

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 full recertification and state licensure survey.</p> <p>Dates of Survey: 7/26/17, 7/27/17, 7/28/17, 7/31/17, 8/1/17 and 8/4/17.</p> <p>Facility Number: 000979 Provider Number: 15G465 AIMS Number: 100244860</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 8/11/17.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 2 of 4 sampled clients (#2 and #3). The governing body failed to</p>	W 0102	<p>CORRECTION:</p> <p><i>The facility must ensure that specific governing body and management requirements are met. Specifically, the governing</i></p>	09/03/2017

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: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250	
(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>exercise general policy, budget and operating direction over the facility to prevent the client to client abuse of clients #2 and #3 by client #1. The governing body neglected to thoroughly investigate 7 allegations of client to client abuse, and the governing body neglected to put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The governing body failed to exercise general policy, budget and operating direction over the facility to prevent the client to client abuse of clients #2 and #3 by client #1. The governing body neglected to thoroughly investigate 7 allegations of client to client abuse, and the governing body neglected to put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner. Please see W104. 2. The facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its written policy and procedures to prevent the client to client abuse of clients #2 and #3 by client #1. The facility neglected to thoroughly 		<p>body facilitated:</p> <p>The Operations Team, including the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews, with all potential witnesses including but not limited to discovered injuries, injuries resulting from falls and peer to peer aggression. The QIDP and Quality Assurance Team (Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment and any allegations of sexual abuse. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the QIDP</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>investigate 7 allegations of client to client abuse, and neglected to put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner. Please see W122.</p> <p>9-3-1(a)</p>		<p>Manager (QA Manager responsible for ICF facilities) will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days, including but not limited to assuring the investigation reconciles discrepancies between witness testimony and documentary evidence. The Quality Assurance Manager and the QIDP Manager will review the scope of all open investigations to assure all allegations receive appropriate examination and analysis.</p> <p>The team has assessed that client 1 could be supported more successfully in a residential environment with fewer housemates and less external stimuli. Therefore the interdisciplinary team has requested a Medicaid Waiver for client #1. In the interim, the team has brought in an outside Masters level behavior behavioral clinician to assist with developing more effective behavior supports.</p> <p>PREVENTION:</p> <p>The QIDP Manager will maintain a tracking spreadsheet for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250	
(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)
				incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager. The QIDP Manager (Administrative level management/quality assurance) will meet with his/her QIDPs weekly to review the progress made on all investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250	
(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>potentially have occurred as a result of staff negligence. The Program Managers will provide weekly updates to the Executive Director and Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process providing follow-up as needed but no less than daily.</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 assuring staff implement proactive and reactive behavior supports as written. The Area Supervisor will be present at the facility observing the staff's provision of skills training and documentation no less than twice weekly for the next 60 days and</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>no less than weekly thereafter.</p> <p>Members of the Operations Team comprised of the Program Managers, Operations Manager, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators will conduct observations during active Treatment sessions and documentation reviews no less twice weekly for 30 days and then 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: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>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 facility. Administrative support at</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250	
(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 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview, for 2 of 4 sampled clients (#2)		W 0104	<p>the home will include but not be limited to assuring that specific training programs and interventions are in place to meet each client's assessed needs and that staff implement behavior supports as included in clients' plans and that corrective measures are developed and implemented in response to verified incidents of peer to peer aggression.</p> <p>Through the process of administrative monitoring, when specific staff experience ongoing difficulty implementing behavior supports as written, the staff will receive formal re-certification training through the agency's positive behavior support curriculum.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> <p>CORRECTION: <i>The Governing body must</i></p>
				09/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>and #3) the governing body failed to exercise general policy, budget and operating direction over the facility to prevent the client to client abuse of clients #2 and #3 by client #1. The governing body neglected to thoroughly investigate 7 allegations of client to client abuse, and the governing body neglected to put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent the client to client abuse of clients #2 and #3 by client #1. The governing body neglected to thoroughly investigate 7 allegations of client to client abuse and the governing body neglected to put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner. Please see W149.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility thoroughly investigated 7</p>		<p><i>exercise general policy, budget and operating direction over the facility.</i> Specifically, the governing body facilitated:</p> <p>The Operations Team, including the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews, with all potential witnesses including but not limited to discovered injuries, injuries resulting from falls and peer to peer aggression. The QIDP and Quality Assurance Team (Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment and any allegations of sexual abuse. When any evidence of staff negligence is uncovered or alleged the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>allegations of client to client abuse regarding client #1 towards clients #2 and #3. Please see W154.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner. Please see W157.</p> <p>9-3-1(a)</p>		<p>Operations Team will take control of all aspects of the investigation process. Additionally, the QIDP Manager (QA Manager responsible for ICF facilities) will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days, including but not limited to assuring the investigation reconciles discrepancies between witness testimony and documentary evidence. The Quality Assurance Manager and the QIDP Manager will review the scope of all open investigations to assure all allegations receive appropriate examination and analysis.</p> <p>The team has assessed that client 1 could be supported more successfully in a residential environment with fewer housemates and less external stimuli. Therefore the interdisciplinary team has requested a Medicaid Waiver for client #1. In the interim, the team has brought in an outside Masters level behavior behavioral clinician to assist with developing more effective behavior supports.</p> <p>PREVENTION:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager. The QIDP Manager (Administrative level management/quality assurance) will meet with his/her QIDPs weekly to review the progress made on all investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Program Managers will provide weekly updates to the Executive Director and Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process providing follow-up as needed but no less than daily.</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 assuring staff implement proactive and reactive behavior supports as written. The Area Supervisor will be present at the facility observing the staff's</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>provision of skills training and documentation no less than twice weekly for the next 60 days and no less than weekly thereafter.</p> <p>Members of the Operations Team comprised of the Program Managers, Operations Manager, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators will conduct observations during active Treatment sessions and documentation reviews no less twice weekly for 30 days and then 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>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 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250	
(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 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and		W 0122	<p>Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include but not be limited to assuring that specific training programs and interventions are in place to meet each client's assessed needs and that staff implement behavior supports as included in clients' plans and that corrective measures are developed and implemented in response to verified incidents of peer to peer aggression.</p> <p>Through the process of administrative monitoring, when specific staff experience ongoing difficulty implementing behavior supports as written, the staff will receive formal re-certification training through the agency's positive behavior support curriculum.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Site Supervisor, Direct Support Staff, Operations Team, Regional Director</p> <p>CORRECTION:</p>
