be relieved	TAG	DEFICIENCY		DATE
	1 -	lities for any reason, another				
		the 1:1 observation duties.				
	For no reason is [cl sight.	ient A] to be out of staff line of				
		around, the 1:1 staff is				
	_	vith him. It is unacceptable for				
	1	one room, and his assigned				
		er. (As stated above, when				
		staff may be in the hallway,				
	_	ly open, in order to maintain y may be maintained in the				
	_	door shut, but the assigned 1:1				
		utside the bathroom door. Prior				
		ag the bathroom, staff must				
		I remove anything he could				
	_	The 1:1 staff must maintain				
		oathroom when [client A]				
	_	ene or shaves and must				
	remove any item he	attempts to swallow.				
	Staff are to monitor	all activities, conversations,				
	sudden movements	of [client A] always. If you are				
	_	the expectation is that you are				
		nt A], and encouraging him to				
		onal learning activities as				
	much as possible.					
	'	here is not enough staff in the				
		late a 1:1, the supervisor must				
		ely. However, the assigned staff cted to stay with [client A]				
	_	as provided coverage for him.				
	until a supervisor in	as provided coverage for fifm.				
	12/7/22: due to toda	ay's incident of swallowing a				
		espite one-to-one supervision,				
	_	team consensually agrees				
	that additional prote	ective measures are required.				
	Staff will implemen	nt house sweeps every half hour				
		y swallowable items. A staff				
		ent A's] one-to-one will				
	complete the sweep	so as not to draw attention to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G465	B. W	ING		12/21/	2022
	PROVIDER OR SUPPLIEF			6025 BI	ADDRESS, CITY, STATE, ZIP COD JCKSKIN CT APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
		y time [client A] has been away					
		f will complete a body check,					
		him empty his pockets to					
	assure he has not pi swallow.	cked up any item he could					
		Identified Maladaptive					
	Behaviors:	S1 77 14 5					
	3. Non-Complian						
	Safety/Swallowing non food items.						
	<ul><li>4. Elopement.</li><li>5. Suicidal Ideations</li></ul>						
	Target Behaviors for	or Reduction Defined: (Primary)					
	_	with Health and Safety/					
	_	od items/Self-harming:					
		nited to periods of behaviors					
		liberately cause harm or injury					
		ody with objects and or od items with the intention of					
	self-harming.	od items with the intention of					
		rately leaving supervision or					
	•	ence without permission;					
	_	ne immediate area or					
		ect result of anger and or with					
	the intention of run	ning away.					
	Frivolous 911 Calls	s: Deliberately making					
		911 for non-emergency					
	I -	false allegations/reports to					
	gain attention from	medical services.					
	Medication seeking	/Opiates: Deliberately causing					
		making false allegations about					
	health issues that do	o no exist to gain access to					
	opiate medications.						
	Suicidal Ideations:	Having thoughts of self harm,					
		sideration or planning of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G465	B. W	ING		12/21/	2022
				CTDEET A	DDDEGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
000404110	MITY ALTERNATIV	EO ADEDT			JCKSKIN CT		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	possible techniques	of causing his own death					
	(examples: Running	g into traffic, swallowing					
	harmful objects etc.	)					
	Restrictions:						
	Rights Restrictions: The team has reviewed the risks for each of the below stated rights						
	restrictions and agre	ees that the restrictions should					
	be implemented as	stated to ensure health and					
		in the environment					
	Enhanced Supervision/ Secured Residential environment:						
	To protect client fro	om placing himself at risk of					
	harm and exploitation	on outside of the residential					
	environment withou	it supervision of staff. Every 3					
	months (quarterly),	progress will be monitored					
	and discussed with	the IDT in order to restore					
	rights.						
	_						
	Modified Enhanced	Supervision Protocols:					
	When Consumer de	monstrates he may be a threat					
	to himself (through	the expression of					
	suicidal ideations or	r other high intensity displays					
	of behaviors), super	vision will move from					
	Modified Enhanced	Supervision to Enhanced					
	Supervision protoco	ols. During these displays,					
	Consumer needs the	e support and heightened					
	supervision protoco	ls that Enhanced Supervision					
	provide; these speci	fic measures are to be					
	implemented when	Consumer is potentially a					
	threat						
	to himself or others	while at home and in the					
	community Consu	amer should not be					
		g this period and the staff					
		umer's movements/activities					
	on the 15-minute Cl	heck sheet/paperwork which					
	should be maintaine						
	documentation bind	ler					
	1		1	J			

