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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00272821. Complaint #IN00272821: Substantiated, Federal and state deficiencies related to the allegation were cited at W153 and W156. Dates of Survey: September 10, 11, 12, 13, 14, 17 and 21, 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 10/1/18.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview the facility failed to meet the Condition of Participation: Governing Body for 1 of 4 sampled clients (C). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the health needs of client C regarding the lack of an assessment of client C's significant weight loss in a timely manner and subsequent diagnosis of esophageal cancer. Findings include:	W 0102	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically: Client C is receiving aggressive treatment from his dietician, oncology team, ResCare nursing and residential staff to maintain his weight, treat his current and emerging medical conditions and	10/21/2018

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

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. The governing body failed to ensure facility staff met the health needs of client C regarding the lack of an assessment of client C's significant weight loss in a timely manner and subsequent diagnosis of esophageal cancer. Please see W104. 2. The governing body failed to ensure the facility's health care services met the health needs of client C regarding the lack of an assessment of client C's significant weight loss in a timely manner and subsequent diagnosis of esophageal cancer. Please see W318. 9-3-1(a)		to provide comfort care. A review of facility medical records indicated this deficient practice of failing to identify and treat emerging medical conditions did not affect additional clients. **PERVENTION:** The nurse manager will review all reports of significant health and safety issues and will meet with the Quality Assurance Manager or designee weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic and emerging health conditions, appropriate communication with doctors and other outside medical professionals, as well as staff training needs. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will maintain a presence in the facility no less than twice weekly for the next 30 days, and after 30 days, will conduct administrative observations no less than weekly until all staff demonstrate competence, as determined by the Executive Director and Regional Director (Area Manager). After this period of intensive administrative monitoring, the	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly. These administrative documentation reviews will include: 1.Assuring chronic and emerging healthcare conditions are properly monitored by facility nursing. 2.Assuring comprehensive High Risk Plans address all clients' chronic and emerging healthcare conditions. 3.Assuring staff are trained and demonstrate competency in caring for chronic and emerging health conditions and implementing high risk plans. Additionally: 1.The Nurse Manager will do side by side audits of SGL homes with the assigned nurse as needed but no less than monthly. 2.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 3.The Executive Director and will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team,	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Direct Support Staff, Operations Team, Regional Director	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 1 of 4 sampled clients (C), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure facility staff met the health needs of client C regarding the lack of an assessment of client C's significant weight loss in a timely manner and subsequent diagnosis of esophageal cancer. Findings include: 1. The governing body failed to ensure the facility's nursing services met the health needs of client C regarding the lack of an assessment of client C's significant weight loss in a timely manner and subsequent diagnosis of esophageal cancer. Please see W331. 2. The governing body failed to ensure the facility's nursing services met the health needs of client B regarding ensuring client B received her prescription medication as ordered by the physician. Please see W368. 9-3-1(a)	W 0104	**CORRECTION:** *The Governing body must exercise general policy, budget and operating direction over the facility.* Specifically, the governing body facilitated: Client C is receiving aggressive treatment from his dietician, oncology team, ResCare nursing and residential staff to maintain his weight, treat his current and emerging medical conditions and to provide comfort care. A review of facility medical records indicated this deficient practice of failing to identify and treat emerging medical conditions did not affect additional clients. **PERVENTION:** The nurse manager will review all reports of significant health and safety issues and will meet with the Quality Assurance Manager or designee weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic and emerging health conditions, appropriate communication with doctors and other outside medical	10/21/2018

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			professionals, as well as staff training needs. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will maintain a presence in the facility no less than twice weekly for the next 30 days, and after 30 days, will conduct administrative observations no less than weekly until all staff demonstrate competence, as determined by the Executive Director and Regional Director (Area Manager). After this period of intensive administrative monitoring, the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly. These administrative documentation reviews will include: 1.Assuring chronic and emerging healthcare conditions are properly monitored by facility nursing. 2.Assuring comprehensive High Risk Plans address all clients' chronic and emerging healthcare conditions. 3.Assuring staff are trained and demonstrate competency in caring for chronic and emerging health conditions and implementing high	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			risk plans. Additionally: 1.The Nurse Manager will do side by side audits of SGL homes with the assigned nurse as needed but no less than monthly. 2.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 3.The Executive Director and will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 17 allegations of abuse, neglect and mistreatment reviewed, the facility failed to immediately report to the administrator regarding an allegation of staff abuse regarding client A. Findings include:	W 0153	**CORRECTION:** *The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law*	10/21/2018

