

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|---|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 | <p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Dates of Survey: 1/31/17, 2/1/17, 2/2/17 and 2/3/17.</p> <p>Facility Number: 000963 Provider Number: 15G449 AIMS Number: 100244740</p> <p>These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/9/17.</p> | W 0000 | | |
| W 0125 Bldg. 00 | <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1 had a surrogate</p> | W 0125 | <p>CORRECTION:</p> <p><i>The facility must ensure the rights of all clients. Therefore, the</i></p> | 03/05/2017 |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>to assist him in decision making.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/1/17 at 9:06 AM. Client #1's ISP (Individual Support Plan) dated 11/22/16 indicated client #1 was an emancipated adult with his maternal aunt serving as his HCR (Health Care Representative)/advocate.</p> <p>Client #1's Person Centered Planning Profile (PCPP) dated 6/22/16 indicated the following:</p> <p>-"[Client #1] does not have any contact currently with his family members, although the program director received a call from [client #1's] aunt in February of 2003. [Aunt] informed the program director that [client #1's] mother was residing with her in [state] due to [illness]. There has been very limited contact made since that time. [Client #1's] aunt is [client #1's] advocate."</p> <p>-"Although [client #1] is an emancipated adult, serving as his own legal guardian, he has not been assessed as being able to give informed consent on major life decisions. In other words, there may be situations where decisions must be made that directly affect [client #1's] life that</p> | | <p><i>facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</i> Specifically, the facility has reassessed client #1's ability to give informed consent and will assist client #1 with obtaining a legal guardian. A review of facility documentation indicated this deficient practice affected one additional client and therefore the team will assist client #4 with finding appropriate representation.</p> <p>PREVENTION:</p> <p>Professional staff will be retrained regarding the need to assure that all individuals have appropriate assistance making major life decision, based on their assessed ability to give informed consent. The Operations Team comprised of the Quality Assurance Manager, Quality Assurance Coordinator, Executive Director, Program Managers, Training Coordinator, Nurse Manager and Area Supervisors will review assessments as part of a monthly audit process and direct the interdisciplinary team to assist clients with obtaining appropriate representation when they lack</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>go beyond his everyday routines (i.e. surgical or medical procedures, chemical or physical interventions, legal claims, etc.) that [client #1's aunt/advocate] will assist with giving informed consent and assist with major life decisions and that would require Human Rights Committee approval before being undertaken."</p> <p>Client #1's Informed Consent Assessment dated 6/22/16 indicated client #1 was not independent and required assistance with routine medical and dental care, elective procedures and surgery, non-elective procedures and surgery, programming and habilitation training, behavioral management and financial management.</p> <p>Client #1's Physician's Orders form dated 11/28/16 indicated client #1's diagnoses included but were not limited to Profound Intellectual Disability, Martin Bell Fragile X Syndrome and behavioral/psychotic condition.</p> <p>Client #1's Consent for Medication form dated 1/29/16 indicated client #1's daily medications included but were not limited to Paliperidone Tablet Extended Release 3 milligrams (schizophrenia). Client #1's Consent for Medication form dated 1/29/16 did not indicate documentation of client #1's aunt/advocate's participation or assistance</p> | | <p>the ability to give informed consent.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|--|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>in helping client #1 give informed consent.</p> <p>Client #1's ISP dated 11/22/16 did not indicate documentation of client #1's aunt/advocate's participation or assistance in helping client #1 make decisions regarding his programming or habilitation services.</p> <p>Client #1's BSP (Behavior Support Plan) dated 11/22/16 did not indicate documentation of client #1's aunt/advocate's participation or assistance in helping client #1 make decisions regarding his programming or behavioral management services/needs.</p> <p>Resident Manager (RM) #1 and QIDP (Qualified Intellectual Disabilities Professional) #1 were interviewed on 2/1/17 at 11:22 AM. RM #1 and QIDP #1 indicated client #1 was not assessed as being able to give informed consent. RM #1 and QIDP #1 indicated client #1's aunt was his HCR and advocate. RM #1 and QIDP #1 indicated client #1's aunt did not participate or assist client #1 make informed decisions regarding his medical, dental, programming, financial or behavioral management care.</p> <p>Client #1 did not communicate verbally and did not respond to attempts to engage</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 0159 Bldg. 00 | <p>or be interviewed throughout multiple attempts on 1/31/17, 2/1/17 or 2/2/17.