STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE STATEMENT OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLE 15G465 B. WING 02/10/2		PLETED					
	ROVIDER OR SUPPLIER			6025 BI	ADDRESS, CITY, STATE, ZIP COD UCKSKIN CT IAPOLIS, IN 46250	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W 0000	REGULATORT OF	A LSC IDENTIFT ING INFORMATION		TAG			DATE
Bldg. 00	#IN00370492. Complaint #IN0037 and state deficiencing are cited at W102, W102 Dates of Survey: Fee Facility Number: 00 Provider Number: 100 These deficiencies a accordance with 46	5G465 0244860 also reflect state findings in	W 0	000			
W 0102 Bldg. 00	The facility must egoverning body ar requirements are Based on record revisampled clients (A meet the Condition Body. The governing general policy, budy over the facility to completed regarding exploitation of clientinappropriate usage media by client B a	met. view and interview for 2 of 3 and B), the facility failed to of Participation: Governing ag body neglected to exercise get and operating direction ensure an investigation was ag an allegation of financial at A, an incident of of electronic devices/social and failed to ensure the facility system regarding ensuring the	W 0	102	CORRECTION: The facility must ensure that specific governing body and management requirements at met. Specifically: The Quality Assurance Manawill complete an investigation an allegation of financial exploitation of client A. If the allegation is substantiated, the governing body will reimburse client A for any missing or unaccounted for funds. Due to the fact that this deficit	ger into e	03/11/2022

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

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	a. building <u>00</u>			COMPLETED	
		15G465	B. W	ING	_	02/10/	2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	8	6025 BUCKSKIN CT					
COMMUI	NITY ALTERNATIV	ES-ADEPT			IAPOLIS, IN 46250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					practice may have affected otl			
		ody failed to exercise general			clients, the governing body ha	s		
		operating direction over the			tasked the Quality Assurance			
	-	investigation was completed			Manager with completing an			
		tion of financial exploitation of			independent audit of the finan			
		dent of inappropriate usage of			for each client who resides at			
		ocial media by client B and			facility, under the oversight of			
		facility had a reproducible			Regional Director. Based on the	ne		
		ompleted investigations.			audit results, clients will be			
	Please see W104.				reimbursed for any expenditur			
		1.63.1			for items not in possession of	the		
		ody failed to exercise general			client, items purchased for			
		operating direction over the			household use (i.e., furnishing			
		Condition of Participation:			linens etc.), or that lack compl	ete		
		or 2 of 3 sampled clients (A			documentation.			
		ing body neglected to exercise			All facility investigations will be	9		
		get and operating direction			completed by trained			
		ensure an investigation was			investigators. When incidents	.		
		g an allegation of financial			requiring investigation occur, t	ine		
	-	nt A and an incident of			QA manager or designee will			
		of electronic devices/social			assign the investigation to a	ار ع		
	-	nd failed to ensure the facility system regarding completed			specific investigator. Copies of			
	investigations. Plea				investigations will be maintain	ea		
	investigations. Freat	se see w122.			by the Quality Assurance			
	This federal tag rate	ates to complaint #IN00370492.			Department to be available for review, as required. Specifical			
	This icuciai tag icia	ics to complaint π111003/0432.			investigators will save electror	-		
	9-3-1(a)				files of all components of	IIC		
	γ·3-1(a)				investigations into a shared			
					investigation folder to provide			
					access and monitoring capabi	litv		
					throughout the investigation	y		
					process and to allow			
					investigations to be reproduce	ed		
					and provided to regulatory ent			
					as required. The QIDP manag			
					will conduct follow-up with the	•		
					investigator to assure complet			
					within required timeframes.			
					In addition to weekly face to fa	ace		
						-		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 02/10/2022		
	PROVIDER OR SUPPLIE		6025 B	ADDRESS, CITY, STATE, ZIP COD UCKSKIN CT IAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
140	REGULATOR TO			training and follow-up with the Quality Assurance Manager, investigators will receive ongomentorship from the QIDP Manager, including but not limb to interview techniques, gather and analysis of documentary evidence. The emphasis of the mentorship/training will be development of appropriate sound conclusions, as well as timanagement skills to facilitate timely completion if investigate The QIDP Manager will provieweekly follow-up to the QA Manager regarding progress additional training needs. PREVENTION: The QIDP Manager will maintracking spreadsheet for incider requiring investigation, follow and corrective/protective measuill be maintained and distributed daily to facility supervisors and Operations Team, comprised the Executive Director, Operations Team, comprised the Executive Director, Operations Team, Quality Assurance Manager, QIDP Manager, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager Assistant Nurse Manager. The Quality Assurance Manager of the Wassurance Manager of	ethe bing nited ering nis cope me etions. de and tain a dents -up asures uted ad the of ations rs, r and e will ment no e ts