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/10/18 at 2:25 PM. A BDDS report dated 8/13/18 indicated on 8/10/18, "[Agency] administrative staff received a report that direct support staff [staff #5] had drawn a mustache and beard on [client A's] face with a marker. Staff [staff #5] has been suspended pending investigation of the allegation...". -A review of the BDDS report dated 8/13/18 indicated on 8/10/18 client A allegedly had a mustache drawn on her face by staff #5. The review indicated the allegation of abuse was not reported to the administrative staff until 8/12/18. An IS (Investigative Summary) dated 8/12/18-8/30/18 indicated, "... Conclusion:" -"1. The evidence substantiates [staff #5] (DSP (Direct Support Professional)/Alleged perpetrator) drew a mustache on [client A's] ... face." -"2. The evidence substantiates [staff #5] (DSP/Alleged perpetrator) violated [agency's] Policies and Procedures." -A review of the IS dated 8/12/18-8/30/18 indicated the facility substantiated staff #5 drew a mustache on client A's face. The review indicated staff #5 violated the agency's policy on the prevention of abuse, neglect and mistreatment. QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 9/12/18 at 1:30 PM. QIDPM #1 indicated the facility did not immediately report to the administrator regarding an allegation of abuse by staff.		*through established procedures.* Specifically, Quality Assurance staff, facility supervisors and direct support staff have been retrained regarding incident reporting requirements. The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. A review of incident documentation indicates that this deficient practice may have affected all clients who reside in the facility. **PREVENTION:** Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to the administrator. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. The Operations Team (comprised of the Executive 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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This federal tag relates to complaint #IN00272821. 9-3-2(a)		Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators and Nurse Manager) will conduct administrative visits to the facility no less than three times weekly for the next 30 days, and no less than weekly until all staff demonstrate competence. At the conclusion of this period of intensive administrative monitoring and support, the Executive Director will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative monitoring will include review of facility progress notes, communication log entries, behavior tracking records and face to face discussion with clients and staff to assure all incidents have been reported and investigated as required. If, through investigation, supervisors discover that an employee has failed to accurately report allegations of mistreatment,	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			neglect or abuse, as well as injuries of unknown source, the governing body will administer written corrective action up to and including termination of employment. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 17 allegations of abuse, neglect and mistreatment reviewed, the facility failed to complete an investigation regarding an allegation of staff abuse regarding client A within 5 business days. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/10/18 at 2:25 PM. A BDDS report dated 8/13/18 indicated on 8/10/18, "[Agency] administrative staff received a report that direct support staff [staff #5] had drawn a mustache and beard on [client A's] face with a marker. Staff [staff #5] has been suspended pending investigation of the allegation...". -A review of the BDDS report dated 8/13/18	W 0156	**CORRECTION:** *The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.* Specifically, sgency Quality Assurance staff have been retrained in their role in the investigative process and the fact that results of investigations must be reported to the Executive Director within five working days of discovery of the allegations. **PREVENTION:** A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective	10/21/2018

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated on 8/10/18 client A allegedly had a mustache drawn on her face by staff #5. The review indicated staff #5 was suspended pending an investigation by the facility. An IS (Investigative Summary) dated 8/12/18-8/30/18 indicated, "... Conclusion:" -"1. The evidence substantiates [staff #5] (DSP (Direct Support Professional)/Alleged perpetrator) drew a mustache on [client A's] ... face." -"2. The evidence substantiates [staff #5] (DSP/Alleged perpetrator) violated [agency's] Policies and Procedures." -A review of the IS dated 8/12/18-8/30/18 indicated the facility substantiated staff #5 drew a mustache on client A's face. The review indicated staff #5 violated the agency's policy on the prevention of abuse, neglect and mistreatment. The review indicated the facility's investigation dated 8/12/18-8/30/18 was not completed within 5 business days. QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 9/12/18 at 1:30 PM. QIDPM #1 indicated the facility did not report the results and recommendations of an allegation of abuse regarding client A to the administrator within 5 business days. This federal tag relates to complaint #IN00272821. 9-3-2(a)		measures will be maintained and distributed daily to facility supervisors and the Operations Team comprised of Program Managers, Nurse Manager, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager, Operations Managers and Executive Director. The Quality Assurance Manager will meet with his/her team (comprised of the QIDP Manager and Quality Assurance Coordinators), as needed but no less than weekly to review the progress made on all open investigations and to assign responsibility for new investigations. The QA Manager will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The QIDP Manager and QA Coordinators will provide weekly updates to the QA Manager on the status of investigations. **RESPONSIBLE PARTIES:** Quality Assurance Team, Operations Team	
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training			