				09/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (#2 and #3). The facility neglected to prevent the client to client abuse of clients #2 and #3 by client #1. The facility neglected to thoroughly investigate 7 allegations of client to client abuse, and neglected to put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility neglected to implement its written policy and procedures to prevent the client to client abuse of clients #2 and #3 by client #1. The facility neglected to thoroughly investigate 7 allegations of client to client abuse and neglected to put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner. Please see W149. 2. The facility failed to thoroughly investigate 7 allegations of client to client abuse regarding client #1 towards clients #2 and #3. Please see W154. 3. The facility failed to put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client 		<p><i>The facility must ensure that specific client protections requirements are met.</i> Specifically, the governing body facilitated the following:</p> <p>The Operations Team, including the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews, with all potential witnesses including but not limited to discovered injuries, injuries resulting from falls and peer to peer aggression. The QIDP and Quality Assurance Team (Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment and any allegations of sexual abuse. When any evidence of staff negligence</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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
	#1 from recurring in a timely manner. Please see W157. 9-3-2(a)		<p>is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the QIDP Manager (QA Manager responsible for ICF facilities) will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days, including but not limited to assuring the investigation reconciles discrepancies between witness testimony and documentary evidence. The Quality Assurance Manager and the QIDP Manager will review the scope of all open investigations to assure all allegations receive appropriate examination and analysis.</p> <p>The team has assessed that client 1 could be supported more successfully in a residential environment with fewer housemates and less external stimuli. Therefore the interdisciplinary team has requested a Medicaid Waiver for client #1. In the interim, the team has brought in an outside Masters level behavior behavioral clinician to assist with developing more effective behavior supports.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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
			PREVENTION: The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager. The QIDP Manager (Administrative level management/quality assurance) will meet with his/her QIDPs weekly to review the progress made on all investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Program Managers will provide weekly updates to the Executive Director and Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process providing follow-up as needed but no less than daily.</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 assuring staff implement proactive and reactive behavior supports as written. The Area Supervisor will be present at the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>facility observing the staff's provision of skills training and documentation no less than twice weekly for the next 60 days and no less than weekly thereafter.</p> <p>Members of the Operations Team comprised of the Program Managers, Operations Manager, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators will conduct observations during active Treatment sessions and documentation reviews no less twice weekly for 30 days and then 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250	
(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)
				work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. 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. 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. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS		<p>As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include but not be limited to assuring that specific training programs and interventions are in place to meet each client's assessed needs and that staff implement behavior supports as included in clients' plans and that corrective measures are developed and implemented in response to verified incidents of peer to peer aggression.</p> <p>Through the process of administrative monitoring, when specific staff experience ongoing difficulty implementing behavior supports as written, the staff will receive formal re-certification training through the agency's positive behavior support curriculum.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Site Supervisor, Direct Support Staff, Operations Team, Regional Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 4 sampled clients (#2 and #3), the facility neglected to implement its written policy and procedures to prevent the client to client abuse of clients #2 and #3 by client #1. The facility neglected to thoroughly investigate 7 allegations of client to client abuse, and the facility neglected to put corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 7/26/17 at 12:44 PM.</p> <p>1. A BDDS report dated 4/25/17 indicated, "...[Client #1] and [client #2] were both sitting in the van when [client #1] without warning hit [client #2] in the nose, as staff immediately separated the two consumers [client #1] became physical (sic) aggressive with staff, staff gently block (sic) and was able to verbally redirect [client #1] to calm herself."</p>	W 0149	<p>CORRECTION:</p> <p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the governing body facilitated:</i></p> <p>The Operations Team, including the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews, with all potential witnesses including but not limited to discovered injuries, injuries resulting from falls and peer to peer aggression. The QIDP and Quality Assurance Team (Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will assure that conclusions are developed that match the collected evidence. The Governing Body will assume</p>	09/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>-A review of the BDDS report dated 4/25/17 indicated client #1 hit client #2 without warning or provocation.</p> <p>-Investigation Final Report (IFR) dated 4/25/17 substantiated client #1 hit client #2. The IDT (Interdisciplinary Team Meeting) form dated 4/25/17 Plan to Resolve indicated, "[Client #1] has a BSP (Behavior Support Plan) in place to address all her (sic) physical aggression. Staff will comply with [client #1's] needs and accompany her (client #1) with any assistance between her and the other consumers preventing her (client #1) from harming her housemates. When in the van, [client #1] will sit (sic) in the seat in front of [client #2] to prevent further incidents of aggression."</p> <p>-Client #1's Progress Note dated 4/25/17 indicated, "[Client #1] had numerous behaviors on van, physical and verbal aggression...".</p> <p>-A review of the IFR/IDT dated 4/25/17 indicated the facility did not increase client #1's level of staffing due to the incident of physical aggression on 4/25/17. The review of the investigation did not indicate documentation of staff interviews regarding the incident of client to client aggression on 4/25/17.</p>		<p>complete responsibility for investigating any discovered injuries that require outside medical treatment and any allegations of sexual abuse. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the QIDP Manager (QA Manager responsible for ICF facilities) will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days, including but not limited to assuring the investigation reconciles discrepancies between witness testimony and documentary evidence. The Quality Assurance Manager and the QIDP Manager will review the scope of all open investigations to assure all allegations receive appropriate examination and analysis.</p> <p>The team has assessed that client 1 could be supported more successfully in a residential environment with fewer housemates and less external stimuli. Therefore the interdisciplinary team has requested a Medicaid Waiver for client #1. In the interim, the team has brought in an outside</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>2. A BDDS report dated 5/8/17 indicated on 5/7/17, "...[Client #1] was agitated and verbally aggressive because she believed [client #2] took her purse and was knocking her (client #1's) personal belongings off her dresser in her room and obtained a 1/2 inch scratch on her right index finger. Staff was able to verbally redirect [client #1] to calm herself and applied first aide (sic) to her scratch. Staff left [client #1's] room at which time [client #1] enter (sic) [client #2's] room and pushed her. [Client #2] fell backward, no visible injuries occurred; staff redirect (sic) [client #1] back to her room where she calmed herself with no further incidents."</p> <p>-A review of the BDDS report dated 5/8/17 indicated client #1 was physically destructive to her property and physically aggressive towards client #2.</p> <p>-The ISF dated 5/9/17 indicated the facility did not substantiate client #1 hit or caused injury to client #2. The IDT/Plan to Resolve dated 5/7/17 indicated, "Staff will continue to give both consumers emotional support and follow their proactive and reactive strategies." The review indicated client #1 pushed client #2 causing client #2 to fall backwards to the floor.</p>		<p>Masters level behavior behavioral clinician to assist with developing more effective behavior supports.</p> <p>PREVENTION:</p> <p>The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager. The QIDP Manager (Administrative level management/quality assurance) will meet with his/her QIDPs weekly to review the progress made on all investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Quality Assurance Team will review each</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 Progress Note dated 5/7/17 indicated, "[Client #1] had a very aggressive behavior all though the evening. She scattered her room (sic) and pick (sic) on housemates."</p> <p>A review of the ISF dated 5/9/17 indicated client #1 was physically aggressive towards client #2. The review did not indicate the facility increased client #1's staffing level due to her physical aggression. The review of the investigation did not indicate documentation of staff interviews regarding the incident of client to client aggression on 5/7/17.</p> <p>3. A BDDS report dated 5/28/17 indicated on 5/27/17, "Staff reported that [client #1] became verbally aggressive with [client #2] while standing in the hallway leading to the bedroom. Staff verbally redirected [client #1] to go to another area of the home and positioned themselves between [client #1] and [client #2]. [Client #1] lightly tapped [client #2] on the side of her right arm...".