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	04/01/2022

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

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00370492 completed on 2/10/22. Dates of Survey: March 28, 29, 30, 31 and April 1, 2022. 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 4/13/22.	W 0000		
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 3 of 3 sampled clients (A, B and C) plus 5 additional clients (D, E, F, G and H), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure a fire exit/egress door was not dead-bolted and to ensure clients A, B, C, D, E, F, G and H had the ability to exit through the fire exit/egress door. Findings include: Observations were conducted at the group home	W 0104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically, the dead bolt lock has been removed from the fire escape egress door in client D and G's bedroom and replaced with a standard entry lock to facilitate exit from the facility in the event of an emergency. **PREVENTION:** Members of the Operations Team	05/01/2022

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

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	on 3/28/22 from 3:00 PM through 6:15 PM and on 3/29/22 from 6:08 AM through 8:20 AM. Clients A, B, C, D, E, F, G and H were observed throughout the observation periods. On 3/28/22 at 3:23 PM the surveyor entered client B and client G's bedroom. Above their bedroom door was a white sign with red lettering which indicated "Exit". Inside the bedroom was a standard size, white door which exited to the backyard. There was no door knob, only a circular, dead bolt lock which could be opened with a key only. DSL (Direct Support Lead) #1 stated, "I'm not sure how long the knob's been off. I'm not even sure if we have a key to that." DSL #1 proceeded to try all of the keys on the group home's key ring and indicated she did not have a key to open the fire exit/egress door. The Life Safety Plan of Correction (POC), not dated, was reviewed on 3/30/22 at 10:00 AM. The POC indicated the following: -"K 222" -"Correction:" -"No door in any means of escape shall be locked against egress when the building is occupied." -"Specifically, the facility will remove the deadbolt lock from bedroom #4 that provides emergency escape...". -"Corrections Completed By: 4/3/21...". A review of the Life Safety POC form indicated Life Safety had directed the facility to remove the deadbolt lock from bedroom #4/client B and G's bedroom, to be removed and completed by 4/3/21.		(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 into scheduled monthly audits to assure prompt evacuation can occur. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	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 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 5 allegations of abuse, neglect and mistreatment	W 0153	**CORRECTION:** *The facility must ensure that all*	05/02/2022

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	reviewed, the facility failed to report to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of knowledge regarding client C communicating inappropriately with a minor via an electronic device. Findings include: Client C's record was reviewed on 3/30/22 at 10:48 AM. A DPN (Daily Progress Note) dated 3/23/22 and completed by staff #1 indicated, "... [Client C] was caught contacting an underage girl on his tablet through a game (video game). [Client C's] electronics were confiscated and an IR (Incident Report) was filed...". -A review of the DPN dated 3/23/22 indicated client C had been communicating with a minor via one of his electronic devices. Client C was interviewed on 3/29/22 at 8:08 AM. Client C was asked why staff monitor his use of electronic devices. Client C stated, "Yes, they watch me because they know how I am. I was talking to a 13 year old girl inappropriately." Staff #1 was interviewed on 3/29/22 at 8:13 AM. Staff #1 was asked if she had observed any inappropriate communication by client C on his tablet/electronic device. Staff #1 stated, "Yes, he (client C) plays [name of a video game] and he would click on it and I saw a picture. He (client C) was saying I wish we could find another app (application) so we could talk dirty. The underage girl was saying if you don't stop you're going to get in trouble again." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 3/30/22 at 12:40 PM. QIDPM #1 indicated the		*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.* Specifically, supervisory staff have been retrained regarding required reporting criteria and timelines. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services, and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager, Assistant Nurse Manager and QIDP) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all	

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	facility did not file a BDDS report regarding client C communicating inappropriately with a minor. QIDPM #1 indicated the facility should have filed a BDDS report regarding this incident. 9-3-2(a)		facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. 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. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction 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 demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative support at	

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			the home will include but not be limited to assuring behavior supports are implemented as written and that required staffing levels are in place. Administrative support will include speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents are reported as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	