STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G486			A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 05/23/2023			ETED
	ROVIDER OR SUPPLIER NITY ALTERNATIV			7919 S	ADDRESS, CITY, STATE, ZIP COD AN RICARDO COURT IAPOLIS, IN 46256		
(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	
W 0000 Bldg. 00	This visit was for the pre-determined full recertification and state licensure survey. Dates of Survey: May 15, 16, 17, 18, and 23, 2023. Facility Number: 001000 Provider Number: 15G486 AIMS Number:100245010 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/6/23.		W	000			
W 0159 Bldg. 00			W	159	CORRECTION: Each client's active treatment program must be integrated, coordinated, and monitored by qualified intellectual disability professional. Specific correct include: Through observation and with from the interdisciplinary team QIDP has completed a Comprehensive Functional Assessment for client #1. The QIDP has developed an individual program plan for client #1 based on current assessment data.	y a ions input n, the	06/22/2023

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

TITLE (X6) DATE

Bob Morris QIDP Manager 06/19/2023

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					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			COMPLETED	
		15G486	B. W	ING		05/23/2023	
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ANDRESS, CITY, STATE, ZIP COD		
0000000		EC ADEDT			AN RICARDO COURT		
COMMO	NITY ALTERNATIV	ES-ADEPT		INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLET	ION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
					The QIDP has updated client	#1's	
	2. The facility's QII	OP failed to ensure client #1's			Behavior Support Plan to refle	ct	
	ISP was completed	within 30 days of admission.			supervision needs consistent		
	Please see W226.	•			client #1's current residential		
					environment.		
	3. Client #1's record	d was reviewed on 5/17/23 at			Through record review, the		
	12:20 PM.				governing body determined th	at I	
					these deficient practices did n		
	Client #1's BSP dat	ed 3/7/23 indicated the			affect additional clients.		
	following:				PREVENTION:		
					When new clients are admitte	t to	
	-"SUPERVISION	J:			the facility, the QIDP will provi		
		l not, at this time, carry a			status updates to the QIDP	10	
		tit the ResCare residential			Manager, no less than weekly	to	
		arget behavior: physical			allow for sufficient oversight o		
	aggression)	arget behavior, physical			initial assessment and Individu		
		ne of city] facility utilizes			Support Plan and Behavior	lai	
	_	mon areas of the facility. No			Support Plan development		
		ized or have access to private			process.		
	areas such as bedro	-			Members of the Operations Te	nam	
		rvision while in the kitchen due			(comprised of the Executive	iaiii	
		trash/off the floor (target			Director, Operations Manager		
	_	riate access to food)			Program Managers, Quality	·,	
		will be locked. When he			Assurance Manager, QIDP		
		ndry, he will ask staff for the			Manager, QIDP, Quality		
	assistance with laur	rovide him with a key and offer			Assurance Coordinators, Area		
		ed on the passthrough			Supervisors, Nurse Manager		
	_	-			Assistant Nurse Manager) will		
		nat [client #1] cannot get into			conduct administrative monito	-	
	-	through their shared			during varied shifts/times, twic		
	bathroom".				weekly, to assure interaction v		
	A marriage - 6 - 1: /	411a DCD datad 2/7/22 : 4:4-1			multiple staff, involved in a full		
		#1's BSP dated 3/7/23 indicated			range of active treatment		
	_	ions associated to prior living			scenarios, until all staff		
	~	nt #1's BSP did not indicate an			demonstrate competence. After	эr	
		vision based on his new living			this period of enhanced		
	environment.				administrative monitoring and		
	OIDD #1 1 0	26/0 1/0 17 1			support, the Executive Directo	r	
		M (Qualified Intellectual			and Regional Director will		
Disabilities Professional Manager) #1 were				determine the level of ongoing			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G486	B. W	ING		05/23/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	IR.			AN RICARDO COURT		
COMMIT	NITY ALTERNATIV	/ES ADEDT			IAPOLIS, IN 46256		
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(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	interviewed on 5/1	8/23 at 10:48 AM. QIDP #1 was			support needed at the facility.		
	asked about client	#1's BSP. QIDP #1 stated, "I			Current Operations Team		
	1	lient #1's BSP indicating			members received training fro	m	
	_	ning to client #1's prior			the QIDP Manager on 5/20/23	s, to	
		d have updated that." QIDPM			assure a clear understanding	of	
	#1 stated, "We sho	ould have noticed this and			administrative monitoring as		
	updated it."				defined below.		
					· The role of the		
	9-3-3(a)				administrative monitor is not		
					simply to observe & report.		
					· When opportunities for		
					training are observed, the mo	nitor	
					must step in and provide the		
					training and document it.		
					· If gaps in active treatme	nt	
					are observed the monitor is		
					expected to step in and mode	l the	
					appropriate provision of suppo	orts.	
					· Assuring the health and		
					safety of individuals receiving		
					supports at the time of the		
					observation is the top priority.		
					· Review all relevant		
					documentation, providing		
					documented coaching and tra	ıning	
					as needed		
					Administrative support at the		
					home will include assuring:		
					All relevant assessment		
					are completed for clients within		
					days of admission, including b	out	
					not limited to Comprehensive		
					Functional Assessments.		
					· Individuals' support plan		
					are developed implemented for	ונ	
					new clients within 30 days of		
					admission.		
					Behavior Support Plans		1
					reflect clients' current needs.	DD	
1	1		- [RESPONSIBLE PARTIES: QI	DP,	I