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/10/2022
	PROVIDER OR SUPPLIE		6025 B	ADDRESS, CITY, STATE, ZIP COD BUCKSKIN CT NAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W 0104	483.410(a)(1)			investigation. QA team member will be required to attend and an in-service documentation at these meetings stating that the are aware of which investigati with which they are required to conduct, as well as the specific components of the investigati which they are responsible, with the Executive Director to assure appropriate follow through assure appropriate follows. The Quality Assurance Team review each investigation, as complete does not meet these criteria. Failure to complete thorough investigation, as complete does not meet these criteria. Failure to complete thorough investigation, as complete does not meet these criteria. Failure to complete thorough investigation, as complete does not meet these criteria. Failure to complete thorough investigation, as complete does not meet these criteria. Failure to complete thorough investigation, as complete does not meet these criteria. Failure to complete thorough and investigation, as complete does not meet these criteria. Failure to complete thorough application to each application to	sign at ey cons co ic con for ithin ne. he ngs ough will cnsure ng ate d, if it rable nay e
Bldg. 00	GOVERNING BC	DY dy must exercise general			
	policy, budget, ar the facility.	d operating direction over view and interview for 2 of 3	W 0104	CORRECTION:	03/11/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u> COMI			TED
		15G465	B. W	B. WING		02/10/2022	
		ı		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEI	3			UCKSKIN CT		
COMM	NITY ALTERNATIV	/ES-ΔDEPT			IAPOLIS, IN 46250		
CONTINIO		LO-ADEI I		וואטואוו	17 11 OLIO, IIV 70230		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		and B), the governing body			The governing body must exe	ercise	
	neglected to exercise general policy, budget and				general policy, budget, and		
		over the facility to ensure an			operating direction over the		
	_	ompleted regarding an			facility. Specifically:		
		ial exploitation of client A, an			The Quality Assurance Manag	_	
		priate usage of electronic			will complete an investigation	into	
		ia by client B and failed to			an allegation of financial		
	-	nad a reproducible system			exploitation of client A. If the		
	ensuring the compl	etion of investigations.			allegation is substantiated, the		
					governing body will reimburse	•	
	Findings include:				client A for any missing or		
					unaccounted for funds.		
	1. The governing body failed to exercise general				Due to the fact that this defici		
		operating direction over the			practice may have affected of		
		implemented its policy and			clients, the governing body ha		
		re an investigation was			tasked the Quality Assurance		
		g an allegation of financial			Manager with completing an		
	_	nt A, an incident of			independent audit of the finar		
		e of electronic devices/social			for each client who resides at		
	-	and failed to ensure the facility			facility, under the oversight of		
		system ensuring the			Regional Director. Based on t	he	
	completion of inve	estigations. Please see W149.			audit results, clients will be		
	l				reimbursed for any expenditu		
		ody failed to exercise general			for items not in possession of	the	
		operating direction over the			client, items purchased for		
		n investigation was completed			household use (i.e., furnishing		
		tion of financial exploitation of			linens etc.), or that lack comp	lete	
		ident of inappropriate usage of			documentation.		
		social media by client B. Please			All facility investigations will b	e	
	see W154.				completed by trained		
		1.1.4/17/100270402			investigators. When incidents		
	This federal tag rela	ates to complaint #IN00370492.			requiring investigation occur,	the	
	0.2.1()				QA manager or designee will		
	9-3-1(a)				assign the investigation to a	,	
					specific investigator. Copies		
					investigations will be maintain	ied	
					by the Quality Assurance		
					Department to be available fo		
					review, as required. Specifica	-	
					investigators will save electro	nic	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 02/10/2022	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
	NITY ALTERNATIV			BUCKSKIN CT NAPOLIS, IN 46250	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	+	DATE
				files of all components of investigations into a shared	
				investigation folder to provide	
				access and monitoring capab	
				throughout the investigation	-
				process and to allow	
				investigations to be reproduce	
				and provided to regulatory en	
				as required. The QIDP manage	-
				will conduct follow-up with the	
				investigator to assure comple	tion
				within required timeframes. In addition to weekly face to f	ace
				training and follow-up with the	
				Quality Assurance Manager,	
				investigators will receive ongo	
				mentorship from the QIDP	
				Manager, including but not lin	nited
				to interview techniques, gathe	ering
				and analysis of documentary	
				evidence. The emphasis of th	is
				mentorship/training will be	
				development of appropriate s	•
				and conclusions, as well as ti management skills to facilitate	
				timely completion if investigat	
				The QIDP Manager will provide	
				weekly follow-up to the QA	
				Manager regarding progress	and
				additional training needs.	
				PREVENTION:	
				The QIDP Manager will main	
				tracking spreadsheet for incid	
				requiring investigation, follow-	
				and corrective/protective mea will be maintained and distrib	
				daily to facility supervisors an	
				Operations Team, comprised	l l
				the Executive Director, Opera	l l
				Managers, Program Manager	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G465	B. WI	NG		02/10/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			UCKSKIN CT		
COMMU	NITY ALTERNATI\	/FS-ADEPT			IAPOLIS, IN 46250		
COMMO		VEG ABELLI		II (IDI) (I (17 11 0210, 111 10200		r
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Area Supervisors, Quality		
					Assurance Manager, QIDP		
					Manager, Quality Assurance		
					Coordinators, Nurse Manager		
					Assistant Nurse Manager. The		
					Quality Assurance Manager w		
					meet with his/her QA Departm investigators as needed but no		
					less than weekly to review the		
					progress made on all	•	
					investigations, review incident	·s	
					and assign responsibility for n		
					incidents/issues requiring	CW	
					investigation. QA team memb	ners	
					will be required to attend and		
					an in-service documentation a	_	
					these meetings stating that the		
					are aware of which investigati	-	
					with which they are required to		
					conduct, as well as the specifi		
					components of the investigation		
					which they are responsible, w	ithin	
					the five-business day timefran	ne.	
					The QA Manager will review to		
					results of these weekly meetir	ngs	
					with the Executive Director to		
					assure appropriate follow thro	ugh	
					occurs.		
					The Quality Assurance Team		
					review each investigation to e		
					that they are thorough –meeti	ng	
					regulatory and operational		
					standards, and will not design		
					an investigation, as completed	d, if it	
					does not meet these criteria.		
					Failure to complete thorough		
					investigations within the allow		
					five business day timeframe n	•	
					result in progressive corrective	Э	
					action to all applicable team		