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	must focus on skills and competencies directed toward clients' health needs. Based on observation, record review and interview for 1 of 4 sampled clients (client C), the facility failed to ensure staff were trained to ensure client C's head was elevated to a 30 degree angle or above while he was lying in bed. Findings include: Observations were conducted at the group home on 9/10/18 from 3:40 PM through 6:15 PM and on 9/11/18 from 6:12 AM through 8:45 AM. Client C was observed throughout the observation period. At 3:50 PM client C was observed in his bedroom seated on the edge of his bed. Client C had a bandage on his left forearm and a bandage over his right elbow. At 5:05 PM client C was observed lying flat on his bed on his right side. On 9/12/18 at 6:15 AM client C was observed lying flat on his bed on his right side. Client C was asleep. Client C had a thin, plastic tube running from his abdomen and the tubing connected to a mechanical feeding pump attached to a metal pole. The feeding pump had a digital display which read 60 ML (milliliters). At 7:49 AM AS (Area Supervisor) #1 entered client C's bedroom. AS #1 disconnected client C's plastic tubing from the mechanical feeding pump. AS #1 proceeded to use a piston syringe to administer client C's crushed medications through client C's feeding tube. Client C was observed laying flat on his bed during the administration of his medications and water flush. On 9/11/18 from 6:15 AM until 7:23 AM client C was observed asleep lying flat on his bed on his right side. Client C's head was not elevated to a 30 degree angle while he received his continuous tube feeding from client C was observed lying flat on his bed on his right side.	W 0192	**CORRECTION:** *For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.* Specifically, facility staff have been retrained regarding the need for client C to remain elevated at a 30-degree angle while lying in bed. Additionally, the governing body has facilitated the purchase of a hospital bed for client C to assure he remains properly elevated while lying in bed. **PREVENTION:** 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 proper implementation of comprehensive high-risk plans. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than twice weekly for the next 30 days, and after 30 days, will conduct administrative	10/21/2018

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Client C's record was reviewed on 9/11/18 at 12:49 PM. Client C's RT (Required Training) form dated 9/10/18 and completed by RN (Registered Nurse) #1 indicated, "... Strict nothing by mouth order. Head of bed elevated above 30 (degrees) at all times. Never lying flat...". A review of the RT dated 9/10/18 indicated staff were trained keep client C's head of bed elevated above a 30 degree angle at all times. The review indicated client C was never to be lying flat in his bed. RN (Registered Nurse) #1 was interviewed on 9/12/18 at 1:02 PM. RN #1 was asked if client C should be lying flat in his bed. RN #1 stated, "No. Due to the risk of aspiration/choking." 9-3-3(a)		observations no less than weekly until all staff demonstrate competence. At the conclusion 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 checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 00 B. WING	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			shift no less than twice monthly –more frequently if training issues or problems are discovered. 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. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring staff implement comprehensive high-risk plans as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Site Supervisor, Direct Support Staff, Operations Team, Regional Director	
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (C). The facility's health care services failed to meet the health/nursing needs of client C, regarding the lack of an assessment of client C's significant weight loss in a timely manner and subsequent diagnosis of esophageal cancer. Findings include: The facility's health care services failed to ensure the health needs of client C regarding an assessment of client C's significant weight loss in a timely manner and subsequent diagnosis of esophageal cancer. Please see W331. 9-3-6(a)	W 0318	**CORRECTION:** *The facility must ensure that specific health care services requirements are met.* Specifically: Specifically: client C is receiving aggressive treatment from his dietician, oncology team, ResCare nursing and residential staff to maintain his weight, treat his current and emerging medical conditions and to provide comfort care. A review of facility medical records indicated this deficient practice of failing to identify and treat emerging medical conditions did not affect additional clients. **PERVENTION:** The nurse manager will review all reports of significant health and safety issues and will meet with the Quality Assurance Manager or	10/21/2018