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G486 B. WING 05/23/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7919 SAN RICARDO COURT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director W 0210 483.440(c)(3) INDIVIDUAL PROGRAM PLAN Bldg. 00 Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3 W 0210 **CORRECTION:** 06/22/2023 sampled clients (#1), the facility failed to ensure Within 30 days after admission, client #1's CFA (Comprehensive Functional the interdisciplinary team must Assessment) was completed within 30 days of perform accurate assessments or admission. reassessments as needed to supplement the preliminary Findings include: evaluation conducted prior to admission. Specifically, through The facility's Residential Client List dated 5/15/23 observation and with input from the reviewed on 5/16/23 at 10:00 AM indicated client interdisciplinary team, the QIDP #1 was admitted to the group home on 3/4/23. has completed a Comprehensive **Functional Assessment for client** Client #1's record was reviewed on 5/17/23 at 12:20 #1. Through record review, the PM. Client #1's record did not indicate governing body determined that documentation of a completed CFA. this deficient practice did not affect additional clients. QIDP (Qualified Intellectual Disabilities PREVENTION: Professional) #1 and OIDPM (Qualified When new clients are admitted to Intellectual Disabilities Professional Manager) #1 the facility, the QIDP will provide were interviewed on 5/18/23 at 10:45 AM. QIDPM status updates to the QIDP #1 was asked what documentation needed to be Manager, no less than weekly, to completed within the first 30 days of admission to allow for sufficient oversight of the the group home. QIDPM #1 stated, "ISP initial assessment process. (Individual Support Plan), BSP (Behavioral For the next 30 days, members of Support Plan), and CFA." QIDP #1 was asked the Operations Team (comprised about client #1's CFA. QIDP #1 stated, "I am still of the Executive Director, working on parts of it." Operations Managers, Program

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Managers, Quality Assurance

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PRINTED: 06/21/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED					
		15G486	B. W	ING		05/23/	2023	
N				STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF I	PROVIDER OR SUPPLIE	K			AN RICARDO COURT			
COMMU	NITY ALTERNATI\	/ES-ADEPT		INDIAN	IAPOLIS, IN 46256			
(X4) ID	SUMMARY	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 APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	9-3-4(a)				Manager, QIDP Manager, QIE			
					Quality Assurance Coordinate			
					Area Supervisors, Nurse Man	-		
					and Assistant Nurse Manager	,		
					conduct administrative monito	-		
					during varied shifts/times, no than three times weekly. After			
					Days, administrative monitoring			
					will occur no less than weekly	•		
					until all staff demonstrate			
					competence. After this period	of		
					enhanced administrative			
					monitoring and support, the			
					Executive Director and Region	nal		
					Director will determine the lev			
					ongoing support needed at the	e		
					facility. Administrative Monitor	ring		
					is defined as follows:			
					· The role of the			
					administrative monitor is not			
					simply to observe & Report.			
					· When opportunities for	.		
					training are observed, the mo	nıtor		
					must step in and provide the			
					training and document it.	4		
					· If gaps in active treatme	nt		
					are observed the monitor is	Ltho		
					expected to step in and mode appropriate provision of support			
					Assuring the health and			
					safety of individuals receiving			
					supports at the time of the			
					observation is the top priority.			
					Review all relevant			
					documentation, providing			
					documented coaching and tra	ining		
					as needed			
					Administrative oversight will			
					include assuring that all releva	ant		
					assessments are completed for			