</p> <p>-A review of the BDDS report dated 5/28/17 indicated client #1 became verbally and physically aggressive towards client #2. The review indicated the BDDS report dated 5/28/17 did not</p>		<p>investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Program Managers will provide weekly updates to the Executive Director and Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process providing follow-up as needed but no less than daily.</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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>indicate client #1 was verbally and physically aggressive towards client #3.</p> <p>-An internal incident report dated 5/28/17 at 1:30 PM indicated, "[Client #1] was on a 15 minute time out from a prior incident. She (client #1) stormed out (sic) her room and threw a shower brush at [client #2] while she (client #2) was sitting on the couch next to [client #7]. The brush hit [client #7] on the side of the head and [client #2's] shoulder. She [client #1] said '(expletive) you' and went to her (client #1's) room and tore her blinds."</p> <p>-An internal incident report dated 5/28/17 at 1:50 PM indicated, "[Client #2] and [staff #3] were doing [client #3's] laundry. [Client #1] began yelling saying [client #2] got to go with [staff #3] although she [client #2] didn't. [Client #2] went to her room as [staff #3] talked to [client #1]. [Client #1] yelled out 'She's (Client #3) a (expletive)'. While [client #3] was drinking a cup of juice [client #1] took the drink and poured it over [client #3's] head. She (client #1) was directed to her room, where [client #1] threw lotion down the hallway."</p> <p>Client #1's progress note completed by staff #1 and completed on 5/28/17 indicated, "[Client #1] had a rough day</p>		<p>with and monitor skills training including but not limited to assuring staff implement proactive and reactive behavior supports as written. The Area Supervisor will be present at the facility observing the staff's provision of skills training and documentation no less than twice weekly for the next 60 days and no less than weekly thereafter.</p> <p>Members of the Operations Team comprised of the Program Managers, Operations Manager, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators will conduct observations during active Treatment sessions and documentation reviews no less twice weekly for 30 days and then 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>today. She had several behaviors. [Client #1] damaged bedroom property (her blinds). Along with hitting other residents in the home [client #2], [client #3] and [client #7]. [Client #1] hit [client #3's] glass of juice while drinking and poured juice on [client #3] while saying 'Take that (expletive).' [Client #1] as well took a back scrubber and through (sic) it which hit [client #7] in the head. [Client #1] as well took a bottle of lotion and poured it all over the hall floors of the home due to frustration. As well as screaming and slamming all doors inside the home."</p> <p>-Client #2's Progress Note dated 5/28/17 indicated, "[Client #2] had a good day overall, although she had been a target during most of [client #1's] behaviors...".</p> <p>-A review of the ISF dated 5/29/17 substantiated client #1 hit client #2. The review did not indicate the facility reported to BDDS client #1 pouring juice over client #3's head. The IDT note dated 5/27/17 Plan to Resolve indicated, "...Due to recent physical aggression toward her peers [client #1] requires enhance (sic) supervision, [client #1] will remain in line of sight in common area and 15 minute checks when she is in her room. Enhance (sic) supervision will be added to her plan (BSP)."</p>		<p>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 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>-The review of the ISF/IDT Plan to Resolve indicated the facility added Staff to complete 15 minute checks and maintain line of sight when client #1 was in common areas of the group home. The review of the investigation did not indicate documentation of staff interviews regarding the incident of client to client aggression on 5/27/17.</p> <p>4. A BDDS report dated 6/21/17 indicated, "...On 6/21/17 [client #1] was agitated because she believed her staff took her housemates on a community outing and was knocking her personal belongings off her dresser in her room and obtained a dime is (sic) bruise on her right forearm."</p> <p>-A review of the BDDS report dated 6/21/17 indicated client #1 was physically destructive to property which caused a dime-sized bruise on client #1's right forearm.</p> <p>5. A BDDS report dated 6/30/17 indicated on 6/29/17, "...[Client #1] and [client #2] were both sitting on the couch when [client #1] became agitated because she believed [client #2] was leaving the home, staff explained to [client #1] that [client #2] was preparing to take a shower. At the time, [client #1] stood up</p>		<p>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 but not be limited to assuring that specific training programs and interventions are in place to meet each client's assessed needs and that staff implement behavior supports as included in clients' plans and that corrective measures are developed and implemented in response to verified incidents of peer to peer aggression.</p> <p>Through the process of administrative monitoring, when specific staff experience ongoing difficulty implementing behavior supports as written, the staff will receive formal re-certification training through the agency's positive behavior support curriculum.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Site Supervisor, Direct Support Staff,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>and hit [client #2] on the top of her head; staff immediately separated the two consumers...[Client #2] sustained a 2 cm scratch on her forehead."</p> <p>-The ISF dated 7/1/17 substantiated client #1 hit client #2 causing an injury to client #2. The IDT/Plan to Resolve dated 6/29/17 indicated, "...Due to recent physical aggression toward her peers [client #1] requires enhance (sic) supervision, [client #1] will remain in line of sight in common areas and 15 minute checks when she (client #1) is in her room." The review indicated the facility's enhanced supervision, initiated on 5/27/17 did not prevent client #1 from hitting client #2. The review did not indicate the facility increased client #1's staffing level due to her increased physical aggression. The review of the investigation did not indicate documentation of staff interviews regarding the incident of client to client aggression on 6/29/17.</p> <p>6. A BDDS report dated 7/2/17 indicated on 7/1/17, "...Staff reported [client #1] became agitated because she wanted to go to the store. Staff reported [client #1] began to be destructive with the decor in the living room. Staff reported [client #1] threw objects at other consumers (unknown), but there were no injuries...".</p>		Operations Team, Regional Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>-A review of the BDDS report dated 7/2/17 indicated client #1 became physically destructive to property and physically aggressive towards her housemates. The review indicated client #1 threw objects at her housemates. The review did not indicate the facility's enhanced supervision, initiated on 5/27/17 prevented client #1's physically aggressive behavior towards her housemates.</p> <p>7. A BDDS report dated 7/4/17 indicated on 7/3/17, "...[Client #1] became upset when she mistakenly thought [client #2] had been taken to the [local] gas station without her. Before staff could position themselves between the two individuals, [client #1] hit [client #2]. Staff separated the two individuals and [client #1] appeared to calm herself down but then pulled down the medication room blinds."</p> <p>-A review of the BDDS indicated client #1 became agitated and hit client #2. The review indicated client #1 was physically destructive to property.</p> <p>The ISF dated 7/6/17 substantiated client #1 hit client #2. The IDT/Plan to Resolve dated 7/3/17 indicated, "...Due to recent physical aggression toward her peers</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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] requires enhance (sic) supervision, [client #1] will remain in line of sight in common area and 15 minute checks when she (client #1) is in her room." The review did not indicate the facility's enhanced supervision, initiated on 5/27/17 prevented client #1 from hitting client #2. The review did not indicate the facility increased client #1's staffing level due to her increased physical aggression. The review of the investigation did not indicate documentation of staff interviews regarding the incident of client to client aggression on 7/3/17.</p> <p>8. A BDDS report dated 7/9/17 indicated on 7/8/17, "...[Client #1] became agitated when she believed her housemates where (sic) leaving without her, and was redirected to a calm area, while in her room with staff [client #1] began knocking her personal belongings off her dresser and ran out of her room into the living room where she kicked [client #3] on her left leg, (sic) staff separated the two and redirected [client #1] to a calm area...[client #2] sustained a 3 inch bruise on her left leg."</p> <p>-A review of the BDDS report dated 7/9/17 indicated client #1 became agitated, physically aggressive and kicked client #3 on her left leg.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>An Internal Incident report completed by staff #1 dated 7/8/17 at 5:25 PM indicated, "[Client #1] got very angry and started throwing objects and cursing and yelling at other residents and staff. [Client #1] was redirected to her bedroom with staff #1 and continued to become aggressive with objects in her room. [Client #1] then ran out of her bedroom into the living room where [client #3] was seated on the couch. [Client #1] went towards [client #3] and kicked her (client #3) in (sic) her leg multiple times...".</p> <p>-The ISF dated 7/10/17 substantiated client #1 kicked client #3 causing an injury to client #3. The IDT/Plan to Resolve dated 7/8/17 indicated, "...Due to recent physical aggression toward her peers [client #1] requires enhance (sic) supervision. Staff is being trained on [client #1's] modified (sic) which addresses staff positioning when [client #1] is agitated...". A review of the IDT/Plan to resolve dated 7/8/17 indicated staff were being trained on positioning when client #1 became agitated. The review did not indicate the facility's enhanced supervision, initiated on 5/27/17, prevented client #1 from kicking client #3 multiple times. The review did not indicate the facility</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>increased client #1's staffing level due to her increased physical aggression. The review of the investigation dated 7/10/17 did not indicate the facility interviewed all staff present during the incident of client to client aggression on 7/8/17.