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2 and #3's active treatment programs by failing to convene clients #1 and #2's IDT (Interdisciplinary Team) in a timely manner to address their individual refusals to participate in medical, dental and vision evaluations/treatments, ensure client #1 had a surrogate to assist him in decision making, to implement client #1's meal time protocol during mealtimes, to ensure clients #2 and #3's CFAs (Comprehensive Functional Assessments) were reviewed annually and to ensure the HRC (Human Rights Committee) obtained written informed</p> | W 0159 | <p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically the governing body will assure that:</i></p> <p>The QIDP has convened the interdisciplinary team to develop an aggressive approach to addressing client #1 and client #2's refusals to participate in medical dental and visual evaluations and treatments. Client #1 and client #2's support plans will be updated accordingly.</p> <p>The facility has reassessed client</p> | 03/05/2017 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>consent from a representative/advocate of client #1's interests regarding his behavioral management services.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 2/1/17 at 9:06 AM. Client #1's Physician's Orders form dated 11/28/16 indicated, "Laboratory Orders: Chemical profile annually, HGB (oxygen/iron levels in the blood), A1C (blood sugar/glucose), Lipid (fat/cholesterol in the blood) annually due to use of anti psychotics. CBC (complete blood count) without differential every month."</p> <p>Record of Visit form dated 1/18/17 indicated client #1 refused to participate in his scheduled TB (Tuberculosis) testing.</p> <p>Dental Summary Progress Report dated 4/8/15 indicated client #1 should return annually for an examination. Client #1's record did not indicate documentation of additional dental examination since 4/8/15.</p> <p>Client #1's Record of Visit form dated 5/16/16 indicated, "Optometrist. Comprehensive Exam. Unable to examine as [client #1] would not sit in chair and walked around constantly.</p> | | <p>#1's ability to give informed consent and will assist client #1 with obtaining a legal guardian. A review of facility documentation indicated this deficient practice affected one additional client and therefore the team will assist client #4 with finding appropriate representation.</p> <p>Client #2 and client #3's Comprehensive Functional Assessment will be updated. A review of facility support documents indicated this deficient practice did not affect any additional clients.</p> <p>Written informed consent from Client #1 for Client #1's Behavior Support Plan and other restrictive programs. Additionally, the team will obtain a legal guardian for Client #1 (See W 125). A review of facility documentation indicated this deficient practice did not affect additional consumers.</p> <p>All direct support staff, including day program staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|--|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>When led to chair was mildly combative. Recommend to have exam in facility were (he) lives. May feel more comfortable. Due to wondering (sic) and inability to be directed, not recommend this setting."</p> <p>Client #1's Record of Visit form dated 9/9/16 indicated, "Bloodwork (labs) refused."</p> <p>Client #1's Record of Visit form dated 7/11/16 indicated, "Bloodwork (labs) refused."</p> <p>Client #1's ISP (Individual Support Plan) Desensitization Plan dated 11/22/15 indicated, "[Client #1's] past history of medical visits has shown that he gets very agitated and physically aggressive during medical appointments and requires some type of sedation."</p> <p>Client #1's IDT note dated 1/19/17 indicated, "Team met to discuss [client #1's] refusal with vision, dental, primary care physician, podiatrist and labs. Staff has administered pre-medication with HRC (Human Rights Committee) approval but [client #1] still refuses treatment. The team agreed that staff will contact [primary care physician] regarding sedation to assist with [client #1's] anxiety with receiving health care</p> | | <p>provide consistent, aggressive and continuous active treatment for all clients including but not limited implementing client #1's meal time protocol. Through observation, supervisory and administrative staff determined this deficient practice did not affect additional clients.</p> <p>PREVENTION:</p> <p>The QIDP will be retrained regarding the need to assure the interdisciplinary team meets in a timely manner to address refusals to participate and other needs in a timely manner when they have been identified through observation and documentation.</p> <p>The QIDP will be retrained regarding the need to assure that all individuals have appropriate assistance making major life decision, based on their assessed ability to give informed consent.</p> <p>The QIDP will be retrained regarding the need to assure that all relevant assessments are reviewed and updated as needed but no less than annually.</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>services."</p> <p>Client #1's record did not indicate documentation of additional IDT review or recommendations to address client #1's refusal to allow or participate in medical, dental, vision or laboratory screening procedures.</p> <p>2. Client #2's record was reviewed on 2/1/17 at 10:24 AM. Client #2's record did not indicate documentation of dental assessment or examination.</p> <p>Client #2's Record of Visit form dated 2/3/16 indicated, "Needs to be seen by a facility with specialized equipment." Client #2's Record of Visit form dated 2/3/16 indicated client #2 refused to participate in his vision assessment.