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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	A. BUILDING <u>00</u> COMPLETED			ETED
		15G486	B. WI	ING		05/23/	2023
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NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
COMMU	NITY ALTERNATIV	ES ADEDT			IAPOLIS, IN 46256		
COMMO	NIII ALIENNAIIV	ES-ADEF I		INDIAN	NAFOLIS, IN 40230		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTION SHOULD) CROSS-REFERENCED TO THE APPROF		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					clients within 30 days of		
					admission, including but not		
					limited to Comprehensive		
					Functional Assessments.		
					RESPONSIBLE PARTIES: QI	DP,	
					Area Supervisor, Residential		
					Manager, Direct Support Staff		
					Health Services Team, Opera	tions	
					Team, Regional Director		
W 0226	483.440(c)(4)						
DII 00	INDIVIDUAL PRO						
Bldg. 00	Within 30 days aft						
	' '	eam must prepare, for each					
		client, an individual program plan. Based on record review and interview for 1 of 3					0 < 10 0 10 00 0
			I w c)226	CORRECTION:		06/22/2023
), the facility failed to ensure			Within 30 days after admission		
	· ·	ividual Support Plan) was			the interdisciplinary team mus	τ	
	completed within 3	0 days of admission.			prepare for each client an		
	Eindings in aluda.				individual program plan.		
	Findings include:				Specifically, the QIDP has		
	The facility's Desid	ential Client List dated 5/15/23			developed an individual progra		
	1	3 at 10:00 AM indicated client			plan for client #1 based on cul assessment data. Through red		
		the group home on 3/4/23.			review, the governing body	Joiu	
	#1 was admitted to	the group home on 3/4/23.			determined that this deficient		
	Client #1's record w	vas reviewed on 5/17/23 at 12:20			practice did not affect addition	ıal	
	PM.	vas 10 vie wed oii 3/1 // 23 at 12.20			clients.	ui	
	1 1111				PREVENTION:		
	Client #1's record in	ndicated an ISP dated 6/14/22.			When new clients are admitte	d to	
		ed 6/14/22 was associated with			the facility, the QIDP will provi		
		o client #1's former living			status updates to the QIDP		
		nt #1's record did not include			Manager, no less than weekly	, to	
	_	n updated ISP since his			allow for sufficient oversight o		
		oup home on 3/4/23.			initial assessment and Individu		
					Support Plan development		
	OIDP (Qualified In	tellectual Disabilities			process.		
		as interviewed on 5/18/23 at			Members of the Operations To	eam	
	· · · · · · · · · · · · · · · · · · ·	1 was asked about client #1's			(comprised of the Executive		
		d, "I am still working on			Director, Operations Manager	s.	
	. `		1		, -,	. ,	

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

PRINTED: 06/21/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G486		A. BUILDING <u>00</u> COMP		(X3) DATE SURVEY COMPLETED 05/23/2023	
	PROVIDER OR SUPPLIER		7919 S	ADDRESS, CITY, STATE, ZIP COD SAN RICARDO COURT NAPOLIS, IN 46256	
(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
IAU	updating his ISP. II		IAG	Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager Assistant Nurse Manager) wil conduct administrative monitor during varied shifts/times, twice weekly, to assure interaction of multiple staff, involved in a full range of active treatment scenarios, until all staff demonstrate competence. Aft this period of enhanced administrative monitoring and support, the Executive Direct and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training fro the QIDP Manager on 5/20/23 assure a clear understanding administrative monitoring as defined below. The role of the administrative monitor is not simply to observe & report. When opportunities for training are observed, the mo must step in and provide the training and document it. If gaps in active treatme are observed the monitor is expected to step in and mode appropriate provision of supp Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority.	a and I bring be with I er or of of on of of the brits.