</p> <p>9. A BDDS report dated 7/10/17 indicated on 7/9/17, "...After spending time on the front porch with staff, [client #1] entered the house and hit [client #2] without warning as she (client #2) walked by...".</p> <p>A witness statement from client #2 dated 7/10/17 indicated, "She (client #1) hit me in the head and leg."</p> <p>An Internal Incident report dated 7/9/17 indicated, "[Client #1] was standing out front with staff and [AS (Area Supervisor #1)] when we began to walk back into the house [client #2] was standing at the door, when [client #1] got to the door she (client #1) then hit [client #2] in the head and began to hold a firm grip on [client #2's] hair and would not let go."</p> <p>A witness statement from staff #1, not dated, indicated, "[Client #1] was out front with staff. While [client #2] (sic) standing in the doorway when [client #1] and staff were proceeding to go inside the home [street address] [client #1]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>immediately got frustrated and hit [client #2] on her head and pulled her (client #2's) hair and wouldn't let go until staff inforced (sic)."</p> <p>-The ISF dated 7/11/17 substantiated client #1 hit client #2 causing injury to client #2. The review did not indicate the facility's enhanced supervision, initiated on 5/27/17, prevented client #1 from hitting client #2 and pulling client #2's hair. The review of the investigation dated 7/11/17 did not indicate the facility interviewed all staff present during the incident of client to client aggression on 7/8/17. The review did not indicate the facility increased client #1's staffing level due to her increased physical aggression.</p> <p>Client #1's record was reviewed on 7/27/17 at 1:15 PM. The RSERRT (Residential Services East Region Required Training) form dated 7/17/17 indicated, "Due to recent incident of aggression, [client #1] will have one-on-one staffing during wakening (sic) hours at home and community. [Client #1's] one on one staff during non-wakening (sic) hours will do 15 minute checks to ensure [client #1's] health and safety. During Day Service [client #1's] one on one staff will transport [client #1] to Day service and remain with [client #1] until she returns</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>home."</p> <p>A review of the RSERRT form dated 7/17/17 indicated client #1's staffing level was increased to 1:1 on 7/17/17. The review indicated client #1 was a 1:1 staffing level at Day Services.</p> <p>DSM (Day Services Manager #1) was interviewed on 7/27/17 at 9:15 AM. DSM #1 was asked if client #1 was on a 1:1 staff ratio. DSM #1 stated, "She (client #1) is not. She's in the sensory room, it's closer to 8 (clients) to 1 (staff). We always have 3 staff in the sensory room."</p> <p>Client #1's BSP dated 4/15/2017 was reviewed on 7/27/17 at 1:15 PM. Client #1's BSP Enhanced Supervision section indicated, "Enhance (sic) Supervision:</p> <ul style="list-style-type: none"> -1. Staff assigned to provide enhanced supervision with [client #1] will take possession of her observation binder/observation tracking sheets after clocking in. -2. Assigned staff will remain within line of sight of [client #1] while she is awake and not in her bedroom. The assigned staff must not be responsible for one to one observation of another individual. If the staff assigned to provide line of 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>sight/15 minute check for [client #1] and or other individuals/ breaks such as going to the bathroom the staff needs to communicate this to other staff that is working. Another staff will monitor [client #1] until her assigned staff returns."</p> <p>A review of the BSP dated 4/15/17 indicated client #1's BSP dated 4/15/17 did not indicate a revision date. The review indicated staff began implementing enhanced supervision, 1:1 staffing for client #1 on 7/17/17.</p> <p>An observation was conducted at the day service program on 7/27/17 from 9:15 AM through 10:05 AM. Client #1 was observed throughout the observation period. At 9:40 AM Group Home staff #2 was observed providing 1:1 staffing with client #1. DSM #1 stated, "I have not noticed the 1:1 staffing." DSM #1 asked DSS (Day Services Staff #1) when client #1 became a 1:1 staffing ratio at Day Services. DSS #1 stated, "That's new here as of today."</p> <p>A review of the RSERRT form dated 7/17/17 indicated the facility did not initiate 1:1 staffing at client #1's Day Service until 7/27/17.</p> <p>Client #2 was interviewed on 7/26/17 at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>4:26 PM. Client #2 was asked if she felt safe at the group home. Client #2 stated, "Somewhat." Client #2 was asked if anyone hits her at the group home. Client #2 stated, "[Client #1] does."</p> <p>Client #6 was interviewed on 7/26/17 at 4:53 PM. Client #6 was asked if client #1 yells/screams a lot. Client #6 stated, "[Client #1] yells because [client #2] gets to do things. It makes me mad sometimes."</p> <p>Staff #3 was interviewed on 7/26/17 at 12:30 PM. Staff #3 was asked why client #1 was not attending Day Services. Staff #3 stated, "She goes to [Work Shop] (sic) 2 x a week on Tuesdays and Thursdays because she (client #1) has behaviors. She (client #1) is a 1:1 right now with 15 minute checks." Staff #1 was asked why client #1 was on a 1:1 staffing ratio. Staff #3 stated, "Physical aggression, it's really 2 clients [client #3] and [client #2] she targets. She (client #1) kicks [client #3] and [client #2] on the knees. She (client #1) throws things. She has thrown a mirror at me (staff #3) and tips dressers over and throws the drawers."</p> <p>Staff #4 was interviewed on 7/26/17 at 5:15 PM. Staff #4 was asked if client #1 is physically aggressive towards the other clients. Staff #4 stated, "I have seen her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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) throw objects. She will throw anything. She's (client #1) always after [client #2]."</p> <p>Staff #1 was interviewed on 7/26/17 at 5:31 PM. Staff #1 was asked if the other clients appeared afraid of client #1. Staff #1 stated, "[Client #3] keeps her distance from [client #1]. Especially when [client #1] gets loud and yelling. She (client #1) does have a lot of aggression, a lot."</p> <p>Staff #5 was interviewed on 7/27/17 at 5:55 AM. Staff #5 was asked when client #1 began presenting with physical aggression towards her housemates. Staff #5 stated, "When I started here (Feb. 2017) her (client #1) behavior was normal. For the last 2 or 3 months she started having behaviors and then she is a 1:1."</p> <p>QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 7/27/17 at 2:43 PM. QIDP #1 indicated the facility implemented enhanced supervision with 15 minute checks and line of sight observation for client #1 on 5/27/17. QIDP #1 was asked when the facility implemented 1:1 staffing for client #1. QIDP #1 stated, "On 7/17/17." QIDP #1 was asked if the facility should have implemented 1:1 staffing for client #1 earlier. QIDP #1 stated, "Yes, it (1:1</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>staffing) should have been implemented sooner to ensure the safety of the housemates."</p> <p>QIDP #1 was interviewed on 7/27/17 at 1:10 PM. QIDP #1 indicated the facility should have implemented its policy on the prevention of abuse, neglect and mistreatment as written. QIDP #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated and all witnesses or potential witnesses should be interviewed during the investigation. QIDP #1 indicated the facility should implement corrective measures based on the recommendations of the IDT and the investigations' recommendations.</p> <p>The facility's policies and procedures were reviewed on 8/1/17 at 11:07 AM. The facility's Abuse, Neglect, Exploitation, Mistreatment Policy dated 2/26/11 indicated the following:</p> <p>"ADEPT staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation or mistreatment shall be reported to the proper authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ADEPT, Rescare, and local, state and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>federal guidelines..."</p> <p>-"Definitions : Physical Abuse: the act or failure to act that results or could result in physical injury to an individual.</p> <p>Non-accidental injury inflicted by another person or persons..."</p> <p>-"Intimidation/emotional abuse: the act or failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language of gestures toward an individual that subject him/her to humiliation or degradation.</p> <p>Discouraging or inhibiting behavior by threatening both actual or implied.</p> <p>Attitude or acts that interfere with the psychological and social well being of an individual..."</p> <p>-"Program intervention neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm.</p> <p>Failure to implement a support plan, inappropriate application of intervention with out a qualified person notification/review."</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#2 and #3), the facility failed to thoroughly investigate 7 allegations of client to client abuse regarding client #1 towards clients #2 and #3.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 7/26/17 at 12:44 PM.</p> <p>1. A BDDS report dated 4/25/17 indicated, "...[Client #1] and [client #2] were both sitting in the van when [client #1] without warning hit [client #2] in the nose, as staff immediately separated the two consumers [client #1] became</p>	W 0154	<p>CORRECTION:</p> <p><i>The facility must have evidence that all alleged violations are thoroughly investigated.</i></p> <p>Specifically: the Operations Team, including the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews, with all potential witnesses including but not limited to discovered injuries, injuries resulting from falls and peer to peer aggression. The QIDP and Quality Assurance</p>	09/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>physical (sic) aggressive with staff, staff gently block and was able to verbally redirect [client #1] to calm herself."</p> <p>-A review of the BDDS report dated 4/25/17 indicated client #1 hit client #2 without warning or provocation.</p> <p>-Investigation Final Report (IFR) dated 4/25/17 substantiated client #1 hit client #2.</p> <p>-Client #1's Progress Note dated 4/25/17 indicated, "[Client #1] had numerous behaviors on van, physical and verbal aggression...".</p> <p>The review of the IFR dated 4/25/17 did not indicate documentation of staff interviews regarding the incident of client to client aggression on 4/25/17.</p> <p>2. A BDDS report dated 5/8/17 indicated on 5/7/17, "...