ENTERS FOR	R MEDICARE & MEDI	CAID SERVICES				OM	IB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 04/01/2022	
NAME OF I	PROVIDER OR SUPPLIE	R	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE		
					UCKSKIN CT		
СОММО	NITY ALTERNATI	VES-ADEPT		INDIAN	IAPOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION
TAG V 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
0000							
Bldg. 00							
U	This visit was for a pre-determined full		W 0000				
	recertification and	state licensure survey.					
	ani · · ·, ·	e ze salar z					
		onjunction with the post					
	certification revisit (PCR) to the investigation of complaint #IN00370492 completed on 2/10/22.						
	Dates of Survey: N	March 28, 29, 30, 31 and April					
	1, 2022.						
	Essilite Manufacture	000070					
	Facility Number: ( Provider Number:						
	AIMS Number: 10						
	These deficiencies	also reflect state findings in					
	accordance with 4						
		this report completed by					
	#15068 on 4/13/22						
V 0104	483.410(a)(1)						
	GOVERNING BO	DDY					
Bldg. 00	policy, budget, a	ody must exercise general nd operating direction over					
	the facility.	ion, record review and	W 01	04	CORRECTION:		05/01/202
		3 sampled clients (A, B and C)	w 01	04	The governing body must		05/01/202
		lients (D, E, F, G and H), the			exercise general policy, bud	aet.	
	-	iled to exercise general policy,			and operating direction over		
		ng direction over the facility			facility. Specifically, the dead		
		t/egress door was not			lock has been removed from		
		ensure clients A, B, C, D, E,			fire escape egress door in cl		
		e ability to exit through the fire			D and G's bedroom and rep		
	exit/egress door.				with a standard entry lock to		
	Findings include:				facilitate exit from the facility the event of an emergency.	In	
					PREVENTION:		
	I	conducted at the group home				Team	1

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

TITLE

PRINTED: 05/04/2022

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G465		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/01/2022	
NAME OF PROVIDER OR SUPPLIER		6025 B	ADDRESS, CITY, STATE, ZIP CODE UCKSKIN CT IAPOLIS IN 46250		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF on 3/28/22 from 3:0 on 3/29/22 from 6:0 Clients A, B, C, D, throughout the obso at 3:23 PM the surv client G's bedroom, was a white sign w indicated "Exit". In standard size, white backyard. There wa circular, dead bolt I with a key only. DS stated, "I'm not surv off. I'm not even su DSL #1 proceeded group home's key r have a key to open The Life Safety Pla dated, was reviewe The POC indicated -"K 222" -"Correction:" -"No door in any m against egress when -"Specifically, the f deadbolt lock from emergency escape -"Corrections Comp A review of the Lift Life Safety had dire the deadbolt lock from	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION) 00 PM through 6:15 PM and 08 AM through 8:20 AM. E, F, G and H were observed ervation periods. On 3/28/22 reyor entered client B and Above their bedroom door ith red lettering which side the bedroom was a e door which exited to the as no door knob, only a ock which could be opened SL (Direct Support Lead) #1 e how long the knob's been re if we have a key to that." to try all of the keys on the ing and indicated she did not the fire exit/egress door. In of Correction (POC), not d on 3/30/22 at 10:00 AM. the following: eeans of escape shall be locked n the building is occupied."	INDIAN ID PREFIX TAG	APOLIS, IN 46250 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will incorporate reviews of the facility's emergency egresses int scheduled monthly audits to assure prompt evacuation can occur. <b>RESPONSIBLE PARTIES:</b> QIDP Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	5

PRINTED: 05/04/2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 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. WING 04/01/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6025 BUCKSKIN CT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Client B was interviewed on 3/29/22 at 8:02 AM. Client B was asked if a client had previously eloped through the egress/fire exit door in his bedroom. Client B stated, "Yes he did, before I was in that room. [FC A (Former Client) A], he ran away every day. That's the reason they took the door knob. [FDSL (Former Direct Support Lead)] #1 said it was a runaway risk." AS (Area Supervisor) #1 was interviewed on 3/28/22 at 3:39 PM. AS #1 was asked for how long the egress/fire exit door had been locked. AS #1 stated, "It's been like this since I ever had this site. We never have been able to access that door. I don't even have a key for that." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 3/30/22 at 12:40 PM. QIDPM #1 was asked if there was currently a deadbolt lock on the egress/fire exit door of the group home. QIDPM #1 stated, "Yes." QIDPM #1 indicated the facility completed a Life Safety POC and agreed to remove the deadbolt lock on the egress/fire exit door by 4/3/21. QIDPM #1 indicated the facility had not removed the deadbolt lock on the egress/fire exit door as indicated in the POC. 9-3-1(a) W 0153 483.420(d)(2) STAFF TREATMENT OF CLIENTS Bldg. 00 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. CORRECTION: Based on record review and interview for 1 of 5 W 0153 05/02/2022 allegations of abuse, neglect and mistreatment The facility must ensure that all FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2MKQ11 Facility ID: 000979 If continuation sheet Page 3 of 6

PRINTED:

05/04/2022

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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. WING 04/01/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6025 BUCKSKIN CT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS. IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) reviewed, the facility failed to report to BDDS allegations of mistreatment, (Bureau of Developmental Disabilities Services) neglect, or abuse, as well as within 24 hours of knowledge regarding client C injuries of unknown source, are communicating inappropriately with a minor via reported immediately to the an electronic device. administrator or to other officials in accordance with State law Findings include: through established procedures. Specifically, supervisory staff Client C's record was reviewed on 3/30/22 at have been retrained regarding 10:48 AM. A DPN (Daily Progress Note) dated required reporting criteria and 3/23/22 and completed by staff #1 indicated, "... timelines. [Client C] was caught contacting an underage girl **PREVENTION:** on his tablet through a game (video game). The Quality Assurance Manager [Client C's] electronics were confiscated and an and the QIDP Manager will IR (Incident Report) was filed ... ". carefully review all incidents reported by the facility and -A review of the DPN dated 3/23/22 indicated outside entities, to assure that client C had been communicating with a minor allegations and other required via one of his electronic devices. incidents are reported to the Bureau of Developmental Client C was interviewed on 3/29/22 at 8:08 AM. Disabilities Services as required Client C was asked why staff monitor his use of by state law. Each day, QIDP electronic devices. Client C stated, "Yes, they Manager or designee will compile watch me because they know how I am. I was a list of incidents requiring reports talking to a 13 year old girl inappropriately." to the Bureau of Developmental Disabilities Services, and Staff #1 was interviewed on 3/29/22 at 8:13 AM. distribute the list to administrative Staff #1 was asked if she had observed any staff (comprised of the Executive inappropriate communication by client C on his Director, Operations Managers, tablet/electronic device. Staff #1 stated, "Yes, he Program Managers, Area (client C) plays [name of a video game] and he Supervisors, Quality Assurance would click on it and I saw a picture. He (client Manager, QIDP Manager, Quality C) was saying I wish we could find another app Assurance Coordinators, Nurse (application) so we could talk dirty. The underage Manager, Assistant Nurse girl was saying if you don't stop you're going to Manager and QIDP) for review get in trouble again." and revision, as needed. The **QIDP** Manager or designee will QIDPM (Qualified Intellectual Disabilities assign reporting responsibilities Professional Manager) #1 was interviewed on daily. 3/30/22 at 12:40 PM. QIDPM #1 indicated the Supervisory staff will review all

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2MKQ11

Facility ID: 000979

PRINTED: 05/04/2022 FORM APPROVED

OMB NO. 0938-0391

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

## If continuation sheet

Page 4 of 6

	R MEDICARE & MEDI			ONGTRUCTION		B NO. 0938-0
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G465		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/01/2022		
		100+00			0-1/01/	2022
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
COMM						
COMMU	INITY ALTERNATI	VES-ADEPT	INDIAN	NAPOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIES	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	TE	COMPLET
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		a BDDS report regarding		facility documentation to assu	re	
	client C communicating inappropriately with a minor. QIDPM #1 indicated the facility should			incidents are reported as required. Additionally, internal	and	
		S report regarding this incident.		day service incident reports w		
				be sent via electronic fax direc		
	9-3-2(a)			to administrative staff. The Qu	-	
				Assurance Manager and the		
				QIDP Manager will coordinate	and	
				follow-up with the Quality	_	
				Assurance Coordinators, QID		
				and other staff responsible for reporting to outside agencies,		
				assure incidents are reported		
				state agencies as required.	.0	
				For the next 30 days, member	rs of	
				the Operations Team (comprise	sed	
				of the Executive Director,		
				Operations Managers, Progra		
				Managers, Quality Assurance		
				Manager, QIDP Manager, QID		
				Quality Assurance Coordinato Area Supervisors, Nurse Man		
				and Assistant Nurse Manager	•	
				conduct daily administrative	,	
				monitoring during varied		
				shifts/times, to assure interact	ion	
				with multiple staff, involved in	a full	
				range of active treatment		
				scenarios, including weekend		
				observations. After 30 days,		
				administrative monitoring will occur no less than three times		
				weekly until all staff demonstra		
				competence. After this period		
				enhanced administrative		
				monitoring and support, the		
				Executive Director and Regior		
				Director will determine the leve		
				ongoing support needed at the		
				facility. Administrative support	at	

	COF HEALTH AND HU					PPROVED . 0938-0391
STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         15G465		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 04/01/2022		
	ROVIDER OR SUPPLIEI		6025 B	ADDRESS, CITY, STATE, ZIP CODE UCKSKIN CT IAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	e CO	(X5) MPLETION DATE
				the home will include but not limited to assuring behavior supports are implemented as written and that required stat levels are in place. Administ support will include speaking staff and clients and reviewin progress notes and behavior tracking to assure all inciden reported as required. <b>RESPONSIBLE PARTIES:</b> Of Area Supervisor, Residentia Manager, Direct Support Stat Operations Team, Regional Director	s ffing rative g with ng ts are QIDP,	

Facility ID: 000979

If continuation sheet Page 6 of 6

PRINTED:

05/04/2022