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G486		A. BUILDING B. WING	00	COMPLETED 05/23/2023	
	ROVIDER OR SUPPLIER		7919 S	ADDRESS, CITY, STATE, ZIP COD AN RICARDO COURT APOLIS, IN 46256	
(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
W 0224	400 400()			documentation, providing documented coaching and trai as needed Administrative support at the home will include assuring individuals' support plans are developed implemented for neclients within 30 days of admission. RESPONSIBLE PARTIES: QII Area Supervisor, health service team, Residential Manager, D Support Staff, Operations Tea Regional Director	DP, es irect
W 0331 Bldg. 00	services in accorda Based on record rev sampled clients (#2) failed to ensure clien PO/MAR (Physician Administration Recommatched pertaining Findings include: Client #2's record w AM. Client #2's record in sodium) risk plan de	rovide clients with nursing ance with their needs. iew and interview for 1 of 3 the facility's nursing services and #2's medical risk plans and	W 0331	CORRECTION: The facility must provide client with nursing services in accordance with their needs. It review of documentation indicates this deficient practice could ha affected all individuals who resin the facility. Specifically, the facility nurse has updated clienty's high-risk plan for hyponatremia to coincide with current physician orders.	A ates ive side
	-"Problem Hyponatremia Actions:			PREVENTION: When a nurse takes over a ne caseload, the Nurse Manager assist the new nurse with	•
	Actions.			completing a comprehensive	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 05/23/2023 15G486 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7919 SAN RICARDO COURT COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46256 (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 [Client #2] must adhere to a prescribed 1800 ml review of medical records and (milliliter) of liquid, daily prescribed by doctor. plans and will establish a timeline for correction of any identified Staff will follow up MAR and will administer deficient practices. Sodium Chloride to keep [client #2's] sodium Members of the Operations Team blood level body within (135-145 mEq/L (comprised of the Executive (millequivalents per liter)...". Director, Operations Managers, Program Managers, Quality Client #2's Physician Order dated 5/16/23 was Assurance Manager, QIDP reviewed on 5/16/23 at 12:02 PM. Manager, QIDP, Quality Assurance Coordinators, Area Client #2's Physician Order did not indicate Supervisors, Nurse Manager and documentation of a prescription from his PCP Assistant Nurse Manager) will (Primary Care Physician) indicating a prescribed incorporate medical record reviews 1800 ml of liquid daily. Client #2's Physician Order into twice weekly administrative did not indicate documentation of a specific monitoring, until home facility amount of liquid client #2 was expected to adhere medical systems are implemented to daily. competently. After this period of enhanced administrative Client #2's MAR dated 5/2023 was reviewed on monitoring and support, the 5/16/23 at 12:11 AM. Client #2's MAR did not Executive Director and Regional indicate documentation of a prescription for staff Director will determine the level of to administer sodium chloride for maintaining ongoing support needed at the client #2's sodium level. Client #2's MAR did not facility. Current Operations Team indicate documentation of a specific amount of members received training from liquid client #2 was expected to adhere to daily. the QIDP Manager on 5/20/23, to assure a clear understanding of LPN #1 was interviewed on 5/18/23 at 10:11 AM. administrative monitoring as LPN #1 was asked about client #2's Hyponatremia defined below. risk plan indicating he must adhere to a prescribed The Nurse Manager will 1800ml of liquid daily and why that was not review issues revealed in audits described in his PO/MAR. LPN #1 stated, "It with the Executive Director and could have been an overlook at the time of the Department heads weekly for update of his plan. It depends on sodium levels follow-up. but doctors will implement a fluid restriction for The Executive Director and hyponatremia. I'm not sure where the 1800ml came will follow-up with the Nurse from but I will have to touch base with the doctor Manager as needed to address and see about getting this updated and clarified." issues raised through audits, LPN #1 was asked about client #2's Hyponatremia incident reports or other concerns