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			designee weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic and emerging health conditions, appropriate communication with doctors and other outside medical professionals, as well as staff training needs. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will maintain a presence in the facility no less than twice weekly for the next 30 days, and after 30 days, will conduct administrative observations no less than weekly until all staff demonstrate competence, as determined by the Executive Director and Regional Director (Area Manager). After this period of intensive administrative monitoring, the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly. These administrative documentation reviews will include: 1.Assuring chronic and emerging healthcare conditions are properly monitored by facility nursing. 2.Assuring comprehensive High	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Risk Plans address all clients' chronic and emerging healthcare conditions. 3.Assuring staff are trained and demonstrate competency in caring for chronic and emerging health conditions and implementing high risk plans. Additionally: 1.The Nurse Manager will do side by side audits of SGL homes with the assigned nurse as needed but no less than monthly. 2.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 3.The Executive Director and will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 sampled clients (C), the facility's nursing services failed to meet the health needs of client C regarding the lack of an assessment of client C's significant weight loss in	W 0331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically: client C is receiving	10/21/2018

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a timely manner and subsequent diagnosis of esophageal cancer. Findings include: Observations were conducted at the group home on 9/10/18 from 3:40 PM through 6:15 PM and on 9/11/18 from 6:12 AM through 8:45 AM. Client C was observed throughout the observation period. At 3:50 PM client C was observed in his bedroom seated on the edge of his bed. Client C had a bandage on his left forearm and a bandage over his right elbow. At 5:05 PM client C was observed lying flat on his bed on his right side. On 9/11/18 at 6:15 AM client C was observed lying flat on his bed on his right side. Client C was asleep. Client C had a thin, plastic tube running from his abdomen and the tubing connected to a mechanical feeding pump attached to a metal pole. The feeding pump had a digital display which read 60 ML (milliliters). At 7:49 AM AS (Area Supervisor) #1 entered client C's bedroom. AS #1 disconnected client C's plastic tubing from the mechanical feeding pump. AS #1 proceeded to use a piston syringe to administer client C's crushed medications through client C's feeding tube. Client C was observed lying flat on his bed during the administration of his medications and water flush. On 9/11/18 from 6:15 AM until 7:23 AM client C was observed asleep lying flat on his bed on his right side. Client C's head was not elevated to a 30 degree angle or above while he received his continuous tube feeding. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/10/18 at 2:25 PM. A BDDS report dated 8/23/18 indicated on 8/22/18, "... On 8/10/18, [client C] was taken to		aggressive treatment from his dietician, oncology team, ResCare nursing and residential staff to maintain his weight, treat his current and emerging medical conditions and to provide comfort care. A review of facility medical records indicated this deficient practice of failing to identify and treat emerging medical conditions did not affect additional clients. **PERVENTION:** The nurse manager will review all reports of significant health and safety issues and will meet with the Quality Assurance Manager or designee weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic and emerging health conditions, appropriate communication with doctors and other outside medical professionals, as well as staff training needs. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will maintain a presence in the facility no less than twice weekly for the next 30 days, and after 30 days, will conduct administrative observations no less than weekly until all staff demonstrate	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Hematology-Oncology [name of clinic] due to a recent increase in weight loss and a mass was discovered in his (client C's) throat. On 8/22/18, he (client C) saw an oncologist who confirmed that [client C] has been diagnosed with Cancer of Esophagus and (sic) GE (Gastroesophageal) Junction...". -A review of the BDDS report dated 8/23/18 indicated client C had been taken to an Oncologist for evaluation due to recent weight loss. The review indicated client C was diagnosed with cancer of the esophagus. A BDDS report dated 9/6/18 indicated on 9/5/18, "... On 9/5/18, [client C] was admitted to [Name] Hospital for his J (Jejunostomy)-Tube and Chemotherapy Port (Intravenous Access) placement to initiate treatment of Cancer of Esophagus and (sic) GE Junction... [Agency] nursing has updated [client C's] high risk plans and all staff will be trained on implementation...". Client C's record was reviewed on 9/11/18 at 12:49 PM. Client C's GHNA (Group Home Nutrition Assessment) dated 7/25/18 and completed RD (Registered Dietician) #1 indicated the following: -"... Date: 10/17 Weight: 160 (pounds), Date: 11/17 Weight: 156 (pounds), Date: 12/17 Weight: 153 (pounds), Date: 1/18 Weight: 145 (pounds), Date: 2/18 Weight: 145 (pounds), Date: 3/18 Weight: 140 (pounds), Date: 4/18 Weight: 140 (pounds), Date: 5/18 Weight: 140 (pounds), Date: 6/18 Weight: (no recorded weight), Date: 7/18 Weight: 103 (pounds), Date: 8/18 Weight: 104 (pounds)... Quarter 2 and 3 2018: No wt. (weight) for quarter 2 to assess. 3 (third quarter) noted wt loss of 40 lbs (pounds) which is significant...".		competence, as determined by the Executive Director and Regional Director (Area Manager). After this period of intensive administrative monitoring, the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly. These administrative documentation reviews will include: 1.Assuring chronic and emerging healthcare conditions are properly monitored by facility nursing. 2.Assuring comprehensive High Risk Plans address all clients' chronic and emerging healthcare conditions. 3.Assuring staff are trained and demonstrate competency in caring for chronic and emerging health conditions and implementing high risk plans. Additionally: 1.The Nurse Manager will do side by side audits of SGL homes with the assigned nurse as needed but no less than monthly. 2.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 3.The Executive Director and will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	-A review of the GHNA dated 7/25/18 indicated a documented weight loss of 57 pounds from November 2017 to July 2018. The review indicated a documented weight loss of 37 pounds for client C from May 2018 to July 2018. The review indicated no documentation of client C's weight for June, 2018. Client C's GHNA (Group Home Nutrition Assessment) dated 8/8/18 and completed by RD #1 indicated, "... Summary of Nutrition Assessment: Severe Wt. loss, undergoing testing to figure out cause of unexplained weight loss. Inadequate oral intake d/t (due to) vomiting and dysphagia (difficulty swallowing) ... sig. (significant) wt. loss x (times) 180 and 90 days...". A HPE (History and Physical Examination) form dated 6/18/18 and completed by client C's Physician indicated, "... Weight: 109.4 (pounds)... Diagnosis: ... Weight Loss, Anxiety...". -A review of the HPE dated 6/18/18 indicated client C weighed 109.4 pounds when he was seen by his physician on 6/18/18. The review indicated client C was given a diagnosis of weight loss by his physician. A NMS (Nursing Monthly Summary) form dated 3/9/18 and completed by FN (Former Nurse) #1 for client C indicated, "... Current weight: 140 (pounds)...". A NMS dated 4/4/18 and completed by FN #1 for client C indicated, "... Current weight: (no weight listed)...". A NMS dated 5/3/18 and completed by FN #1 for client C indicated, "... Current weight: (no weight listed)...".		management attention. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, 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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A NMS dated 6/4/18 and completed by FN #1 for client C indicated, "... Current weight: (no weight listed)...".