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Event ID:

0PXO11 Facility ID: 000979

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED		
		15G465	B. WI	NG		12/21	/2022	
NAME OF P	PROVIDER OR SUPPLIER	}	_		ADDRESS, CITY, STATE, ZIP COD			
					JCKSKIN CT			
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION Lighters (Access Restricted):		TAG	DEFICIENCE		DATE	
	*	al from accessing items which						
	_	h himself and/or others within						
	the environment. Every 3 months (quarterly), progress will be monitored and discussed with the IDT to restore rights. Consumer has a history of collecting lighters, flints, magnifying glasses and							
	other fire-starting d							
		e removal of these devices						
	•	to ensure his safety as well						
	as his housemates' s	as his housemates' safety						
	Self-Injury/S							
	wallowing non fo	ood items:The direct,						
	deliberate destru	ction of one's own body						
	tissues without s	uicidal intent (e.g. includes						
	striking his head	against an object or striking						
	his head with an	object; hits (a) solid object,						
	typically a door	or wall or floor, table,						
	window; scratch	self that leaves a mark with						
	own fingernails;	scratch/cut/stab self with						
	self-made weapo	on that leaves a mark; pinch						
	_	vith object) or tries swallow						
	· ·	d itemsDoor and window						
		of window and door alarms						
		of Consumer as well as						
	1	have the risk of elopement.						
		or alarms will be reviewed						
		IDT meetings".Staff #1						
		on 12/16/22 at 7:05 AM.						
		I am the 1:1 staff for [client						
		goes I have to go. He						
	_	t go anywhere without staff						
	, ,	• •						
	_	ff #1 was asked if client A						
	i snouid be able to	elope from the home or	1				Ī	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE A. BUILDING B. WING	A. BUILDING <u>00</u> CC		DATE SURVEY COMPLETED 12/21/2022	
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CO BUCKSKIN CT	OD	
COMMU	NITY ALTERNATIV	/ES-ADEPT		NAPOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH		
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE AI DEFICIENCY)		
		Good items. Staff #1 stated,				_
		ot, not without staff at least				
		it from happening."HM				
		r) #1 was interviewed on				
	12/16/22 at 7:48	AM. HM #1 stated,				
	"[Client A] has a	a 1:1 staff with him at all				
	times. Staff are	to complete body checks				
	anytime he leave	es the house, and we do				
	room sweeps ev	ery 30 minutes to check for				
	anything he (clie	ent A) could potentially				
	swallow. Staff s	hould also be documenting				
	every 15 minute	s on 15 minute check				
	forms." HM #1	was asked how long these				
	measures have b	peen in place. HM #1 stated,				
	"Since he started	d eloping and swallowing				
	things." HM #1	was asked about client A				
	swallowing non-	-food items. HM #1				
	indicated client	A had not presented the				
	behavior prior to	the first incident on				
	11/2/22. HM #1	stated, "The swallowing				
	things is new. So	omething he started doing in				
	the hospital to st	tay in the hospital when they				
	would tell him the	hey were going to discharge				
	him. That's why	he swallowed the spoon at				
	- '	11/2/22). He wanted to stay				
	at the hospital.	Then he started doing it at				
	home because h	e knew he would go to the				
	hospital." HM #	1 was asked about client #1				
	swallowing a to	othbrush on 11/11/22. HM				
	#1 stated, "He h	ad just returned home from				
	a hospital stay a	nd I guess wanted to go				
	back." HM #1 w	vas asked about the incident				

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Event ID:

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

PRINTED: 02/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTI A. BUILDI B. WING		nstruction <u>00</u>	(X3) DATE COMPL 12/21/	ETED			
	PROVIDER OR SUPPLIER		60	STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	III PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	on 11/28/22 whe	ere client A swallowed a							
	toothbrush while with his 1:1 staff. HM #1								
	stated, "He (clien	nt A) was with his one on							
	one staff and wh	en that staff went to the							
	bathroom, he for	and one of his toothbrushes							
	and swallowed i	t. I think he was doing this							
	behavior because	e he just wanted to go to the							
	hospital. He wer	nt to the hospital and they							
	got it (the toothbrush) out." HM #1 indicated								
	since the incident they had obtained lock								
	boxes for all of the clients and their small								
	items and he has	n't had access to them							
	unless using the	m and staff supervising. HM							
	#1 was asked ab	out the incident on 12/7/22							
	involving client	A complaining of abdominal							
	pain and telling	the hospital he had							
	swallowed a raze	or. HM #1 stated, "We							
	think he must of	gotten it (razor) during one							
	of his hospital st	ays. We don't have razors in							
	the home. He bro	oke the razor in half, took							
	the handle off, a	nd swallowed it. This is one							
	of the reasons th	e body checks are now							
	being completed	l." HM #1 was asked if							
	client A should l	have been able to continue to							
	elope and swallo	ow non-food items if the							
	supervision leve	ls were being met. HM #1							
	indicated there h	ave been times the							
	supervision leve	l was not followed as							
	expected and a c	couple incidents occurred							
	but, "It has gotte	n better."QIDPM (Qualified							
	Intellectual Disa	bilities Professional							
	Manager) #1 wa	s interviewed on 12/16/22							

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Event ID:

0PXO11 Facility ID: 000979

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` ′		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED  B. WING 12/21/2022					
		15G465	<u> </u>		12/21/2022			
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD				
COMMUI	NITY ALTERNATIV	ES-ADEPT	6025 BUCKSKIN CT INDIANAPOLIS, IN 46250					
(X4) ID	Г		ID ID		(V5)			
PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
	at 1:30 PM. QID	PM #1 was asked about						
	client A's supervision level when client A							
	moved into the g	group home on 10/6/22.						
	QIDPM #1 stated	d, "15 minute checks which						
	is the expected s	upervision level for new						
	admissions for th	ne first 30 days." QIDPM						
	#1 indicated clie	nt A was moved to line of						
	sight supervision	during waking hours and 15						
	minute checks during the night after his first							
	elopements on 10/30/22. QIDPM #1 was							
	asked if client A should have been able to							
	elope from the ho	ome multiple times on the						
	evening of 10/30	0/22. QIDPM #1 stated,						
	"No." QIDPM #3	l indicated client A's						
	supervision level	l was changed to 24/7 1:1						
	supervision and	sharps and small items were						
	secured followin	g his discharge from the						
	hospital on 11/11	1/22 (after he had eloped						
	and then swallow	ved a non-food item).						
	QIDPM #1 indic	ated client A should not						
	have been able to	o continue to elope or						
	swallow non-foo	d items following the						
	implementation of	of the enhanced supervision						
	levels. QIDPM #	<sup>‡</sup> 1 stated, "The expected						
	(supervision) lev	rels were not						
	implemented."Tl	he facility's policy and						
	procedures were	reviewed on 12/16/22 at						
	12:45 PM. The fa	acility's Abuse, Neglect,						
	Exploitation poli	icy revised on 2/26/18						
	indicated, "ResC	are staff actively advocate						
	for the rights and	l safety of all individuals. All						
	allegations or oc	currences of abuse, neglect,						