risk plan indicating staff were to administer

brought to management attention.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLET	ΓED
		15G486	B. WI	NG		05/23/20	023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7919 SAN RICARDO COURT INDIANAPOLIS, IN 46256				
COMMO	NIII ALIENNAIIV	ES-ADEF I		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		client #2 to maintain his			Administrative support at the		
		his was not addressed on his			home will include assuring tha	ıt	
		ed, "I'm not sure why this is on			risk plans correspond with		
	-	d the doctor and [client #2] has			physician orders and other		
	-	ed sodium chloride, so that			professional recommendation		
		s risk plan. We must have			RESPONSIBLE PARTIES: QI	DP,	
	missed this when up	odating his plans."			Area Supervisor, Residential		
	0.2 ((-)				Manager, Health Services Tea		
	9-3-6(a)				Direct Support Staff, Operation	ns	
					Team, Regional Director		
W 0368	483.460(k)(1)						
VV 0000	DRUG ADMINIST	RATION					
Bldg. 00		ug administration must					
Diag. 00		gs are administered in					
		ne physician's orders.					
		view and interview for 1 of 3	$ \mathbf{w} _{0}$	268	CORRECTION:		06/22/2023
) plus 1 additional client (#5),	" 0	300	The system for drug		00/22/2023
	-	ensure clients #1 and #5			administration must assure the	at all	
		ribed medications as ordered.			drugs are administered in		
	received then prese				compliance with the physician	's	
	Findings include:				orders. Specifically, all clients		
	i mamga matawa.				currently receiving their	ui o	
	The facility's BDDS	S (Bureau of Developmental			medications as prescribed.		
		s) reports were reviewed on			Agency nursing staff will retrai	in	
	5/15/23 at 11:15 AM				facility supervisors and direct		
					support staff on proper		
	1. A BDDS report d	lated 3/30/23 indicated, "On			implementation of the facility's	,	
	•	did not receive his 8:00 AM			medication inventory process,		
		prescribed Cetirizine (allergy)			including reordering medication		
		(milligram), due to no available			PREVENTION:		
	supply. The nurse a	nd supervisor were notified of			The facility nurse will conduct		
	the error".	-			weekly follow-up to assure		
					medication audits occur as		
	2. A BDDS report d	lated 4/11/23 indicated, "A			scheduled and that medication	ns	
	-	on and documentation indicated			are administered as ordered.		
	that [client #5] did r	not receive his 8:00 AM, dose			A management staff will be		
		bed Fiber Adult Chew			present, supervising active		
		23 - 4/10/23, due to no available			treatment during no less than	five	
	supply. The nurse a				active treatment sessions per		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G486		(X2) MULTIPLE CO A. BUILDING B. WING			
NAME OF E	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD	
				SAN RICARDO COURT	
COMMUI	NITY ALTERNATIV	ES-ADEPT	INDIAN	NAPOLIS, IN 46256	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	supervisor were not	ified".		week, on varied shifts to assist	
				with and monitor skills training	
	PM.	vas reviewed on 5/17/23 at 12:20		including but not limited to	
	PM.			including but not limited to	
	Client #1's MAD (A	Medication Administration		assuring medications are	
		23 indicated the following:		administered as prescribed. Members of the Operations Te	nom.
	Record) dated 3/202	23 indicated the following.		(comprised of the Executive	am
	-"Cetirizine Tab 1	Oma		Director, Operations Managers	
		nouth once daily for		Program Managers, Quality	2,
	allergies".	ioutil once duily for		Assurance Manager, QIDP	
	unergres			Manager, QIDP, Quality	
	Client #5's record w	vas reviewed on 5/17/23 at 1:41		Assurance Coordinators, Area	
	PM.			Supervisors, Nurse Manager a	
				Assistant Nurse Manager) will	
	Client #5's MAR da	ated 4/2023 indicated the		conduct administrative monitor	ring
	following:			during varied shifts/times, twic	•
				weekly, to assure interaction w	I
	-"Fiber Adult Che	ew Gummies		multiple staff, involved in a full	
	give one gummy by	mouth once daily".		range of active treatment	
				scenarios, until all staff	
		ewed on 5/17/23 at 11:14 AM.		demonstrate competence. After	er
		what staff were to do when a		this period of enhanced	
		ow on a medication. Staff #2		administrative monitoring and	
		posed to notify the nurse		support, the Executive Directo	r
		ication gets down to 7 days		and Regional Director will	
		l be made." Staff #2 was asked		determine the level of ongoing	
		n out of a prescribed		support needed at the facility.	
	medication. Staff #2	z stated, "No."		Current Operations Team	
	I DNI #1 (T : 1 T	Dunatical Names #1		members received training from	I
	•	Practical Nurse) #1 was 8/23 at 10:11 AM. LPN #1 was		the QIDP Manager on 5/20/23	I
		staff ensure notification of		assure a clear understanding of administrative monitoring as	וע
		low for clients. LPN #1 stated,		defined below.	
	_	ead of the meds (medications)		The role of the	
		staff) are supposed to reorder		administrative monitor is not	
		then notify us (nursing)." LPN		simply to observe & Report.	
		client should go without a		· When opportunities for	
		o supply in the home. LPN #1		training are observed, the mor	nitor
	stated, "No."			must step in and provide the	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		15G486	B. WING 05/23/2023			2023	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				AN RICARDO COURT		
COMMUN	NITY ALTERNATIV	ES ADEDT			APOLIS, IN 46256		
COMMON	NIIT ALIEKNAIIV	ES-ADEPT		INDIAN	APOLIS, IN 40250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
					training and document it.		
	9-3-6(a)				· If gaps in active treatmer	nt	
					are observed the monitor is		
					expected to step in and model	the	
					appropriate provision of suppo		
					· Assuring the health and		
					safety of individuals receiving		
					supports at the time of the		
					observation is the top priority.		
					· Review all relevant		
					documentation, providing		
					documented coaching and trai	nina	
					as needed.	9	
					Administrative support at the		
					home will include assuring		
					medications are administered	as I	
					prescribed.	40	
					RESPONSIBLE PARTIES: QIE	ne l	
					Residential Manager, facility	,	
					nurse, Direct Support Staff, He	alth	
					Services Team, Operations Te		
W 9999							
Bldg. 00							
	State Findings:		W 9	999	CORRECTION:		06/22/2023
					Prior to assuming residential jo	ob	
	_	munity Residential Facilities for			duties and annually thereafter,		
		opmental Disabilities Rules			each residential staff person si	hall	
	were not met.				submit written evidence that a		
					Mantoux tuberculosis skin test	or	
	460 IAC 9-3-3 Faci	lity Staffing			chest x-ray was completed.		
					Specifically, staff #1 and #2 wi		
		g residential job duties and			receive Mantoux or chest x-ray		
	•	each residential staff person			tuberculosis testing as required		
		evidence that a Mantoux			and Human Resources staff w		
		st or chest x-ray was			review all facility employee file		
	-	ılts of the Mantoux shall be			assure current TB test results	are	
		ter of induration (sic) with the			present. If deficiencies are		
	date given, date read	d, and by whom administered.			detected, the identified employ	ees	
			<u> </u>				