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

	IT OF DEFICIENCIES OF CORRECTION				(X3) DATE (COMPL 02/10/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W 0122	483.420(a) CLIENT PROTEC	TIONS			members. RESPONSIBLE PARTIES: QII Area Supervisor, Residential Manager, Direct Support Staff Operations Team, Regional Director	·	
Bldg. 00	The facility must eclients. Therefore Based on record reversal failed to meet the Composition of the facility neglectory recedures to ensure completed regarding exploitation of clientina propriate usage media by client Bashad a reproducible scompletion of investing the facility negleting and procedures to ecompleted regarding exploitation of clientina propriate usage media by client Bashad a reproducible scompleted regarding exploitation of clientina propriate usage media by client Bashad a reproducible scompletion of investing the facility failed was completed regarding exploitation of clienting the facility failed was completed regarding exploitation of clienting the facility failed was completed regarding exploitation of clienting the facility failed was completed regarding exploitation of clienting the facility failed was completed regarding exploitation of clienting the facility failed was completed regarding exploitation of clienting the facility failed was completed regarding exploitation of clienting the facility failed was completed regarding exploitation of clienting the facility failed was completed regarding exploitation of clienting the facility failed was completed regarding exploitation of clienting the failed was completed regarding exploitation explored the failed was complete	the facility must riew and interview, the facility ondition of Participation: Client 3 sampled clients (A and B). The detail of	WO	0122	CORRECTION: The facility must ensure that specific client protections requirements are met. Specifically, the governing bod facilitated the following: The Quality Assurance Manag will complete an investigation an allegation of financial exploitation of client A. If the allegation is substantiated, the governing body will reimburse client A for any missing or unaccounted for funds. Due to the fact that this deficie practice may have affected oth clients, the governing body hat tasked the Quality Assurance Manager with completing an independent audit of the financior each client who resides at facility, under the oversight of Regional Director. Based on the audit results, clients will be reimbursed for any expenditur for items not in possession of client, items purchased for household use (i.e., furnishing linens etc.), or that lack completing an independent use (i.e., furnishing linens etc.)	er into into into into into into into into	03/11/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/10/2022	
	PROVIDER OR SUPPLIER NITY ALTERNATIV		6025 B	ADDRESS, CITY, STATE, ZIP COD BUCKSKIN CT NAPOLIS, IN 46250	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
TAG		ates to complaint #IN00370492.	TAG	documentation. All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, QA manager or designee will assign the investigation to a specific investigator. Copies investigations will be maintain by the Quality Assurance Department to be available for review, as required. Specifical investigators will save electrofiles of all components of investigations into a shared investigation folder to provide access and monitoring capable throughout the investigation process and to allow investigations to be reproduced and provided to regulatory endors as required. The QIDP management of training and follow-up with the investigator to assure complewithin required timeframes. In addition to weekly face to for training and follow-up with the Quality Assurance Manager, investigators will receive ongo mentorship from the QIDP Manager, including but not ling to interview techniques, gather and analysis of documentary evidence. The emphasis of the mentorship/training will be development of appropriate so and conclusions, as well as timanagement skills to facilitate timely completion if investigation to provide the completion if investigations will provide the providence wil	of all ned or allty, nic sility ed tities ger en tion acce en the bing mited ering his cope me en tions.