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

PRINTED: 02/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CONSTRUCTION (X:  A. BUILDING 00  B. WING			X3) DATE SURVEY COMPLETED 12/21/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT					
COMMU	NITY ALTERNATIV	ES-ADEPT	INDIANAPOLIS, IN 46250					
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION treatment or violation of an	TA	NG	DETRIENCT		DATE	
	•	ts shall be reported to the						
	appropriate authorities through the							
		rvisory channels and will be						
		tigated under the policies of						
	ResCare, local, s	_						
		Care strictly prohibits abuse,						
	-	tion, mistreatment, or						
	violation of an Individual's rights3. Any							
	staff person who is suspected of abuse,							
	neglect, exploitation, mistreatment or							
	violation of an Individual's rights toward an							
		e immediately suspended						
		on can be fully investigated.						
	After the investig	gation, if the allegation is not						
	substantiated, the	e employee will be paid for						
	missed scheduled	d hours7. If the allegation						
	is substantiated,	the staff person accused will						
	follow progressiv	ve corrective action up to						
	and including ter	mination".This federal tag						
	relates to compla	ints #IN00393849 and						
	#IN00395040.9-3	3-2(a)						
W 0186	483.430(d)(1-2)							
Bldg. 00	DIRECT CARE ST	I AFF rovide sufficient direct care						
Diag. 00	•	nd supervise clients in						
	accordance with the	neir individual program						
	plans.							
	Direct care staff a	re defined as the present						
		lated over all shifts in a						
	•	each defined residential						
	living unit.	riew and interview for 1 of 3	W 0186	,	CORRECTION:		01/20/2023	
		, the facility failed to deploy	W 0180	_	The facility must provide suffic	ient	01/20/2023	

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PRINTED: 02/08/2023

EPARTMEN ENTERS FO		FORM APPROVED OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	(X3) DAT COMI	E SURVEY PLETED 1/2022		
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COD BUCKSKIN CT			
COMMU	NITY ALTERNATIV	ES-ADEPT		ANAPOLIS, IN 46250			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG			DATE	
	~	a manner to implement client		direct care staff to manage			
	A's plan for superv	ision.		supervise clients in accord			
	Findings include:			with their individual program	-		
				Specifically, supervisory st been retrained to assure a			
	The facility's RDD	S (Bureau of Developmental		staffing is in place at the fa	-		
		es) reports and investigations		and in the community to as	-		
		2/15/22 at 11:50 AM and		client A's one-to-one super			
	indicated the follow			is supported and all staff h			
	indicated the following.			been retrained that at least			
	1. A BDDS report dated 11/23/22 indicated, "On			staff must be present at all			
	-	22, [client A] ran out of his		at the facility and in the			
		and staff lost line of sight. Staff		community with client A to	prevent		
	contacted the reside	ential supervisor who located		-	gaps in one-to-one supervision.		
	[client A] three blo	cks from the home. [Client A]					
	willingly rode back	to the house		PREVENTION:			
	with the supervisor	[Client A] has a history of		A management staff will be	)		
	elopement addresse	ed in his Behavior Support		present, supervising active	;		
		nave plan approved alone time		treatment during no less th	an five		
		staff supervision for		active treatment sessions p			
		minutes. [Client A] will receive		week, on varied shifts to as			
	· ·	ys a week) one-to-one		appropriate staffing is in pl			
		reduce and prevent further		implementation of clients' I			
	·	l staff will be trained toward		Support Plans. For the nex			
		tion of the enhanced		days, members of the Ope			
	supervision protoco	ols".		Team (comprised of the Ex			
	A IC 4-4-4 11/20/	22 : 4: 4- 4 41 - 5-11		Director, Operations Mana	-		
	All 15 dated 11/50/.	22 indicated the following:		Program Managers, Qualit	•		
	-"Introduction			Assurance Manager, QIDF Manager, QIDP, Quality			
		/23/22, [client A] ran out of his		Assurance Coordinators, A	ırea		
		and staff lost line of sight. Staff		Supervisors, Nurse Manag			
		ential supervisor who located		Assistant Nurse Manager)			
		cks from the home. [Client A]		conduct twice weekly	******		
	1	to the house with the		administrative monitoring a	at the		
	supervisor.			day service facility at varie			
	•			to assure interaction with n			

[Staff #10]

I (staff #10) was getting the other consumers

medications ready in the medication room.