[Client #1] was agitated and verbally aggressive because she believed [client #2] took her purse and was knocking her (client #1's) personal belongings off her dresser in her room and obtained a 1/2 inch scratch on her right index finger. Staff was able to verbally redirect [client #1] to calm herself and applied first aide (sic) to her scratch. Staff left [client #1's] room at which time [client #1] enter (sic) [client</p>		<p>Team (Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will assure that conclusions are developed that match the collected evidence. The Governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment and any allegations of sexual abuse. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Additionally, the QIDP Manager (QA Manager responsible for ICF facilities) will provide direct oversight and hands-on coaching of the QIDP throughout the investigation process for the next 90 days, including but not limited to assuring the investigation reconciles discrepancies between witness testimony and documentary evidence. The Quality Assurance Manager and the QIDP Manager will review the scope of all open investigations to assure all allegations receive appropriate examination and analysis.</p> <p>PREVENTION:</p> <p>The QIDP Manager will maintain</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>#2's] room and pushed her. [Client #2] fell backward, no visible injuries occurred; staff redirect (sic) [client #1] back to her room where she calmed herself with no further incidents."</p> <p>-A review of the BDDS report dated 5/8/17 indicated client #1 was physically destructive to her property and physically aggressive towards client #2.</p> <p>-The ISF dated 5/9/17 indicated the facility did not substantiate client #1 hit or caused injury to client #2. The ISF Plan of resolution indicated, "Staff will continue to give both consumers emotional support and follow their proactive and reactive strategies." The review indicated client #1 pushed client #2 causing client #2 to fall backwards to the floor.</p> <p>-Client #1's Progress Note dated 5/7/17 indicated, "[Client #1] had a very aggressive behavior all though the evening. She scattered her room (sic) and pick (sic) on housemates."</p> <p>A review of the ISF dated 5/9/17 did not indicate documentation of staff interviews regarding the incident of client to client aggression on 5/7/17.</p> <p>3. A BDDS report dated 5/28/17</p>		<p>a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager. The QIDP Manager (Administrative level management/quality assurance) will meet with his/her QIDPs weekly to review the progress made on all investigations that are open for their homes. QIDPs will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>indicated on 5/27/17, "Staff reported that [client #1] became verbally aggressive with [client #2] while standing in the hallway leading to the bedroom. Staff verbally redirected [client #1] to go to another area of the home and positioned themselves between [client #1] and [client #2]. [Client #1] lightly tapped [client #2] on the side of her right arm...".</p> <p>-An internal incident report dated 5/28/17 at 1:30 PM indicated, "[Client #1] was on a 15 minute time out from a prior incident. She (client #1) stormed out (sic) her room and threw a shower brush at [client #2] while she (client #2) was sitting on the couch next to [client #7]. The brush hit [client #7] on the side of the head and [client #2's] shoulder. She [client #1] said '(expletive) you' and went to her (client #1's) room and tore her blinds."</p> <p>-An internal incident report dated 5/28/17 at 1:50 PM indicated, "[Client #2] and [staff #3] were doing [client #3's] laundry. [Client #1] began yelling saying [client #2] got to go with [staff #3] although she [client #2] didn't. [Client #2] went to her room as [staff #3] talked to [client #1]. [Client #1] yelled out 'She's (Client #3) a (expletive)'. While [client #3] was drinking a cup of juice [client #1] took the drink and poured it over</p>		<p>serious incidents that could potentially have occurred as a result of staff negligence. The Program Managers will provide weekly updates to the Executive Director and Quality Assurance Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Site Supervisor, Direct Support Staff, Operations Team, Regional Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 #3's] head. She (client #1) was directed to her room, where [client #1] threw lotion down the hallway."</p> <p>Client #1's progress note completed by staff #1 and completed on 5/28/17 indicated, "[Client #1] had a rough day today. She had several behaviors. [Client #1] damaged bedroom property (her blinds). Along with hitting other residents in the home [client #2], [client #3] and [client #7]. [Client #1] hit [client #3's] glass of juice while drinking and poured juice on [client #3] while saying 'Take that (expletive).' [Client #1] as well took a back scrubber and through (sic) it which hit [client #7] in the head. [Client #1] as well took a bottle of lotion and poured it all over the hall floors of the home due to frustration. As well as screaming and slamming all doors inside the home."</p> <p>-Client #2's Progress Note dated 5/28/17 indicated, "[Client #2] had a good day overall, although she had been a target during most of [client #1's] behaviors...".</p> <p>-A review of the ISF dated 5/29/17 substantiated client #1 hit client #2. The review of the investigation did not indicate documentation of staff interviews regarding the incident of client to client aggression on 5/27/17.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>4. A BDDS report dated 6/30/17 indicated on 6/29/17, "...[Client #1] and [client #2] were both sitting on the couch when [client #1] became agitated because she was believed [client #2] was leaving the home, staff explained to [client #1] that [client #2] was preparing to take a shower. At the time, [client #1] stood up and hit [client #2] on the top of her head; staff immediately separated the two consumers...[Client #2] sustained a 2 cm scratch on her forehead."</p> <p>-The ISF dated 7/1/17 substantiated client #1 hit client #2 causing an injury to client #2. The review of the investigation did not indicate documentation of staff interviews regarding the incident of client to client aggression on 6/29/17.</p> <p>5. A BDDS report dated 7/4/17 indicated on 7/3/17, "...[Client #1] became upset when she mistakenly thought [client #2] had been taken to the [local] gas station without her. Before staff could position themselves between the two individuals, [client #1] hit [client #2]. Staff separated the two individuals and [client #1] appeared to calm herself down but then pulled down the medication room blinds."</p> <p>-The ISF dated 7/6/17 substantiated client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>#1 hit client #2. The review of the investigation did not indicate documentation of staff interviews regarding the incident of client to client aggression on 7/3/17.</p> <p>6. A BDDS report dated 7/9/17 indicated on 7/8/17, "...[Client #1] became agitated when she believed her housemates where (sic) leaving without her, and was redirected to a calm area, (sic) while in her room with staff [client #1] began knocking her personal belongings off her dresser and ran out of her room into the loving room where she kicked [client #3] on her left leg, (sic) staff separated the two and redirected [client #1] to a calm area...[client #2] sustained a 3 inch bruise on her left leg."</p> <p>-An Internal Incident report completed by staff #1 dated 7/8/17 at 5:25 PM indicated, "[Client #1] got very angry and started throwing objects and cursing and yelling at other residents and staff. [Client #1] was redirected to her bedroom with staff #1 and continued to become aggressive with objects in her room. [Client #1] then ran out of her bedroom into the living room where [client #3] was seated on the couch. [Client #1] went towards [client #3] and kicked her (client #3) in (sic) her leg multiple times...".</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>-The ISF 7/10/17 substantiated client #1 kicked client #3 causing an injury to client #3. The review of the investigation dated 7/10/17 did not indicate the facility interviewed all staff present during the incident of client to client aggression on 7/8/17.</p> <p>7. A BDDS report dated 7/10/17 indicated on 7/9/17, "...After spending time on the front porch with staff, [client #1] entered the house and hit [client #2] without warning as she (client #2) walked by...".</p> <p>A witness statement dated 7/10/17 from client #2 indicated, "She (client #1) hit me in the head and leg."</p> <p>An Internal Incident report dated 7/9/17 indicated, "[Client #1] was standing out front with staff and [AS (Area Supervisor #1)] when we began to walk back into the house [client #2] was standing at the door, when [client #1] got to the door she (client #1) then hit [client #2] in the head and began to hold a firm grip on [client #2's] hair and would not let go."</p> <p>A witness statement from staff #1, not dated, indicated, "[Client #1] was out front with staff. while [client #2] (sic) standing in the doorway when [client #1]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 0157 Bldg. 00	<p>and staff were proceeding to go inside the home [street address] [client #1] immediately got frustrated and hit [client #2] on her head and pulled her (client #2's) hair and wouldn't let go until staff inforced (sic)."</p> <p>-The ISF dated 7/11/17 substantiated client #1 hit client #2 causing injury to client #2. The review of the investigation dated 7/11/17 did not indicate the facility interviewed all staff present during the incident of client to client aggression on 7/8/17.</p> <p>QIDP #1 was interviewed on 7/27/17 at 1:10 PM. QIDP #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated and all witnesses or potential witnesses should be interviewed during the investigation.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 2 of 4 sampled clients (#2 and #3), the facility failed to put</p>	W 0157	CORRECTION: <i>If the alleged violation is verified, appropriate corrective action</i>	09/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>corrective measures in place to prevent the client to client abuse of clients #2 and #3 by client #1 from recurring in a timely manner.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 7/26/17 at 12:44 PM.</p> <p>1. A BDDS report dated 4/25/17 indicated, "...[Client #1] and [client #2] were both sitting in the van when [client #1] without warning hit [client #2] in the nose, as staff immediately separated the two consumers [client #1] became physical (sic) aggressive with staff, staff gently block and was able to verbally redirect [client #1] to calm herself."</p> <p>-A review of the BDDS report dated 4/25/17 indicated client #1 hit client #2 without warning or provocation.