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	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/10/2022	
	PROVIDER OR SUPPLIER		6025 B	ADDRESS, CITY, STATE, ZIP COD JUCKSKIN CT JAPOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	IAG	weekly follow-up to the QA Manager regarding progress a additional training needs. PREVENTION: The QIDP Manager will maint tracking spreadsheet for incid requiring investigation, follow- and corrective/protective mea will be maintained and distribut daily to facility supervisors and Operations Team, comprised the Executive Director, Operat Managers, Program Manager Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager Assistant Nurse Manager. The Quality Assurance Manager with mischer QA Departm investigators as needed but in less than weekly to review the progress made on all investigations, review incident and assign responsibility for in incidents/issues requiring investigation. QA team membry will be required to attend and an in-service documentation at these meetings stating that th are aware of which investigation with which they are required to conduct, as well as the specific components of the investigation which they are responsible, we the five-business day timefrar The QA Manager will review to results of these weekly meetir with the Executive Director to assure appropriate follow through	ain a ents up sures uted d the of tions s, and e vill nent o e sew pers sign at ey ons o ic on for ithin ne. he ngs	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15G465	B. WI	NG		02/10	/2022
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE	DATE
W 0149 Bldg. 00	written policies and mistreatment, neg Based on record revisampled clients (A a implement its policy investigation was concluded allegation of financi incident of inappropriate devices/social medicensure the facility his regarding ensuring the investigations. Findings include: The facility's BDDS	evelop and implement d procedures that prohibit lect or abuse of the client. riew and interview for 2 of 3 and B), the facility neglected to y and procedures to ensure an completed regarding an ial exploitation of client A, an oriate usage of electronic a by client B and failed to ad a reproducible system	W 0	1149	review each investigation to e that they are thorough —meetin regulatory and operational standards, and will not design an investigation, as completed does not meet these criteria. Failure to complete thorough investigations within the allow five business day timeframe mesult in progressive corrective action to all applicable team members. RESPONSIBLE PARTIES: QIA rea Supervisor, Residential Manager, Direct Support Staff Operations Team, BDDS Generalist, Regional Director CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abus the client. Specific corrections include: The Quality Assurance Manage will complete an investigation an allegation of client A. If the allegation is substantiated, the governing body will reimburse client A for any missing or unaccounted for funds.	nsure ng ate d, if it able nay e DP, .;	03/11/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER 15G465			(X2) MUI A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/10/2022	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					UCKSKIN CT		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P:	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were reviewed on 2	/7/22 at 9:32 AM.			Due to the fact that this defici		
					practice may have affected of		
	_	lated 12/28/21 indicated the			clients, the governing body ha		
	-	2/28/21, [client A] told the Area			tasked the Quality Assurance		
	-	May 2021, he (client A)			Manager with completing an		
		RS (Internal Revenue Service)			independent audit of the finar		
		alleged that he spent \$700 and			for each client who resides at	1	
		nager [FRM (Former			facility, under the oversight of		
	_	er) #1] kept the remaining \$700.			Regional Director. Based on t	ne	
		tly suspended pending			audit results, clients will be		
		inrelated matter. The executive			reimbursed for any expenditu		
	director has been notified and an investigation has been initiated." -"Plan to Resolve (Immediate and Long Term)."				for items not in possession of	tne	
					client, items purchased for		
					household use (i.e., furnishing		
	- Plan to Resolve (I	immediate and Long Term).			linens etc.), or that lack comp	iete	
	"[Cliant Alia aum	anthy on thomas autic I cave (sie)			documentation.	_	
		ently on therapeutic Leave (sic) I his team will provide him with			All facility investigations will b	e	
		ResCare's investigation is			completed by trained		
		ney is owed to [client A],			investigators. When incidents		
		urse him. Residential Manager			requiring investigation occur,	ıne	
		ain suspene4d (sic) pending			QA manager or designee will		
		of his termination".			assign the investigation to a specific investigator. Copies	of all	
	iormar notification	or his termination			investigations will be maintain		
	-A review of the RI	DDS report dated 12/28/21 did			by the Quality Assurance	ieu	
		entation of an investigation			Department to be available for	<u> </u>	
		tion of financial exploitation by			review, as required. Specifica		
		. The review did not indicate			investigators will save electro	-	
		ated whether any of the other			files of all components of	1110	
		stimulus checks. The review			investigations into a shared		
		facility had reimbursed the			investigation folder to provide		
		e been taken from client A.			access and monitoring capab		
	±,00 mogea to nav				throughout the investigation	y	
	2. A BDDS report of	lated 1/3/22 indicated the			process and to allow		
	following:				investigations to be reproduce	ed	
	-onemg.				and provided to regulatory en		
	-"On 01/03/2022 h	ousemates reported to staff that			as required. The QIDP manag		
		ent B] was on the phone in a			will conduct follow-up with the		
	_	th a male. It was reported by			investigator to assure comple		
	_	that the male on the phone			within required timeframes	uon	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		15G465	B. W	ING		02/10/	2022
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			UCKSKIN CT		
COMMU	NITY ALTERNATIV	/ES-ΔDEPT			APOLIS, IN 46250		
COMMO				וואטואוו	7.1 OLIO, IIN 70200		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		ient B] with sending the police			In addition to weekly face to fa	ice	
		communicating with his			training and follow-up with the		
	1 -	minor, via social media and			Quality Assurance Manager, t		
		ictures. The supervisor was			investigators will receive ongo	ing	
	notified."				mentorship from the QIDP		
					Manager, including but not lim		
	-"Plan to Resolve (Immediate and Long Term)."			to interview techniques, gathe	ring	
	urat: p-				and analysis of documentary		
		ot injured in this alleged event,			evidence. The emphasis of thi	S	
		him regarding (sic) safe use of			mentorship/training will be		
		ponse to this emerging			development of appropriate so	•	
		lisciplinary team has revised			and conclusions, as well as tin		
	[client B's] Behavior Support Plan (BSP) to require				management skills to facilitate		
		ave direct staff supervision			timely completion if investigati		
	_	nic communication devices.			The QIDP Manager will provid	е	
		be implemented once the team			weekly follow-up to the QA		
		ghts Committee (HRC)			Manager regarding progress a	ind	
		nistrative team is aware of the			additional training needs.		
	incident".				PREVENTION:		
	A CALDA	DDG 11 11/2/22 111			The QIDP Manager will mainta		
		DDS report dated 1/3/22 did not			tracking spreadsheet for incide		
		ation of an investigation			requiring investigation, follow-		
		nt of inappropriate use of			and corrective/protective meas		
	electronic devices/s	social media by client B.			will be maintained and distribu		
	Client A was interes	riewed on 2/7/22 at 7:32 AM.			daily to facility supervisors and		
		if he knew FRM #1. Client A			Operations Team, comprised of		
		ger of the house." Client A was			the Executive Director, Operat		
	' '	-		Managers, Program Managers,		,	
		ad asked client A for money. here would be times he would			Area Supervisors, Quality		
		shouldn't use. I told him (FRM			Assurance Manager, QIDP		
	I	-			Manager, Quality Assurance	and	
	#1) I had some money come in, a stimulus check				Coordinators, Nurse Manager		
	and I wasn't supposed to cash it." Client A was asked how much money was in his stimulus				Assistant Nurse Manager. The		
		-			Quality Assurance Manager will		
	check. Client A stated, "It was \$1,400.00, he (FRM #1) gave me \$700.00 but I never got the rest. No				meet with his/her QA Departm investigators as needed but no		
	one knows if the money went into my account.				less than weekly to review the		
		sor)] #1 said she didn't even			progress made on all		
		ey was in the group home and			· •		
	1				investigations, review incident		
	that it (stimulus check) came through the mail. I				and assign responsibility for no	₽W	