</p> <p>Client #2's ISP (Individual Support Plan) Desensitization Plan dated 11/25/15 indicated, "[Client #2's] past history of medical visits has shown that he gets very agitated and physically aggressive during medical appointments and requires some type of sedation."</p> <p>Client #2's IDT note dated 1/19/17 indicated, "Team met to discuss [client #2's] refusal with vision, dental, primary care physician, podiatrist and labs. Staff has administered pre-medication with</p> | | <p>The QIDP will be retrained regarding the need to assure written informed consent is obtained prior to the implementation of restrictive programs.</p> <p>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 meal preparation, family style dining (including provision of specially prescribed diets and implementation of dining objectives), other domestic skills and meaningful leisure activities. The Day Service Activity Manager will assist with and monitor mealtime skills training including but not limited to provision of specially prescribed diets and implementation of dining objectives. The Area Supervisor and/or the QIDP will be in the home to provide hands-on coaching and monitor skills training including but not limited to meal preparation, family style dining (including provision of specially prescribed diets and implementation of dining objectives), other domestic skills</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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) |
| | <p>HRC (Human Rights Committee) approval but [client #2] still refuses treatment. The team agreed that staff will contact [primary care physician] regarding sedation to assist with [client #2's] anxiety with receiving health care services."</p> <p>Client #2's record did not indicate documentation of additional IDT review or recommendations to address client #2's refusal to allow or participate in medical, dental, vision or laboratory screening procedures.</p> <p>Resident Manager (RM) #1 and QIDP (Qualified Intellectual Disabilities Professional) #1 were interviewed on 2/1/17 at 11:22 AM. RM #1 indicated clients #1 and #2 both refused to participate in medical and dental procedures or appointments. RM #1 indicated clients #1 and #2 both receive pre-appointment sedation medication prior to appointments. RM #1 indicated clients #1 and #2's pre-medication is not effective and clients #1 and #2 remain unable/unwilling to be assessed for medical, dental and vision needs. QIDP #1 indicated the IDT had met on 1/18/17 to discuss and make recommendations regarding clients #1 and #2's medical, dental and vision refusals. QIDP #1 indicated there was not additional</p> | | | <p>and meaningful leisure activities. Members of the Operations Team, comprised of the Program Managers, Day Service Manager, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than twice weekly for the next 30 days, and 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. Administrative monitoring is defined as:</p> <p>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.</p> |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>documentation of IDT review or discussion regarding clients #1 or #2's medical, dental or vision refusals.</p> <p>3. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure client #1 had a surrogate to assist him in decision making. Please see W125.</p> <p>4. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure facility and day services staff implemented client #1's meal time protocol during mealtimes. Please see W249.</p> <p>5. The QIDP failed to integrate, coordinate and monitor clients #2 and #3's active treatment programs by failing to ensure clients #2 and #3's CFA were reviewed annually. Please see W259.</p> <p>6. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure the facility's HRC obtained written informed consent from a representative/advocate of client #1's interests regarding his behavioral management services. Please see W263.</p> <p>9-3-3(a)</p> | | <p>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.</p> <p>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.</p> <p>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 <i>facility</i>. Administrative support at the home will include</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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) |
| W 0249 Bldg. 00 | 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the | | | <ul style="list-style-type: none"> · Assuring all clients have adequate representation to assist with decision making based on their informed consent assessment. · Assuring the QIDP convenes the interdisciplinary team in a timely manner to address refusals to participate and other needs in a timely manner when they have been identified through observation and documentation. · Assuring staff provide continuous active treatment during formal and informal opportunities, including provision of specially prescribed diets and implementation of dining objectives. · Assuring all relevant assessments are current. · Assuring prior written informed consent has been obtained for all restrictive programs. <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure facility and day program staff implemented client #1's meal time protocol during mealtimes.