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

Event ID:

RTUZ11 Facility ID: 001000

If continuation sheet Page 12 of 13

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

PRINTED: 06/21/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		15G486	B. WI	NG _		05/23/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER		7919 SAN RICARDO COURT				
COMMUNITY ALTERNATIVES-ADEPT				APOLIS, IN 46256			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					will receive required Tuberculo	osis	
	This state rule was not met as evidenced by:				Testing.		
					PREVENTION:		
		riew and interview for 2 of 3			The Human Resources team (HR	
		, the facility failed to ensure			Specialist, HR Coordinators,		
		's Mantoux screenings were			Training Coordinator) and Hea		
	completed annually				Services Team (Nurse Manag	er,	
					LPNs, Medical Assistant) are		
	Findings include:				coordinating to assure initial a		
					subsequent annual Tuberculos		
		oyee Records were reviewed on			screenings occur for all agenc	y	
	5/18/23 at 11:30 AN	A and indicated the following:			employees.		
					Members of the Operations Te	eam	
		indicated staff #1's last			(comprised of the Executive		
		was completed on 9/2/20. The			Director, Operations Managers	3,	
		ate documentation of a current			Program Managers, Quality		
	Mantoux screening	for staff #1.			Assurance Manager, QIDP		
					Manager, QIDP, Quality		
		indicated staff #2's last			Assurance Coordinators, Area		
	_	was completed on 10/7/21.			Supervisors, and Nurse Mana	ger)	
		indicate documentation of a			will incorporate reviews of		
	current Mantoux sci	reening for staff #2.			Personnel files into the quarter	rly	
					audit process. Administrative		
		Intellectual Disabilities			support will include but not lim		
	-	er) #1 was interviewed on			to assuring facility staff receive		
		И. QIDPM #1 indicated staff			initial and annual Tuberculosis	;	
		x screenings completed			screening.		
		1 indicated the facility did not			RESPONSIBLE PARTIES:		
		ux screenings for staff #1 and			QIDP, Human Resources		
	staff #2.				Department, Health Services		
					Team, Operations Team		
	9-3-3(e)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RTUZ11 Facility ID: 001000 If continuation sheet Page 13 of 13