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
15G465			B. WING 02/10/2022				
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD UCKSKIN CT		
CONANALII	NIITV AT TEDNIATIV	ES ADEDT					
COMMO	NITY ALTERNATIV	ES-ADEPT		INDIAN	IAPOLIS, IN 46250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	spent it that same da	ay." Client A was asked if the			incidents/issues requiring		
	facility had reimbur	rsed the remaining \$700 to his			investigation. QA team memb	ers	
	account. Client A st	tated, "No, I'm pretty sure it			will be required to attend and	sign	
	didn't. He (FRM #1) was going to lie and say it			an in-service documentation a	ıt	
	came from my pare	nts. He (FRM #1) told me to lie			these meetings stating that the	әу	
	and say the money	came from my parents." Client			are aware of which investigation	ons	
		e reported this incident to.			with which they are required to)	
		told the guys first, [client D],			conduct, as well as the specifi	С	
		parents first. It didn't feel right			components of the investigation	on for	
		. He (FRM #1) told me to lie to			which they are responsible, w		
	my parents."				the five-business day timefran		
					The QA Manager will review the	ne	
	Client B was interviewed on 2/7/22 at 8:16 AM.				results of these weekly meetir	ıgs	
		if he remembered FRM #1.			with the Executive Director to		
		es he was really nice." Client B			assure appropriate follow thro	ugh	
		A had told him FRM #1 had			occurs.		
	l -	m his stimulus check. Client B			The Quality Assurance Team		
		he just said he had it from him			review each investigation to e		
	(FRM #1)."				that they are thorough –meeti	ng	
					regulatory and operational		
		ewed on 2/7/22 at 6:54 AM.			standards, and will not design		
		if she had worked with FRM			an investigation, as completed	J, if it	
	· ·	"I think he used to work here."			does not meet these criteria.		
		if FRM #1 currently worked at			Failure to complete thorough		
	the group home. Sta	aff#l stated, "No."			investigations within the allow		
	AG //1	1 0/7/00 + 7 10 + 35 + 5			five business day timeframe m	-	
		wed on 2/7/22 at 7:40 AM. AS			result in progressive corrective)	
		had worked with FRM #1. AS			action to all applicable team		
		took over (supervision of the			members.		
		#1] was here. He would use			RESPONSIBLE PARTIES: QI	DP,	
		personal use. He (FRM #1)			Area Supervisor, Residential		
		ats against me because I would			Manager, Direct Support Staff	,	
		le." AS #1 was asked if she			Operations Team, BDDS		
	received any reports regarding FRM #1 taking money from the clients. AS #1 stated, "This came				Generalist, Regional Director		
	1						
		was going to move in with his					
		brought it to my attention that					
		stimulus check and that he					
		all his money." AS #1 was					
asked if the money had been reimbursed to client							