</p> <p>-Investigation Final Report (IFR) dated 4/25/17 substantiated client #1 hit client #2. The IDT (Interdisciplinary Team Meeting) form dated 4/25/17 Plan to Resolve indicated, "[Client #1] has a BSP (Behavior Support Plan) in place to address all her (sic) physical aggression. Staff will comply with [client #1's] needs</p>		<p><i>must be taken.</i> Specifically, the team has assessed that client 1 could be supported more successfully in a residential environment with fewer housemates and less external stimuli. Therefore the interdisciplinary team has requested a Medicaid Waiver for client #1. In the interim, the team has brought in an outside Masters level behavior behavioral clinician to assist with developing more effective behavior supports.</p> <p>PREVENTION:</p> <p>When incidents occur, The QIDP Manager will guide the QIDP through the investigation and corrective measure implementation process providing follow-up as needed but no less than daily.</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 assuring staff implement proactive and reactive behavior supports as written. The Area Supervisor will be present at the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>and accompany her (client #1) with any assistance between her and the other consumers preventing her (client #1) from harming her housemates. When in the van, [client #1] will set (sic) in the seat in front of [client #2] to prevent further incidents of aggression."</p> <p>-Client #1's Progress Note dated 4/25/17 indicated, "[Client #1] had numerous behaviors on van, physical and verbal aggression...".</p> <p>-A review of the IFR/IDT dated 4/25/17 indicated the facility did not increase client #1's level of staffing due to the incident of physical aggression on 4/25/17.</p> <p>2. A BDDS report dated 5/8/17 indicated on 5/7/17, "...[Client #1] was agitated and verbally aggressive because she believed [client #2] took her purse and was knocking her (client #1's) personal belongings off her dresser in her room and obtained a 1/2 inch scratch on her right index finger. Staff was able to verbally redirect [client #1] to calm herself and applied first aide (sic) to her scratch. Staff left [client #1's] room at which time [client #1] enter (sic) [client #2's] room and pushed her. [Client #2] fell backward, no visible injuries occurred; staff redirect (sic) [client #1]</p>		<p>facility observing the staff's provision of skills training and documentation no less than twice weekly for the next 60 days and no less than weekly thereafter.</p> <p>Members of the Operations Team comprised of the Program Managers, Operations Manager, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators will conduct observations during active Treatment sessions and documentation reviews no less twice weekly for 30 days and then 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</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>back to her room where she calmed herself with no further incidents."</p> <p>-A review of the BDDS report dated 5/8/17 indicated client #1 was physically destructive to her property and physically aggressive towards client #2.</p> <p>-The ISF dated 5/9/17 indicated the facility did not substantiate client #1 hit or caused injury to client #2. The ISF Plan of resolution indicated, "Staff will continue to give both consumers emotional support and follow their proactive and reactive strategies." The review indicated client #1 pushed client #2 causing client #2 to fall backwards to the floor.</p> <p>-Client #1's Progress Note dated 5/7/17 indicated, "[Client #1] had a very aggressive behavior all though the evening. She scattered her room (sic) and pick (sic) on housemates."</p> <p>A review of the ISF dated 5/9/17 indicated client #1 was physically aggressive towards client #2. The review did not indicate the facility increased client #1's staffing level due to her physical aggression.</p> <p>3. A BDDS report dated 5/28/17 indicated on 5/27/17, "Staff reported that</p>		<p>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 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.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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] became verbally aggressive with [client #2] while standing in the hallway leading to the bedroom. Staff verbally redirected [client #1] to go to another area of the home and positioned themselves between [client #1] and [client #2]. [Client #1] lightly tapped [client #2] on the side of her right arm...".</p> <p>-A review of the BDDS report dated 5/28/17 indicated client #1 became verbally and physically aggressive towards client #2. The review indicated the BDDS report dated 5/28/17 did not indicate client #1 was verbally and physically aggressive towards client #3. The review indicated the BDDS report dated 5/28/17 did not indicate client #1 threw a back scrubber brush which struck client #7 on his head.</p> <p>-An internal incident report dated 5/28/17 at 1:30 PM indicated, "[Client #1] was on a 15 minute time out from a prior incident. She (client #1) stormed out (sic) her room and threw a shower brush at [client #2] while she (client #2) was sitting on the couch next to [client #7]. The brush hit [client #7] on the side of the head and [client #2's] shoulder. She [client #1] said '(expletive) you' and went to her (client #1's) room and tore her blinds."</p>		<p>As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include but not be limited to assuring that specific training programs and interventions are in place to meet each client's assessed needs and that staff implement behavior supports as included in clients' plans and that corrective measures are developed and implemented in response to verified incidents of peer to peer aggression.</p> <p>Through the process of administrative monitoring, when specific staff experience ongoing difficulty implementing behavior supports as written, the staff will receive formal re-certification training through the agency's positive behavior support curriculum.</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: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>-An internal incident report dated 5/28/17 at 1:50 PM indicated, "[Client #2] and [staff #3] were doing [client #3's] laundry. [Client #1] began yelling saying [client #2] got to go with [staff #3] although she [client #2] didn't. [Client #2] went to her room as [staff #3] talked to [client #1]. [Client #1] yelled out 'She's (Client #3) a (expletive)'. While [client #3] was drinking a cup of juice [client #1] took the drink and poured it over [client #3's] head. She (client #1) was directed to her room, where [client #1] threw lotion down the hallway."</p> <p>Client #1's progress note completed by staff #1 and completed on 5/28/17 indicated, "[Client #1] had a rough day today. She had several behaviors. [Client #1] damaged bedroom property (her blinds). Along with hitting other residents in the home [client #2], [client #3] and [client #7]. [Client #1] hit [client #3's] glass of juice while drinking and poured juice on [client #3] while saying 'Take that (expletive).' [Client #1] as well took a back scrubber and through (sic) it which hit [client #7] in the head. [Client #1] as well took a bottle of lotion and poured it all over the hall floors of the home due to frustration. As well as screaming and slamming all doors inside the home."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 #2's Progress Note dated 5/28/17 indicated, "[Client #2] had a good day overall, although she had been a target during most of [client #1's] behaviors..." .</p> <p>-A review of the ISF dated 5/29/17 substantiated client #1 hit client #2. The IDT note dated 5/27/17 Plan to Resolve indicated, "...Due to recent physical aggression toward her peers [client #1] requires enhance (sic) supervision, [client #1] will remain in line of sight in common area and 15 minute checks when she is in her room. Enhance (sic) supervision will be added to her plan (BSP)."</p> <p>-The review of the ISF/IDT Plan to Resolve indicated the facility added Staff to complete 15 minute check's and maintain line of sight when client #1 was in common areas of the group home. The review did not indicate the facility increased client #1's staffing level due to her increased physical aggression.</p> <p>4. A BDDS report dated 6/30/17 indicated on 6/29/17, "...[Client #1] and [client #2] were both sitting on the couch when [client #1] became agitated because she was believed [client #2] was leaving the home, staff explained to [client #1] that [client #2] was preparing to take a shower. At the time, [client #1] stood up</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>and hit [client #2] on the top of her head; staff immediately separated the two consumers...[Client #2] sustained a 2 cm scratch on her forehead."</p> <p>-The ISF dated 7/1/17 substantiated client #1 hit client #2 causing an injury to client #2. The IDT/Plan to Resolve dated 6/29/17 indicated, "...Due to recent physical aggression toward her peers [client #1] requires enhance (sic) supervision, [client #1] will remain in line of sight in common areas and 15 minute checks when she (client #1) is in her room." The review indicated the facility's enhanced supervision, initiated on 5/27/17, did not prevent client #1 from hitting client #2. The review did not indicate the facility increased client #1's staffing level due to her increased physical aggression.</p> <p>5. A BDDS report dated 7/2/17 indicated on 7/1/17, "...Staff reported [client #1] became agitated because she wanted to go to the store. Staff reported [client #1] began to be destructive with the decor in the living room. Staff reported [client #1] threw objects at other consumers, but there were no injuries...".</p> <p>-A review of the BDDS report dated 7/2/17 indicated client #1 became physically destructive to property and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>physically aggressive towards her housemates. The review indicated client #1 threw objects at her housemates. The review did not indicate the facility's enhanced supervision, initiated on 5/27/17, prevented client #1 physically aggressive behavior towards her housemates.</p> <p>6. A BDDS report dated 7/4/17 indicated on 7/3/17, "...[Client #1] became upset when she mistakenly thought [client #2] had been taken to the [local] gas station without her. Before staff could position themselves between the two individuals, [client #1] hit [client #2]. Staff separated the two individuals and [client #1] appeared to calm herself down but then pulled down the medication room blinds."</p> <p>-A review of the BDDS indicated client #1 became agitated and hit client #2.</p> <p>The ISF dated 7/6/17 substantiated client #1 hit client #2. The IDT/Plan to Resolve dated 7/3/17 indicated, "...Due to recent physical aggression toward her peers [client #1] requires enhance (sic) supervision, [client #1] will remain in line of sight in common area and 15 minute checks when she (client #1) is in her room." The review did not indicate the facility's enhanced supervision,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>initiated on 5/27/17, prevented client #1 from hitting client #2. The review did not indicate the facility increased client #1's staffing level due to her increased physical aggression.</p> <p>7. A BDDS report dated 7/9/17 indicated on 7/8/17, "...[Client #1] became agitated when she believed her housemates where (sic) leaving without her, and was redirected to a calm area, (sic) while in her room with staff [client #1] began knocking her personal belongings off her dresser and ran out of her room into the loving room where she kicked [client #3] on her left leg, (sic) staff separated the two and redirected [client #1] to a calm area...[client #2] sustained a 3 inch bruise on her left leg."</p> <p>-A review of the BDDS reported dated 7/9/17 indicated client #1 became agitated, physically aggressive and kicked client #3 on her left leg.</p> <p>An Internal Incident report completed by staff #1 dated 7/8/17 at 5:25 PM indicated, "[Client #1] got very angry and started throwing objects and cursing and yelling at other residents and staff. [Client #1] was redirected to her bedroom with staff #1 and continued to become aggressive with objects in her room. [Client #1] then ran out of her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250	