staff, involved in a full range of

active treatment scenarios. After

30 days, administrative monitoring

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  12/21/2022				
		130403			12/21/2022			
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD				
COMMU	NITY ALTERNATIV	ES-ADEPT		6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
	[Client A] sneaked			will occur no less than weekly				
		know he (client A) left.		until all staff demonstrate				
	•	A) was in the medication room		competence. After this period	of			
	with me.			enhanced administrative				
	He (client A) went			monitoring and support, the				
	· ·	ient A) sneaked (sic) out.		Executive Director and Region				
		look for [client A].		Director will determine the lev				
		m a couple of blocks away.		ongoing support needed at the				
	[Client A] returned	home with me.		facility. Current Operations Te				
				members received training fro				
	Factual Findings			the QIDP Manager to assure	a			
		lient A] was in the medication		clear understanding of				
	·	client A) said he (client A) was		administrative monitoring as				
		om, and he (client A) left.		defined below.				
		follow [client A] to the		· The role of the				
	bathroom, per the p	lan (BSP).		administrative monitor is not				
				simply to observe & Report.				
	Conclusion			· When opportunities for				
		ated that [client A's] Behavior		training are observed, the mo	nitor			
		to address Elopement.		must step in and provide the				
		I that [client A] was without		training and document it.				
	staff supervision.	ta reat can be		If gaps in active treatme	nt			
		I that [client A] was without		are observed the monitor is				
	_	r approximately 5 minutes.		expected to step in and mode				
		I that staff failed to follow		appropriate provision of suppo	ons.			
	[client A's] Behavio	or Support Plan. lated that staff failed to follow		· Assuring the health and				
				safety of individuals receiving				
	ResCare's Policies	and Flocedules.		supports at the time of the				
	Recommendations			observation is the top priority.				
		[client A's] Behavior Support		<ul> <li>Review all relevant documentation, providing</li> </ul>				
	Plan.	Leuent V 2 Denasion 20hhort		documented coaching and tra	ining			
	Plan. [Client A] will receive 24/7 one to one staffing".			1	illing			
		_		as needed.				
	•	dated 11/29/22 indicated, "On		Administrative support at the	day			
		was at home with his		service facility will include but	not			
		ne other staff on duty was		be limited to assuring sufficier				
		A's] housemates to their day		staff are present to implement	t			
	activities. [Client A	's] one-to-one staff used the		behavior supports.				
	bathroom and once	finished [client A]		RESPONSIBLE PARTIES: QI	DP.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED					
		15G465	B. W	ING	12/21/2022			
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
					JCKSKIN CT			
COMMUNITY ALTERNATIVES-ADEPT				INDIAN.	APOLIS, IN 46250			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX PREFIX  CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY  Apple Current in an Experiment Learning Control of the Con			COMPLETION	
TAG	ĭ	R LSC IDENTIFYING INFORMATION					DATE	
	told him he had swallowed a toothbrush. Staff notified the supervisor and nurse and transported				Area Supervisor, Residential			
	1	-			Manager, Direct Support Staff Operations Team, Regional	,		
	_	him to the [name of hospital] Emergency Department per nurse instructions. After an initial			Director			
	assessment, the attending physician admitted				Director.			
		[client A] to the hospital for observation[Client						
		swallowing non-food items						
	addressed in his Behavior Support Plan. ResCare							
		supervisory staff will assure sufficient staff are						
	l ~	present to maintain [client A's] one-to-one						
	supervision when staff take care of personal needs".							
	needs							
	Client A's record in	dicated an IDT Meeting Form						
		e IDT form dated 11/29/22						
	indicated the follow	ving:						
	113.5 A 1.4	T. ' D' 1/D1						
	1	Topics Discussed/Plan						
	Changes On 11/28/22 Iclien	t A] was home alone with his						
	1:1 staff.	(11) was nome alone with his						
		used the bathroom, [client A]						
	swallowed a toothb							
		pitalized and the toothbrush						
	was removed succe	ssfully via endoscope.						
	Action Steps:							
	Provide [MLBC #1	with all incident						
	documentation.	1						