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

Event ID:

HXLU11 Facility ID: 000979

If continuation sheet Page 14 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> CO			COMPL	COMPLETED	
15G465			B. W	ING	· ·	02/10/	/2022	
				CTREET	DDRESS SITN STATE ZIR COD			
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD JCKSKIN CT			
00040411		VEC ADEDT						
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	A. AS #1 stated, "T	his has just been within a						
	month and a half."							
	QIDPM (Qualified	Intellectual Disabilities						
	Professional Manag	ger) #1 was interviewed on						
	2/7/22 at 2:25 PM.	QIDPM #1 was asked if the						
	facility reported an	allegation of possible financial						
		ing FRM #1 allegedly taking						
	\$700.00 from Clien	t A. QIDPM #1 stated, "Yes."						
		ted if the the facility's						
	investigation had su	abstantiated the financial						
	_	nt A. QIDPM #1 stated, "Not						
	yet, because the investigation is not available for							
		as asked if the facility should						
	have documentation of a thorough investigation							
		tion of possible financial						
		M#1. QIDPM#1 stated, "Yes,						
	to assure that peopl	_						
		reimburse if they have been						
		#1 was asked if client A had						
		e \$700.00. QIDPM #1 stated,						
		ne completion of the						
		PPM #1 was asked if the facility						
	_	er clients received stimulus						
	•	stated, "We have not had any						
	1 -	else received a stimulus						
	-	indicated the facility did not						
		n of an investigation regarding						
		riate usage of electronic						
		ia. QIDPM #1 indicated the						
		the prevention of abuse,						
	neglect and mistreatment should be implemented							
	as written. QIDPM #1 indicated all allegations of abuse, neglect and mistreatment should be							
	_							
	thoroughly investig	rated.						
	The Facility of 1	d						
		y and procedures were						
		at 9:30 AM. The facility's						
		ploitation policy revised on						
	//10/19 indicated, "	Policy: Adept staff actively						

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

Event ID:

HXLU11 Facility ID: 000979

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PRINTED: 03/14/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/10/2022				
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP COD 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	abuse, neglect and e to the appropriate au appropriate supervis thoroughly investiga ADEPT, ResCare an guidelines"Emotio provide goods and/o individual to avoid provide the support psychological and someet the basic need shelter, clothing and environment." "Program interventi implement a support application of interventi qualified person not	gations or occurrences of exploitation shall be reported athorities through the sory channels and will be ated under the policies of and local, state and federal onal/physical neglect: failure to or services necessary for the physical harm. Failure to necessary to an individual's ocial well being. Failure to requirements such as food, I to provide a safe on neglect:Failure to t plan, inappropriate rention with out (sic) a						
W 0154 Bldg. 00	alleged violations a Based on record rev allegations of abuse reviewed, the facilit investigation was co- allegation of financi an incident of inapp devices/social media Findings include:	ave evidence that all are thoroughly investigated. iew and interview for 2 of 8 , neglect and mistreatment y failed to ensure an ompleted regarding an al exploitation of client A and ropriate usage of electronic	W 0154	CORRECTION: The facility must have evident that all alleged violations are thoroughly investigated. Specifically: All facility investigations will be complete trained investigators. The faci must have evidence that all alleged violations are thoroug investigated. Specifically: The Quality Assurance Management of the control of the con	ed by lity hly			

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

Event ID:

HXLU11

Facility ID: 000979

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		15G465	B. WING		_	02/10/2022	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					UCKSKIN CT		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	IAPOLIS, IN 46250		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	16	DATE
	Disabilities Service	es) reports and investigations			will complete an investigation	into	
	were reviewed on 2	2/7/22 at 9:32 AM.			an allegation of financial		
					exploitation of client A. If the		
	1. A BDDS report	dated 12/28/21 indicated the			allegation is substantiated, the	;	
	following: " On 1	2/28/21, [client A] told the Area			governing body will reimburse		
	Supervisor that in N	May 2021, he (client A)			client A for any missing or		
	received a \$1,400 I	RS (Internal Revenue Service)			unaccounted for funds.		
	stimulus check. He	alleged that he spent \$700 and			Due to the fact that this deficie	ent	
	that Residential Ma	nager [FRM (Former			practice may have affected otl	ner	
	Residential Manage	er) #1] kept the remaining \$700.			clients, the governing body ha	s	
	[FRM #1] is curren	tly suspended pending			tasked the Quality Assurance		
	termination for an u	inrelated matter. The executive			Manager with completing an		
	director has been notified and an investigation				independent audit of the finan	ces	
	has been initiated."				for each client who resides at	the	
					facility, under the oversight of	the	
	-"Plan to Resolve (Immediate and Long Term)."			Regional Director. Based on the	ne	
					audit results, clients will be		
	-"[Client A] is curre	ently on therapeutic Leave (sic)			reimbursed for any expenditur	es	
	with his mother and	l his team will provide him with			for items not in possession of	the	
	emotional support.	ResCare's investigation is			client, items purchased for		
		ney is owed to [client A],			household use (i.e., furnishing	s,	
		urse him. Residential Manager			linens etc.), or that lack compl	ete	
	[FRM #1] will rema	ain suspene4d (sic) pending			documentation.		
	formal notification	of his termination".			All facility investigations will be	e	
					completed by trained		
		ODS report dated 12/28/21 did			investigators. When incidents		
		entation of an investigation			requiring investigation occur, t	he	
	regarding an allega	tion of financial exploitation by			QA manager or designee will		
		. The review did not indicate			assign the investigation to a		
		ated whether any of the other		specific investigator. Copies of all			
		stimulus checks. The review			investigations will be maintain	ed	
	did not indicate the facility had reimbursed the				by the Quality Assurance		
	\$700 alleged to hav	re been taken from client A.			Department to be available for		
					review, as required. Specifical	-	
	2. A BDDS report dated 01/03/2022 indicated the				investigators will save electror	nic	
	following:				files of all components of		
					investigations into a shared		
		ousemates reported to staff that			investigation folder to provide		
	_	ent B] was on the phone in a			access and monitoring capabi	lity	
	verbal argument wi	th a male. It was reported by			throughout the investigation		

		STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G465		(X2) MULT A. BUILD B. WING		nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/10/2022		
100 100			b. who	_		02/10	12022		
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				s ² 6 IN					
	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		D			(X5)	
	PREFIX			PRE	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)	IE	DATE	
		housemates to staff	that the male on the phone			process and to allow			
		was threatening [cli	ient B] with sending the police			investigations to be reproduce	d		
		to his residence for	communicating with his			and provided to regulatory ent			
		daughter, who is a r	minor, via social media and			as required. The QIDP manag	er		
		sending her nude pi	ictures. The supervisor was		will conduct follow-up with the				
		notified."				investigator to assure complet	ion		
						within required timeframes.			
		-"Plan to Resolve (1	Immediate and Long Term)."			In addition to weekly face to fa	ice		
						training and follow-up with the			
		-"[Client B] was no	t injured in this alleged event,			Quality Assurance Manager, t	he		
		and staff counseled him regarding (sic) safe use of social media. In response to this emerging				investigators will receive ongo	ing		
						mentorship from the QIDP			
		behavior, his interd	isciplinary team has revised			Manager, including but not lim	ited		
		[client B's] Behavior Support Plan (BSP) to require that he (client B) have direct staff supervision while using electronic communication devices.				to interview techniques, gathe	ring		
						and analysis of documentary			
						evidence. The emphasis of thi	s		
			be implemented once the team			mentorship/training will be			
			ghts Committee (HRC)			development of appropriate so	оре		
		approval. The admi	nistrative team is aware of the			and conclusions, as well as tir	ne		
		incident".				management skills to facilitate			
						timely completion if investigati	ons.		
			ODS report dated 1/3/22 did not			The QIDP Manager will provid	е		
			tion of an investigation			weekly follow-up to the QA			
			nt of inappropriate use of			Manager regarding progress a	and		
		electronic devices/s	social media by client B.			additional training needs.			
						PREVENTION:			
			riewed on 2/7/22 at 7:32 AM.			The QIDP Manager will mainta			
			if he knew FRM #1. Client A			tracking spreadsheet for incide			
		_	ger of the house." Client A was			requiring investigation, follow-	•		
			ad asked client A for money.			and corrective/protective meas			
			nere would be times he would			will be maintained and distribu			
			shouldn't use. I told him (FRM			daily to facility supervisors and			
			ney come in, a stimulus check			Operations Team, comprised			
		and I wasn't supposed to cash it." Client A was				the Executive Director, Operat			
			oney was in his stimulus			Managers, Program Managers	5,		
			ted, "It was \$1,400.00, he (FRM			Area Supervisors, Quality			
		, •	00 but I never got the rest. No			Assurance Manager, QIDP			
			oney went into my account.			Manager, Quality Assurance			
			sor)] #1 said she didn't even			Coordinators, Nurse Manager			
	know that my money was in the group home and					Assistant Nurse Manager. The	•		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/10/2022 15G465 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6025 BUCKSKIN CT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE that it (stimulus check) came through the mail. I Quality Assurance Manager will spent it that same day." Client A was asked if the meet with his/her QA Department facility had reimbursed the remaining \$700 to his investigators as needed but no account. Client A stated, "No, I'm pretty sure it less than weekly to review the didn't. He (FRM #1) was going to lie and say it progress made on all came from my parents." He (FRM #1) told me to lie investigations, review incidents and say the money came from my parents. Client and assign responsibility for new A was asked who he reported this incident to. incidents/issues requiring Client A stated, " I told the guys first, [client D], investigation. QA team members [client B]. I told my parents first. It didn't feel right will be required to attend and sign to lie to my parents. He (FRM #1) told me to lie to an in-service documentation at my parents." these meetings stating that they are aware of which investigations Client B was interviewed on 2/7/22 at 8:16 AM. with which they are required to Client B was asked if he remembered FRM #1. conduct, as well as the specific Client B stated, "Yes he was really nice." Client B components of the investigation for was asked if client A had told him FRM #1 had which they are responsible, within given him \$700 from his stimulus check. Client B the five-business day timeframe. stated, "Yes he did, he just said he had it from him The QA Manager will review the (FRM #1)." results of these weekly meetings with the Executive Director to Staff #1 was interviewed on 2/7/22 at 6:54 AM. assure appropriate follow through Staff #1 was asked if she had worked with FRM occurs. #1. Staff #1 stated, "I think he used to work here." The Quality Assurance Team will Staff #1 was asked if FRM #1 currently worked at review each investigation to ensure the group home. Staff #1 stated, "No." that they are thorough -meeting regulatory and operational AS #1 was interviewed on 2/7/22 at 7:40 AM. AS standards, and will not designate #1 was asked if she had worked with FRM #1. AS an investigation, as completed, if it #1 stated, "When I took over (supervision of the does not meet these criteria. group home) [FRM #1] was here. He would use Failure to complete thorough the van for his own personal use. He (FRM #1) investigations within the allowable would turn the clients against me because I would five business day timeframe may hold him accountable." AS #1 was asked if she result in progressive corrective received any reports regarding FRM #1 taking action to all applicable team money from the clients. AS #1 stated, "This came members. up when [client A] was going to move in with his **RESPONSIBLE PARTIES: QIDP,** mother. His mother brought it to my attention that Area Supervisor, Residential he (client A) got a stimulus check and that he Manager, Direct Support Staff, didn't get to spend all his money." AS #1 was Operations Team, Regional

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Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
	15G465		B. WING			02/10/2022	
				CED FEET A	DDDEGG CVTV CTATE JID COD		
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP COD		
000404110	NUTY ALTERNATIV	EO ADEDT			JCKSKIN CT		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	asked if the money	had been reimbursed to client			Director		
	A. AS #1 stated, "T	his has just been within a					
	month and a half."	,					
	QIDPM (Qualified)	Intellectual Disabilities					
		ger) #1 was interviewed on					
	_	QIDPM #1 was asked if the					
		allegation of possible financial					
	* *	ng FRM #1 allegedly taking					
		t A. QIDPM #1 stated, "Yes."					
		ed if the the facility's					
	-	ibstantiated the financial					
	exploitation of client A. QIDPM #1 stated, "Not yet, because the investigation is not available for						
		as asked if the facility should					
		of a thorough investigation					
		tion of possible financial					
		#1. QIDPM #1 stated, "Yes,					
	to assure that people						
		o reimburse if they have been					
		#1 was asked if client A had					
	-	e \$700.00. QIDPM #1 stated,					
	"Not yet pending th	-					
		PM #1 was asked if the facility					
	-	er clients received stimulus					
	_	stated, "We have not had any					
		else received a stimulus					
	*	indicated the facility did not					
	,	-					
		n of an investigation regarding					
		iate usage of electronic					
		a. QIDPM #1 indicated all					
	_	e, neglect and mistreatment					
	should be thoroughl	ly investigated.					
	Th: 6.1. 1. 1	441-in4 #B100270402					
	inis federal tag rela	ites to complaint #IN00370492.					
	0.2.2(-)						
	9-3-2(a)						
					1		

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