(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>bedroom into the living room where [client #3] was seated on the couch. [Client #1] went towards [client #3] and kicked her (client #3) in (sic) her leg multiple times...".</p> <p>- The ISF 7/10/17 substantiated client #1 kicked client #3 causing an injury to client #3. The IDT/Plan to Resolve dated 7/8/17 indicated, "...Due to recent physical aggression toward her peers [client #1] requires enhance (sic) supervision. Staff is being trained on on [client #1's] modified (sic) which addresses staff positioning when [client #1] is agitated...". A review of the IDT/Plan to resolve dated 7/8/17 indicated staff were being trained on positioning when client #1 becomes agitated. The review did not indicate the facility's enhanced supervision, initiated on 5/27/17, prevented client #1 from kicking client #3. The review did not indicate the facility increased client #1's staffing level due to her increased physical aggression.</p> <p>8. A BDDS report dated 7/10/17 indicated on 7/9/17, "...After spending time on the front porch with staff, [client #1] entered the house and hit [client #2] without warning as she (client #2) walked by...".</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>A witness statement dated 7/10/17 from client #2 indicated, "She (client #1) hit me in the head and leg."</p> <p>An Internal Incident report dated 7/9/17 indicated, "[Client #1] was standing out front with staff and [AS (Area Supervisor #1)] when we began to walk back into the house [client #2] was standing at the door, when [client #1] got to the door she (client #1) then hit [client #2] in the head and began to hold a firm grip on [client #2's] hair and would not let go."</p> <p>A witness statement from staff #1, not dated, indicated, "[Client #1] was out front with staff. while [client #2] (sic) standing in the doorway when [client #1] and staff were proceeding to go inside the home [street address] [client #1] immediately got frustrated and hit [client #2] on her head and pulled her (client #2's) hair and wouldn't let go until staff inforced (sic)."</p> <p>-The ISF dated 7/11/17 substantiated client #1 hit client #2 causing injury to client #2. The review did not indicate the facility's enhanced supervision, initiated on 5/27/17, prevented client #1 from hitting client #3 and pulling client #2's hair. The review did not indicate the facility increased client #1's staffing level due to her increased physical aggression.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 record was reviewed on 7/27/17 at 1:15 PM. The RSERRT (Residential Services East Region Required Training) form dated 7/17/17 indicated, "Due to recent incident of aggression, [client #1] will have one-on-one staffing during wakening hours at home and community. [Client #1's] one on one staff during non-wakening hours will do 15 minute checks to ensure [client #1's] health and safety. During Day Service [client #1's] one on one staff will transport [client #1] to Day service and remain with [client #1] until she returns home."</p> <p>A review of the RSERRT form dated 7/17/17 indicated client #1's staffing level was increased to 1:1 on 7/17/17. The review indicated client #1 was a 1:1 staffing level at Day Services.</p> <p>DSM (Day Services Manager #1) was interviewed on 7/27/17 at 9:15 AM. DSM #1 was asked if client #1 was on a 1:1 staff ratio. DSM #1 stated, "She (client #1) is not. She's in the sensory room, it's closer to 8 (clients) to 1 (staff). We always have 3 staff in the sensory room."</p> <p>An observation was conducted at the day service program on 7/27/17 from 9:15</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>AM through 10:05 AM. Client #1 was observed throughout the observation period. At 9:45 AM Group Home staff #2 was observed providing 1:1 staffing with client #1. DSM #1 stated, "I have not noticed the 1:1 staffing." DSM #1 asked DSS (Day Services Staff #1) when client #1 became a 1:1 staffing ratio at Day Services. DSS #1 stated, "That's new here as of today."</p> <p>A review of the RSERRT form dated 7/17/17 indicated the facility did not initiate 1:1 staffing at client #1's Day Service until 7/27/17.</p> <p>QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 7/27/17 at 2:43 PM. QIDP #1 indicated the facility implemented enhanced supervision with 15 minute checks and line of sight observation for client #1 on 5/27/17. QIDP #1 was asked when the facility implemented 1:1 staffing for client #1. QIDP #1 stated, "On 7/17/17." QIDP #1 was asked if the facility should have implemented 1:1 staffing for client #1 earlier. QIDP #1 stated, "Yes, it (1:1 staffing) should have been implemented sooner to ensure the safety of the housemates."</p> <p>QIDP #1 was interviewed on 7/27/17 at 1:10 PM. QIDP #1 indicated the facility</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 0331 Bldg. 00	<p>should have implemented corrective measures based on the recommendations of the completed investigations.</p> <p>9-3-2(a)</p> <p>483.460(c)</p> <p>NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the nurse failed to ensure client #1's medication order was correct.</p> <p>Findings include:</p> <p>A medication observation was conducted on 7/27/17 from 6:10 AM through 6:45 AM. At 6:40 AM staff #5 was observed administering medications to client #1. Staff #5 administered client #1's 7 AM medications including client #1's Latuda (Anti-Psychotic) 80 mg (milligram) to client #1.</p> <p>A BDDS (Bureau of Developmental Disabilities Services) report dated 7/27/17 at 3:15 PM was reviewed on 7/28/17 at 11:00 AM. The BDDS report</p>	W 0331	<p>CORRECTION:</p> <p><i>The facility must provide clients with nursing services in accordance with their needs. Specifically: The improperly transcribed physician's order in client #1's Medication Administration Record (MAR) has been corrected and client #1's medications are being administered as prescribed. A review of facility support documents indicated that this deficient practice did not affect any additional clients.</i></p> <p>PERVENTION:</p> <p>The Registered Nurse and the Nurse Manager will provide direct oversight of the facility nurse to</p>	09/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>dated 7/27/17 indicated, "...During [client #1's] home's annual re-certification survey, it was discovered that due to a transcription error [client #1] had received an extra 40 mg of Latuda daily".</p> <p>A review of the BDDS report dated 7/27/17 indicated client #1 received an extra dose of 40 MG of Latuda from 7/18/17 through 7/26/17.</p> <p>-Client #1's record was reviewed on 7/27/17 at 1:15 PM. Client #1's physicians orders dated 7/1/17 through 7/31/17 indicated, "Latuda 40 mg Tab Give one tablet by mouth every evening after dinner on a full stomach-5 PM."</p> <p>-A review of client #1's physicians orders dated 7/1/17 through 7/31/17 indicated client #1 was to receive 1 40 MG tablet of Latuda at 5 PM.</p> <p>-Client #1's MAR (Medication Administration Record) dated 7/1/17 through 7/31/17 was reviewed on 7/27/17 at 1:15 PM. Client #1's order for Latuda was written by the physician on 6/14/17. Client #1's MAR listed Latuda 40 MG. A line was crossed through 40 MG and '80mg' was hand-written in ink next to it. The time of 5 PM was replaced in hand written ink with a medication</p>		<p>assure new medications are transcribed into the Medication Administration Record as written. When transcription of a new medication order is delegated to a facility staff, a copy of the transcribed order will be scanned to a ResCare nurse for review, prior to initiating a new or changed medication order. The facility nurse will conduct weekly audits of medication and administration records to assure new orders are transcribed as written and medications are administered as ordered.</p> <p>Members of the Operations Team comprised of the Program Managers, Operations Manager, Nurse Manager, Registered Nurse, Executive Director, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators will incorporate reviews of the Medication Administration Record and Physician's Orders into audits of facility documentation as needed but no less than twice monthly.</p> <p>RESPONSIBLE PARTIES: Health Services Team, QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>administration time of 9 PM. Also, a medication administration time of 7 AM was hand-written in ink on client #1's MAR. Starting on 7/13/17, staff were initialing for 80 MG of Latuda administered at 7 AM and 9 PM for a total dose of 160 MG of Latuda.</p> <p>-Client #1's medication cards/bubble packs were reviewed on 7/27/17 at 1:15 PM. Client #1 had 2 separate medication cards of Latuda in her medication box.</p> <p>-The first medication card indicated, "Latuda 40 MG give 1 tab by mouth after dinner-5 PM." A review of this medication card indicated (twenty) 40 MG Latuda tablets, had been popped and initialed out of the medication card. Some of the Latuda 40 MG tablets had been popped out of numeric sequence.</p> <p>-The second medication card indicated, "Latuda 80 MG give 1 tablet by mouth daily at 7 AM." A review of this medication card indicated 10 Latuda 80 MG tablets had been popped and initialed out of the medication card, dated 7/18/17 through 7/27/17.</p> <p>A review of client #1's MAR dated 7/1/17 through 7/31/17 and client #1's 2 separate medication cards indicated client #1 received 120 MG of Latuda for 10</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>days.</p> <p>Nurse #1 was interviewed on 7/27/17 at 2:15 PM. Nurse #1 was asked what was client #1's current dosage of Latuda. Nurse #1 stated, "I am 90% sure it's 40 MG." Nurse #1 was informed that client #1's MAR dated 7/1/17 through 7/31/17 indicated client #1 was to receive 80 MG twice daily at 7 AM and 9 PM. Nurse #1 stated, "Oh wow, that doesn't make sense." At 2:23 PM Nurse #1 called QIDP (Qualified Intellectual Disabilities Professional #1) and indicated client #1's order for Latuda was increased by the Psychiatrist on 7/6/17 to 80 MG daily at 7 AM. Nurse #1 was asked what should client #1's dosage of Latuda be as of 7/6/17. Nurse #1 stated, "80 MG of Latuda PO (by mouth) daily."</p> <p>A review of client #1's MAR dated 7/1/17-7/31/17 indicated staff began administering client #1's 80 MG Latuda tablet at 7 AM on 7/18/17. The review indicated staff continued to administer 40 MG Latuda tablet at 9 PM from 7/18/17 through 7/31/17.</p> <p>Nurse #1 and Nurse #2 arrived at the group home on 7/27/17 at 2:35 PM. Nurse #2 was asked if she wrote the order for 80 mg Latuda twice daily at 7 AM and 9 PM. Nurse #2 stated, "I told the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250	