A NMS dated 7/24/18 and completed by FN #2 for client C indicated, "... Current weight: 101 (pounds)... Any significant changes? June wt. (weight) not in chart, 1 yr (year) ago wt. in chart (on) 11/17 was 156 (pounds), 55 (pound) decrease... Comments: This Nurse (FN #2) began managing resident (client C) this date (7/24/18). No report left from previous nurse (FN #1), no labs or medical visits noted in chart. A general report received from home manager. Noted wt. 101 pounds. Instructed manager to schedule appointment to see Dr. [name] ASAP (as soon as possible)...".

A review of the NMS forms dated 3/9/18 through 6/4/18 did not indicate documentation of client C's weight by FN #1. A review of the NMS dated 7/24/18 and completed by FN #2 indicated client C's weight was 101 pounds on 7/24/18. The review indicated client C had weighed 156 pounds in November of 2017. The review indicated a client C had a documented 55 pound weight loss in the previous months.

A CHRHP (Comprehensive High Risk Health Plan) dated 6/21/18 and completed by FN #1 indicated, "... Problem: Weight Loss, history of. Triggers to Notify Nurse: Weight below 104 lbs., vomiting, meal refusal, decreased appetite. Expected Outcome: [Client C's] weight will be maintained between 109 lb and 104 lb through 6/2019... Actions: ... 6. Check weight weekly as indicated on MAR (Medication Administration Record) and record result. 7. Notify Nurse if weight is below 104 lbs. 8. Nurse will monitor weight trend at least