	Assure two staff are	e present wherever [client A] is						
		supervision can be supported						
	when staff must tak	e care of personal needs".						
	3 A RDDS report (	dated 12/8/22 indicated, "On						
		complained to staff of						
		staff contacted the nurse and						
	_	ER, [client A] disclosed that he						
	1 -	zor which was confirmed by an						
		nputerized topography) scan.						
	The ER physician a	dmitted [client A] to the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED				
		15G465	B. W	ING		12/21/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			JCKSKIN CT		
COMMUNITY ALTERNATIVES-ADEPT				APOLIS, IN 46250			
	Г		1	┸——,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DLI ICILACTI		DATE
		for removal of the object and red to the facility's behavioral					
		unclear how [client A]					
	I -	cause they are not currently					
		[Client A] has a history of					
		od items addressed in his					
	_	Plan. The interdisciplinary team					
		d that in addition to [client A's]					
		sion, staff will complete					
	1	e every half-hour to remove					
	_	A] could potentially swallow,					
		complete a body check each					
		urns from outside of the home.					
		m members will train all staff on					
	implementation of	[client A's] revised safety					
	protocols".						
	Client A's record w	vas reviewed on 12/16/22 at 9:08					
	AM. Client A's red	cord indicated an IDT Meeting					
	Form dated 12/7/22	2. The IDT form dated 12/7/22					
	indicated the follow	ving:					
		opics Discussed/Plan Changes					
		tht hours of 12/7/22, [client A]					
		ere abdominal pain and was					
	taken to the ER.						
	1:1 staffing was in	-					
		A] told staff he swallowed a					
	razor.	5-11 - 1					
	[Client A] was hos	pitanzed.					
	Action Steps:						
	Provide [MLBC #1	Il with all incident					
	documentation.	i j with an meldent					
		2 hour house sweeps,					
		1 to 1 staff to not draw					
	attention to the task						
		ecks each time [client A]					
		away from the home.					
	_	m members to provide all house					
		an incase	ı				l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		15G465	B. WI	ING		12/21/	2022
	PROVIDER OR SUPPLIER			6025 BU	DDRESS, CITY, STATE, ZIP COD JCKSKIN CT APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	<b></b>	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ilE	DATE
		with retraining on 1:1					
	protocols and training on new house sweep protocol".  Client A's BSP dated 12/7/22 indicated the following:  -"Plan Date: 11/17/22, revised 12/7/22						
	since Consumer's tr placement are: Phys Intimidation; Verba calls and Elopemen Medication Seeking Additional behavior they have been obse in/displayed by Cor the residence are: S (spoons, forks straw Dietary/Health; and into busy roadways, to watch have typic	History:  It is identified and displayed ransition to the residential sical Aggression/Physical al Aggression; Frivolous 911 tt/Leaving Assigned Area and g (opiates).  It is to be added and monitor as reved to be engaged resumer since his transition to wallowing non-food items vs., etc.), Noncompliance with a Suicidal ideations (running /Traffic) - these two behaviors ally been observed to occur at					
	the same time and warrant to be listed as new target behaviors to be decreased but were not previously an issue before his transitions into the home.						
	swallowing non-foc psychiatric hospital procedures, [client 2 24/7. This supervisi sight at all times, cl up an item to swallo	ERVISION:  tern of elopement and od items that has led to ization and inpatient medical A] will receive 1:1 supervision ion is defined as within line of ose enough to react if he picks ow. When [client A] is in bed, nemselves outside of the door					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED				ETED
		15G465	B. WING 12/21/2022				/2022
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	JCKSKIN CT		
COMMU	NITY ALTERNATIV	ES ADEDT			APOLIS, IN 46250		
COMMO	NIII ALIEKNAIIV	ES-ADEF I		INDIAN	APOLIS, IN 40250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	with the door cracked so that line of sight is						
	_	ent A] gets out of bed, staff					
		n to prevent him from picking					
	up an item to swallo						
	_	l be assigned to provide [client					
	_	supervision at all times. If for					
		gned staff needs to be relieved					
	_	lities for any reason, another					
		the 1:1 observation duties.					
		ient A] to be out of staff line of					