(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 0368 Bldg. 00	<p>staff to transcribe the order on the MAR."</p> <p>Nurse #2 was asked which staff member transcribed the order for the increase in client #1's Latuda. Nurse #2 stated, "I'm not sure." Nurse #2 was asked who is responsible for ensuring client #1's MAR and Physicians Orders were accurate.</p> <p>Nurse #2 stated, "The nurse of the house (group home)."</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1 received her medications as ordered by the physician.</p> <p>Findings include:</p> <p>A medication observation was conducted on 7/27/17 from 6:10 AM through 6:45 AM. At 6:40 AM staff #5 was observed administering medication to client #1. Staff #5 administered client #1's 7 AM medications including administering 80 mg (milligram) of Latuda (Anti-Psychotic) to client #1.</p>		W 0368	<p>CORRECTION:</p> <p><i>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Specifically, the improperly transcribed physician's order in client #1's Medication Administration Record (MAR) has been corrected and client #1's medications are being administered as prescribed. A review of facility support documents indicated that this deficient practice did not affect any additional clients.</i></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>A BDDS (Bureau of Developmental Disabilities Services) report dated 7/27/17 at 3:15 PM was reviewed on 7/28/17 at 11:00 AM. The BDDS report dated 7/27/17 indicated, "...During [client #1's] home's annual re-certification survey, it was discovered that due to a transcription error [client #1] had received an extra 40 mg of Latuda daily...".</p> <p>A review of the BDDS report dated 7/27/17 indicated client #1 received an extra dose of 40 MG of Latuda from 7/18/17 through 7/26/17.</p> <p>-Client #1's record was reviewed on 7/27/17 at 1:15 PM. Client #1's physicians orders dated 7/1/17 through 7/31/17 indicated, "Latuda Tab Give one tablet by mouth every evening after dinner on a full stomach-5 PM."</p> <p>-A review of client #1's physicians orders dated 7/1/17 through 7/31/17 indicated client #1 was to receive 1 40 MG tablet of Latuda at 5 PM.</p> <p>-Client #1's MAR (Medication Administration Record) dated 7/1/17 through 7/31/17 was reviewed on 7/27/17 at 1:15 PM. Client #1's order for Latuda was written by the physician on 6/14/17.</p>		<p>PREVENTION:</p> <p>The Registered Nurse and the Nurse Manager will provide direct oversight of the facility nurse to assure new medications are transcribed into the Medication Administration Record as written. When transcription of a new medication order is delegated to a facility staff, a copy of the transcribed order will be scanned to a ResCare nurse for review, prior to initiating a new or changed medication order. The facility nurse will conduct weekly audits of medication and administration records to assure new orders are transcribed as written and medications are administered as ordered.</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 assuring staff administer medications as ordered. The Area Supervisor will be present at the facility observing the staff's provision of skills training and documentation no less than twice weekly for the next 60 days and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 MAR listed Latuda 40 MG. A line was drawn through 40 MG and '80mg' was hand-written in ink next to it. The time of 5 PM was replaced in hand written ink with a medication administration time of 9 PM. Also, a medication administration time of 7 AM was hand-written in ink on client #1's MAR. Starting on 7/13/17, staff were initialing for 80 MG of Latuda administered at 7 AM and 9 PM for a total dose of 160 MG of Latuda.</p> <p>-Client #1's medication cards were reviewed on 7/27/17 at 1:15 PM. Client #1 had 2 separate medication cards of Latuda in her medication box.</p> <p>-The first medication card indicated, "Latuda 40 MG give 1 tab by mouth after dinner-5 PM." A review of this medication card indicated 20 40 MG Latuda tablets, had been popped and initialed out of the medication card. Some of the Latuda 40 MG tablets had been popped out of numeric sequence.</p> <p>-The second medication card indicated, "Latuda 80 MG give 1 tablet by mouth daily at 7 AM." A review of this medication card indicated 10 Latuda 80 MG tablets had been popped and initialed out of the medication card, dated between 7/18/17 through 7/27/17.</p>		<p>no less than weekly thereafter. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger and Registered Nurse) will review facility support documents and perform visual assessments of the facility no less than twice weekly for the next 30 days, and after 30 days, will conduct administrative observations no less than weekly until all staff demonstrate competence. 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. Active Treatment sessions to be monitored are 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: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>A review of client #1's MAR dated 7/1/17 through 7/31/17 and client #1's 2 separate medication cards indicated client #1 received 120 MG of Latuda for 10 days.</p> <p>Nurse #1 was interviewed on 7/27/17 at 2:15 PM. Nurse #1 was asked what was client #1's current dosage of Latuda. Nurse #1 stated, "I am 90% sure it's 40 MG." Nurse #1 was informed that client #1's MAR dated 7/1/17 through 7/31/17 indicated client #1 was to receive 80 MG twice daily at 7 AM and 9 PM. Nurse #1 stated, "Oh wow, that doesn't make sense." At 2:23 PM Nurse #1 called QIDP (Qualified Intellectual Disabilities Professional #1) and indicated client #1's order for Latuda was increased by the Psychiatrist on 7/6/17 to 80 MG daily at 7 AM. Nurse #1 was asked what should client #1's dosage of Latuda be as of 7/6/17. Nurse #1 stated, "80 MG of Latuda PO (by mouth) daily."</p> <p>A review of client #1's MAR dated 7/1/17-7/31/17 indicated staff began administering client #1's 80 MG Latuda tablet at 7 AM on 7/18/17. The review indicated staff continued to administer 40 MG Latuda tablet at 9 PM from 7/18/17 through 7/31/17.</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 and Area Supervisor 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 assuring</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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 0440 Bldg. 00	<p>QIDP was notified of the medication error on 7/27/17 at 2:30 PM. QIDP#1 indicated he would report the medication error regarding client #1's Latuda to BDDS.</p> <p>Nurse #1 and Nurse #2 arrived at the group home on 7/27/17 at 2:35 PM. Nurse #2 was asked if she wrote the order for 80 mg Latuda twice daily at 7 AM and 9 PM. Nurse #2 stated, "I told the staff to transcribe the order on the MAR." Nurse #2 was asked which staff member transcribed the order for the increase in client #1's Latuda. Nurse #2 stated, "I'm not sure." Nurse #2 was asked who is responsible for ensuring client #1's MAR and Physicians Orders were accurate. Nurse #2 stated, "The Nurse of the house (group home)."</p> <p>9-3-6(a)</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 4 of 4 sampled clients (#1, #2, #3 and #4) plus 3 additional clients (#5, #6 and #7), the facility failed to conduct fire drills for each quarter of each shift of personnel.</p>	W 0440	<p>staff administer medications without error. Administrative oversight will include assuring prescribed medications are available and administered as ordered.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, facility nurse, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Specifically, the facility has conducted</p>	09/03/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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>The facility's fire evacuation drills were reviewed on 7/27/17 at 11:19 AM. The review did not indicate documentation of a fire evacuation drill being conducted on the overnight shift for the second quarter of 2017 (April, May, June) for clients #1, #2, #3, #4, #5, #6 and #7. The review did not indicate documentation of a fire evacuation drill being conducted on the day shift and the overnight shift for the third quarter of 2016 (July, August, September) for clients #1, #2, #3, #4, #5, #6 and #7. The review did not indicate documentation of a fire evacuation drill being conducted on the day shift and the overnight shift for the fourth quarter of 2016 (October, November, December) for clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 7/27/17 at 2:43 PM. QIDP #1 indicated the facility should complete fire evacuation drills for every shift of personnel and every quarter of the year. QIDP #1 indicated he did not have documentation of fire evacuation drills for the overnight shift for the second quarter of 2017, the day shift and the overnight shift for the third quarter of 2016 and for the day shift and overnight</p>		<p>additional evacuation drills on each shift during the current quarter.</p> <p>PREVENTION: 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>	

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

PRINTED: 08/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2017	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250		
(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
	shift for the fourth quarter of 2016 for clients #1, #2, #3, #4, #5, #6 and #7. 9-3-7(a)				