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	monthly and document in the medical record...". A review of the CHRHP dated 6/21/18 indicated the nurse was to monitor client C's weight for trends at a minimum of monthly and document results in client C's medical record. An ISIS (Inservice Sign-in Sheet) dated 6/22/18 and completed by FN #1 indicated, "... Topic: vitals and weights... Detailed Description: How to take vitals and weights...". A review of the ISIS dated 6/22/18 indicated FN #1 completed a training for the group home staff regarding how to take the clients vital signs and weights. A Follow-up Note completed by the Oncologist (Cancer Specialist) and dated 8/22/18 indicated, "... [Client C]... who had been on a pureed diet for years, who (client C) who subsequently present to his primary care physician (PCP), [Name of Physician], with a history of progressive dysphagia associated with weight loss, as a result of which patient (client C) was referred to [Name of Physician] for further evaluation, ultimately resulting in an upper GI (Gastro-Intestinal) endoscopy (used to look inside the body) which was performed on August 10, 2018 which revealed a large fungating (becomes like a fungus) mass at lower third of the esophagus approximately 25-31 cm (centimeters) from the incisors with the mass being partially circumferential and non-obstructing with involvement of one-half of the luminal circumference (inner open space or cavity of a tubular organ). No obvious bleeding was noted... Biopsies (medical test) were obtained, and pathology (typical behavior of a disease) is consistent with an invasive adenocarcinoma (Cancer)... Subsequently, a staging CT			

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Computerized Tomography) scan of the chest was performed on August 14, 2018 which revealed a mass in the distal esophagus suspicious for esophageal carcinoma... Given the above, the patient (client C) is now referred for medical oncologic evaluation... I (Oncologist) have discussed the above findings with [client C] and the patient's (client C's) accompanied caregiver. The patient does have a longstanding history of intellectual disability. Therefore, it is unclear whether the patient (client C) is able to make a decision, but the patient (client C) stated he wishes to pursue aggressive therapy. I (Oncologist) have explained to him (client C) that he has a malignancy (the state of a cancerous tumor) for which aggressive therapy is warranted. This will include potentially chemo-radiation therapy and surgical resection...". -A review of the Follow-up Note completed by the Oncologist and dated 8/22/18 indicated client C had a GI examination and subsequent endoscopy on 8/10/18 which revealed a malignant mass measuring at 25-31 cm. The review indicated client C requested aggressive treatment of the esophageal carcinoma which included chemotherapy and radiation treatments. A PSR (Patient Summary Report) dated 9/9/18 indicated, "... J tube in place with tube feedings running through... Assessment and Plan (A/P): Problem 1: Dysphagia and malnutrition. A/P 1: Secondary to esophageal cancer with partially obstructing mass s/p (status/post) mediport (venous access) and J-tube placement 9/5 (18)...". Client C was interviewed on 9/10/18 at 3:41 PM. Client C was asked if he was feeling alright. Client C stated, "Fine, they gave me a tube so I wouldn't get cancer." Client C was asked if he had been			

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	losing weight recently. Client C stated, "You better believe it." Client C was asked if the feeding tube recently placed in his abdomen on 9/5/18 was hurting him. Client C stated, "No." Staff #1 was interviewed on 9/10/18 at 5:54 PM. Staff #1 was asked if he had weighed client C. Staff #1 stated, "Sometimes." Staff #1 was asked if he noticed client C was losing weight. Staff #1 stated, "No." CI (Confidential Interview) #1 was conducted. CI #1 was asked if they had noticed client C's significant weight loss. CI #1 stated, "When we took him (client C) out for his birthday I noticed his weight loss. That was July [date]. I didn't see him from January until July and that's when I noticed he (client C) lost 40 or 50 pounds. I was horrified." CI #1 was asked if they felt client C received adequate supervision at the group home. CI #1 stated, "It's a revolving door every time I'm there (group home) there's someone (staff) new. I am very concerned. So no there's not adequate supervision." RN (Registered Nurse) #1 was interviewed on 9/12/18 at 1:02 PM. RN #1 was asked to explain how staff documented a 32 pound weight loss for client C from 5/19/18 (141 lbs.) to 6/18/18 (109.4 lbs.). RN #1 stated, "It could have been a malfunction of the scale. It could have been inaccurate documentation by staff and it could have been newly diagnosed esophageal cancer." RN #1 was asked if client C's weight loss of 55 pounds documented on 7/25/18 by the dietician was a significant weight loss. RN #1 stated, "Yes, the dietician does note that it is significant and that is what we have to go by." RN #1 was asked if FN #1 had documented client C's weight in her monthly progress notes for 3/18, 4/18 and 5/18.			