</p> <p>Findings include:</p> <p>Observations were conducted at client #1's day service provider on 1/31/17 from 11:15 AM through 12:00 PM. Client #1 participated in his assigned room's lunch from 11:25 AM through 11:48 AM. Client #1 ate his lunch in his assigned classroom with client #2, 2 unknown day service clients and Day Service Staff (DSS) #1. Throughout the observation of client #1's meal, he consumed his food at a fast pace without chewing his food before placing additional portions/bites into his mouth. DSS #1 verbally cued client #1 to slow down his pace of placing additional food items in his mouth. DSS #1 did not prompt or encourage client #1 to alter his bites of food with his drink or to place his utensil on the table between bites.</p> <p>DSS #1 was interviewed on 1/31/17 at 11:25 AM. When asked what client #1's dietary orders were, DSS #1 indicated</p> | W 0249 | <p>CORRECTION:</p> <p><i>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically, all direct support staff, including day program staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited implementing client #1's meal time protocol. Through observation, supervisory and administrative staff determined this deficient practice did not affect additional clients.</i></p> <p>PREVENTION:</p> <p>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</p> | 03/05/2017 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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) |
| | <p>client #1's food was mechanical soft, thickened liquids and prompts to slow down.</p> <p>Observations were conducted at the group home on 1/31/17 from 4:45 PM through 6:00 PM. Client #1 participated in the home's evening family style meal from 5:40 PM through 6:00 PM. Throughout the observation of client #1's meal, he consumed his food at a fast pace without chewing his food before placing additional portions/bites into his mouth. RM (Resident Manager) #1 verbally cued client #1 to slow down his pace of placing additional food items in his mouth. RM #1 did not prompt or encourage client #1 to alter his bites of food with his drink or to place his utensil on the table between bites.</p> <p>Observations were conducted at the group home on 2/1/17 from 6:40 AM through 8:00 AM. Client #1 participated in the home's morning family style meal from 7:22 AM through 7:50 AM. Throughout the observation of client #1's meal, he consumed his food at fast pace without chewing his food before placing additional portions/bites into his mouth. RM #1 verbally cued client #1 to slow down his pace of placing additional food items in his mouth. RM #1 did not prompt or encourage client #1 to alter his</p> | | | <p>including but not limited to meal preparation, family style dining (including provision of specially prescribed diets and implementation of dining objectives), other domestic skills and meaningful leisure activities. The Day Service Activity Manager will assist with and monitor mealtime skills training including but not limited to provision of specially prescribed diets and implementation of dining objectives. The Area Supervisor and/or the QIDP will be in the home to provide hands-on coaching and monitor skills training including but not limited to meal preparation, family style dining (including provision of specially prescribed diets and implementation of dining objectives), other domestic skills and meaningful leisure activities. Members of the Operations Team, comprised of the Program Managers, Day Service Manager, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than twice weekly for the next 30 days, and no less than weekly until all staff demonstrate competence. At the conclusion of this period of enhanced</p> |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>bites of food with his drink or to place his utensil on the table between bites.</p> <p>Client #1's record was reviewed on 2/1/17 at 9:06 AM. Client #1's Physician's Orders form dated 11/28/16 indicated, "One to one supervision during meals. Set utensils down between bites and sips of nectar thickened liquids."</p> <p>Client #1's ISP (Individual Support Plan) dated 11/22/16 indicated client #1 had a formal training objective to place a single bite size amount of food in his mouth. Client #1's meal time objective methodology indicated the following:</p> <p>-"4. When [client #1] seems to be over filling his spoon, staff should encourage [client #1] to decrease the amount he has on his spoon by giving him a verbal prompt. This will be [client #1's] first verbal prompt. Continue training as needed. If [client #1] still has not complied offer him a demonstration by showing him the amount he should have on his spoon.</p> <p>5. Because [client #1] has (a) tendency to eat (at) a rapid pace, staff should also offer [client #1] prompts to slow down and rest his spoon between bites, which can also be helpful by prompting him to take sips between bites and if he declines</p> | | <p>administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative monitoring is defined as:</p> <p>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.</p> <p>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.</p> <p>In addition to active treatment observations, Operations Team</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|---|--|---|---|--|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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) |