	sight.						
	If [client A] moves around, the 1:1 staff is						
	expected to move with him. It is unacceptable for						
		one room, and his assigned					
		er. (As stated above, when					
		staff may be in the hallway,					
	_	ly open, in order to maintain					
	_	ry may be maintained in the					
		door shut, but the assigned 1:1					
		utside the bathroom door. Prior					
		ng the bathroom, staff must					
	_	d remove anything he could					
	1 *	The 1:1 staff must maintain					
	_	oathroom when [client A]					
		iene or shaves and must					
	1	e attempts to swallow.					
		all activities, conversations,					
		of [client A] always. If you are					
		the expectation is that you are					
		nt A], and encouraging him to					
		onal learning activities as					
	much as possible.	l					
	I -	here is not enough staff in the late a 1:1, the supervisor must					
		ely. However, the assigned staff					
		ected to stay with [client A]					
		as provided coverage for him.					
	uniin a supervisor na	as provided coverage for film.					
	12/7/22: due to toda	ay's incident of swallowing a					
		espite one-to-one supervision,					
	disposable fazor, de	spite one-to-one supervision,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED				
		15G465	B. WIN	NG		12/21/	/2022
			<del></del>	CTREET A	DDDECC CITY CTATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
COMMUN	NIITV AT TEDNIATIV	TE ADEDT			JCKSKIN CT APOLIS, IN 46250		
COMMUNITY ALTERNATIVES-ADEPT				INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the interdisciplinary team consensually agrees						
	that additional prote	ective measures are required.					
	Staff will implemen	nt house sweeps every half hour					
	to secure potentially	y swallowable items. A staff					
	not assigned as [clie	ent A's] one-to-one will					
	complete the sweep	so as not to draw attention to					
	it. Additionally, any	y time [client A] has been away					
		f will complete a body check,					
	including watching	him empty his pockets to					
	assure he has not pi	cked up any item he could					
	swallow.						
	Staff #1 was interviewed on 12/16/22 at 7:05 AM.						
		m the 1:1 staff for [client A].					
	_	have to go. He (client A)					
		e without staff supervision.					
		if client A should be able to					
	_	e or ingest any non-food items.					
		he should not, not without					
	staff at least there p	reventing it from happening."					
		er) #1 was interviewed on					
		M. HM #1 stated, "[Client A]					
		him at all times. Staff are to					
		eks anytime he leaves the					
		oom sweeps every 30 minutes					
		ng he (client A) could					
	1 ^	Staff should also be					
		15 minutes on 15-minute					
		#1 was asked how long these					
		n in place. HM #1 stated,					
		oping and swallowing things."					
		f client A should have been elope and swallow non-food					
		-					
	#1 indicated there h	sion levels were being met. HM					
		as not followed as expected					
	_	-					
	_	nts occurred but, "It has					
	gotten better."						

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

PRINTED: 02/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/21/2022	
	PROVIDER OR SUPPLIER		•	6025 BI	ADDRESS, CITY, STATE, ZIP COD JCKSKIN CT APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	QIDPM (Qualified Professional Manage 12/16/22 at 1:30 PM client A's supervision into the group home "15 minute checks" supervision level for 30 days." QIDPM # moved to line of sign hours and 15 minute his first elopements asked if client A she from the home mule 10/30/22. QIDPM # indicated client A's changed to 24/7 1:1 small items were seef from the hospital or and then swallowed indicated client A's continue to elope or following the imple supervision levels. expected (supervisitimplemented."	Intellectual Disabilities ger) #1 was interviewed on M. QIDPM #1 was asked about on level when client A moved e on 10/6/22. QIDPM #1 stated, which is the expected or new admissions for the first #1 indicated client A was ght supervision during waking e checks during the night after e on 10/30/22. QIDPM #1 was ould have been able to elope tiple times on the evening of #1 stated, "No." QIDPM #1 supervision level was supervision and sharps and ecured following his discharge in 11/11/22 (after he had eloped if a non-food item). QIDPM #1 hould not have been able to r swallow non-food items ementation of the enhanced QIDPM #1 stated, "The					

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