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	RN #1 stated, "No." RN #1 was asked if FN #1 should have documented client C's weights in her monthly progress notes for 3/18, 4/18 and 5/18. RN #1 stated, "Yes, to monitor for fluctuation." RN #1 was asked if FN #2 had documented a weight of 101 pounds for client C on 7/24/18. RN #1 stated, "Yes." RN #1 was asked if a documented eight pound decrease since client C's weight was recorded at 109.4 by his PCP's office on 6/18/18. RN #1 stated, "Yes, the trend is concerning." 9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 4 sampled clients (B), the facility failed to ensure client B received her prescription medication as ordered by the physician. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 9/10/18 at 2:25 PM. 1. A BDDS report dated 9/2/18 indicated on 9/1/18, "... On 9/1/18 and 9/2/19/ (sic), [client B] did not receive her 7:00 am dose of physician prescribed clonazepam (Anxiety) due to no available supply. A new prescription is required due to Lorazepam (sic) being a scheduled (Controlled) medication...". -A review of the BDDS report dated 9/2/18 indicated client B did not receive her 7:00 AM	W 0368	**CORRECTION:** *The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.* Specifically, client B's supply of clonazepam 0.5 mg was replenished and client B has been receiving the medication as scheduled. Facility staff will complete a weekly audit of medications for all clients' medication to assure an adequate supply is in place. When a low supply is identified, staff will immediately reorder the medication from the pharmacy. When new prescriptions are needed, staff will following-up with the supervisor and facility nurse to assure timely refills are obtained.	10/21/2018

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dose of clonazepam as ordered by the physician on 9/1/18 and 9/2/18. 2. A BDDS report dated 9/4/18 indicated on 9/3/18, "... On 9/3/18 per [Agency] nursing instruction, staff transported [client B] to the [Name] hospital Emergency Department to attempt to obtain an emergency prescription of clonazepam 0.5 mg to hold her (client B) over until her psychiatrist appointment on 9/6/18. She (client B) is currently out of the medication... Hospital personnel declined to fill the prescription, provided a safety plan and released her (client B) to [Agency] staff with a recommendation to follow-up with her psychiatrist... [Agency] nursing obtained an interim prescription from her (client B's) psychiatrist on 9/4/18 and [client B] will resume her medication at 7:00 AM, on 9/5/18." -A review of the BDDS report dated 9/2/18 indicated client B did not receive her 7:00 AM dose of clonazepam as ordered by the physician on 9/3/18 and 9/4/18. The review did not indicate client B received an additional dosage of Clonazepam as ordered by her physician. Client B's record was reviewed on 9/12/18 at 10:12 AM. Client B's MAR (Medication Administration Record) dated 9/1/18 to 9/30/18 indicated. "... Clonazepam Tab 0.5 MG (milligrams)... Give One Tablet By Mouth Every Morning. * No Refills* 7 AM... Clonazepam Tab 1 MG Give One Tablet By Mouth At Bedtime. * No Refills* 9 PM..." Client B's MAR 9/1/18 to 9/30/18 did not indicate documentation client B received her Clonazepam 0.5 MG at 7 AM or her Clonazepam 01 MG at 9 PM from 9/1/18 through 9/4/18 as ordered by the physician. RN (Registered Nurse) #1 was interviewed on		**PREVENTION:** The facility nurse will conduct weekly follow-up to assure medication audits occur as scheduled and that medications are ordered as needed. 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 available to administer as prescribed. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than twice weekly for the next 30 days, and after 30 days, will conduct administrative observations no less than weekly until all staff demonstrate competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9/12/18 at 1:02 PM. RN #1 was asked if client B had received her doses of Clonazepam 0.5 MG and 1 MG as ordered by the physician. RN #1 stated, "No. There was no refills on the script (prescription) by the Doctor." 9-3-6(a)		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 checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			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. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring medications are available to be administered as prescribed.	

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	09/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Additionally: 1.The Nurse Manager will do side by side audits of SGL homes with the assigned nurse as needed but no less than monthly. 2.Copies of Nurse Manager Audits will be provided to the Executive Director and Regional Director (Area Manager) for review. 3.The Executive Director will meet with the Nurse Manager weekly to review concerns raised through audits, incident reports or other concerns brought to management attention. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, facility nurse, Direct Support Staff, Operations Team	