| W 0259 | <p>try counting to five giving him a marker when to take the next bite. These are also guidelines addressed in [client #1's] dining guidelines."</p> <p>Resident Manager #1 and QIDP #1 were interviewed on 2/1/17 at 11:22 AM. RM #1 indicated client #1 should be prompted to slow down the pace of placing additional bites of food into his mouth while eating, place his utensil down on the table between bites and encouraged to alternate bites of food with liquids. RM #1 indicated she had verbally cued client #1 to slow his rate of eating. When asked if she had encouraged client #1 to place his utensil down on the table between bites, or encouraged him to alternate bites of food with liquids, RM #1 stated, "No." QIDP #1 indicated active treatment and programs should be implemented at client #1's day services and home.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE</p> | | | <p>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.</p> <p>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 provision of specially prescribed diets and implementation of dining objectives.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| Bldg. 00 | <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on record review and interview for 2 of 3 sampled clients (#2 and #3), the facility failed to ensure clients #2 and #3's CFAs (Comprehensive Functional Assessments) were reviewed annually.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client #2's record was reviewed on 2/1/17 at 10:24 AM. Client #2's CFA dated 11/6/15 indicated client #2's CFA was reviewed by the facility. Client #2's record did not indicate documentation of additional review of client #2's CFA since 11/6/15. Client #3's record was reviewed on 2/1/17 at 10:52 AM. Client #3's CFA dated 8/26/15 indicated client #3's CFA was reviewed by the facility. Client #3's record did not indicate documentation of additional review of client #3's CFA since 8/26/15. <p>Resident Manager (RM) #1 and QIDP (Qualified Intellectual Disabilities Professional) #1 were interviewed on 2/1/17 at 11:22 AM. RM #1 and QIDP #1 indicated there was not additional documentation available for review regarding clients #2 or #3's CFAs. RM #1</p> | W 0259 | <p>CORRECTION:</p> <p><i>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Specifically, Client #2 and client #3's Comprehensive Functional Assessment will be updated. A review of facility support documents indicated this deficient practice did not affect any additional clients.</i></p> <p>PREVENTION:</p> <p>The QIDP will be retrained regarding the need to assure that all relevant assessments are reviewed and updated as needed but no less than annually. The Clinical Supervisor and other members of the Operations Team will review facility support documents no less than monthly to assure appropriate re-assessment occurs as required. Members of the Operations Team (including Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager,</p> | 03/05/2017 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|--|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 0263 Bldg. 00 | <p>and QIDP #1 indicated clients #2 and #3's CFAs should be reviewed and updated annually.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#1), the facility's HRC (Human Rights Committee) failed to obtain written informed consent from a representative/advocate of client #1's interests regarding his behavioral management services.</p> | W 0263 | <p>Training Coordinator and Quality Assurance Coordinator) will conduct documentation reviews no less than twice weekly for the next 30 days, weekly until the QIDP demonstrates competence. At the conclusion of this period of intensive administrative monitoring and support, the Executive Director and Regional Director (area manager) will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include assuring all relevant assessments are current.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> <p>CORRECTION:</p> <p><i>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically, written informed consent from Client #1</i></p> | 03/05/2017 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>Findings include:</p> <p>Client #1's record was reviewed on 2/1/17 at 9:06 AM. Client #1's HRC form dated 9/2/16 indicated the facility's HRC reviewed and approved the use of Invega 60 milligrams (anti-psychotic) daily for the management of client #1's behavior.</p> <p>Client #1's HRC form dated 11/22/16 indicated the facility's HRC reviewed and approved the use of Invega 60 milligrams and Buspirone 5 milligrams (anxiety) daily for the management of client #1's behavior.</p> <p>Client #1's Physician's Orders form dated 11/28/16 indicated client #1 had physician's orders for Triazolam tablet .25 milligrams (sedative) PRN (As Needed) before appointments, Buspirone tablet 5 milligrams, Diazepam tablet 10 milligrams (sedative) before appointments and Invega 3 milligram tablet.</p> <p>Client #1's ISP (Individual Support Plan) dated 11/22/16 indicated client #1 was an emancipated adult with his maternal aunt serving as his HCR (Health Care Representative)/advocate.</p> <p>Client #1's Person Centered Planning</p> | | <p>for Client #1's Behavior Support Plan and other restrictive programs. Additionally, the team will obtain a legal guardian for Client #1 (See W 125). A review of facility documentation indicated this deficient practice did not affect additional consumers.</p> <p>PREVENTION:</p> <p>The QIDP will be retrained regarding the need to assure written informed consent is obtained prior to the implementation of restrictive programs. Members of the Operations Team (including Program Managers, Nurse Manager and Executive Director, Quality Assurance Manager, Training Coordinator and Quality Assurance Coordinator) will review restrictive programs on an ongoing basis to assure prior written informed consent has been obtained.</p> <p>Initially administrative monitoring will occur with increased frequency as follows: Members of the Operations Team will conduct documentation reviews no less than twice weekly for the next 30 days, weekly for an additional 60</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>Profile (PCPP) dated 6/22/16 indicated the following:</p> <p>- "[Client #1] does not have any contact currently with his family members, although the program director received a call from [client #1's] aunt in February of 2003. [Aunt] informed the program director that [client #1's] mother was residing with her in [state] due to [illness]. There has been very limited contact made since that time. [Client #1's] aunt is [client #1's] advocate."</p> <p>- "Although [client #1] is an emancipated adult, serving as his own legal guardian, he has not been assessed as being able to give informed consent on major life decisions. In other words, there may be situations where decisions must be made that directly affect [client #1's] life that go beyond his everyday routines (i.e. surgical or medical procedures, chemical or physical interventions, legal claims, etc.) that [client #1's aunt/advocate] will assist with giving informed consent and assist with major life decisions and that would require Human Rights Committee approval before being undertaken."</p> <p>Client #1's Informed Consent Assessment dated 6/22/16 indicated client #1 was not independent and required assistance with behavioral management services.</p> | | <p>Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. These administrative documentation reviews will include assuring prior written informed consent has been obtained for all restrictive programs.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|--|--|---|--|---|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>Client #1's Consent for Medication form dated 1/29/16 indicated client #1's daily medications included but were not limited to Paliperidone Tablet Extended Release 3 milligrams (schizophrenia). Client #1's Consent for Medication form dated 1/29/16 did not indicate documentation of client #1's aunt/advocate's participation or assistance in helping client #1 give informed consent. Client #1's record did not indicate documentation of client #1's aunt or advocate assisting client #1 give his written informed consent regarding the use of Triazolam tablet .25 milligrams, Buspirone tablet 5 milligrams and Diazepam tablet 10 milligrams for the management of client #1's behavior.</p> <p>Client #1's BSP (Behavior Support Plan) dated 11/22/16 did not indicate documentation of client #1's aunt/advocate's participation or assistance in helping client #1 make decisions regarding his programming or behavioral management services/needs.</p> <p>Resident Manager (RM) #1 and QIDP (Qualified Intellectual Disabilities Professional) #1 were interviewed on 2/1/17 at 11:22 AM. RM #1 and QIDP #1 indicated client #1 was not assessed as being able to give informed consent. RM</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 |
|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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) |
| W 0440 Bldg. 00 | <p>#1 and QIDP #1 indicated client #1's aunt was his HCR and advocate. RM #1 and QIDP #1 indicated client #1's aunt did not participate or assist client #1 make informed decisions regarding his behavioral management care. QIDP #1 indicated written informed consent was needed for the use of behavior controlling medications.</p> <p>Client #1 did not communicate verbally and did not respond to attempts to engage or be interviewed throughout multiple attempts on 1/31/17, 2/1/17 or 2/2/17.</p> <p>9-3-4(a)</p> | | W 0440 | <p>CORRECTION: The facility must hold evacuation drills at least quarterly for each shift of personnel. Specifically, the facility has conducted additional evacuation drills on each shift during the current quarter.</p> <p>PREVENTION:</p> |
| | <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), plus 3 additional clients (#4, #5 and #6), the facility failed to conduct evacuation drills quarterly for each shift of personnel for clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:</p> <p>The facility's fire evacuation drills record was reviewed on 2/1/17 at 7:30 AM. The</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G449 | (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | (X3) DATE SURVEY COMPLETED 02/03/2017 | |
|--|---|--|---|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7859 DELBROOK DR INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| | <p>review indicated the facility failed to conduct evacuation drills for clients #1, #2, #3, #4, #5 and #6 for the day and overnight shift of personnel for the second quarter, April, May and June of 2016.</p> <p>RM (Resident Manager) #1 was interviewed on 2/1/17 at 7:40 AM. RM #1 indicated the group home should conduct evacuation drills one time per quarter per shift of personnel.</p> <p>9-3-7(a)</p> | | | <p>Professional staff will be retrained regarding the need to conduct evacuation drills on each shift for all staff each quarter. The Operations Team will review all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled. Program Manager will track evacuation drill compliance and follow up with facility professional staff and the agency Safety Committee accordingly.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> | |