STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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 000 Bldg. 00	This visit was for an annual recertification and state licensure survey. Dates of survey: April 28, 29 and May 1, 2015 Facility number: 001000 Provider number: 15G486 AIM number: 100245010 The following deficiencies also reflect state findings in accordance with 460 IAC 9.	W 000		
W 126 Bldg. 00	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on observation and interview, for 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to encourage and teach each client to access their personal finances.	W 126	**CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so*	05/31/2015

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	Findings include: A morning observation was conducted at the group home on 4/28/15 from 6:05 A.M. until 8:45 A.M.. At 8:05 A.M., Direct Support Professional (DSP) #1 was asked to reconcile clients #1, #2, #3, #4, #5, #6, #7 and #8's personal petty cash funds. DSP #1 stated "I don't have access to it, it's locked up." An interview with client #5 was conducted on 4/28/15 at 8:10 A.M.. Client #5 indicated he did not have any of his money and further indicated he would have to ask the Group Home Manager for some of his money because it was locked up. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/29/15 at 4:15 P.M.. The QIDP indicated the clients should be taught how to manage their personal funds and should have access at all times to some of their money to make purchases they may want. 9-3-2(a)		*to the extent of their capabilities.* Specifically, the facility will arrange for weekly spending money to be available for all clients, with the daily dispersed amounts based on their assessed developmental status. **PREVENTION:** Professional staff will be retrained regarding each client's right to carry personal spending money. The Clinical Supervisor will perform monthly reviews of Resident Financial Management System records to assure weekly spending money is being dispersed appropriately. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Clinical Supervisor	
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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	The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed to report the results of 2 of 2 reviewed investigations, involving 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7 and #8), to the administrator within five business days. Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 4/28/15 at 10:32 A.M. and indicated: -Investigation record dated 2/20/15 to 3/6/15 involving client #8 indicated: "Investigation Type: Allegation of physical abuse and staff leaving the site while unattended...[Nurse] stated that during today's visit that [client #8] stated that on Friday 'a short black male staff tried to hit him on his right ear and the top of his head with a belt on Friday night after 6 P.M..'" Further review of the record indicated the investigation was not concluded until 3/6/15. There was no written documentation to indicate the	W 156	**CORRECTION:** *The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.* Specifically, the agency's Operations Team comprised of the Clinical Supervisors, Executive Director, Program Manager and Nurse Manager have been trained on expectations regarding the investigation process. The training included the need to report results on investigations in accordance with state law. **PREVENTION:** 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. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G486		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
	results of the investigation were reported to the administrator within 5 business days. -Investigation record dated 5/4/14 to 6/17/14 involving clients #1, #2, #3, #4, #5, #6, #7 and #8 indicated: "Investigation Type: Alleged sleeping on duty...Term DSS (Terminate Direct Service Staff) [DSS name] for sleeping on duty." Further review of the record indicated the investigation was not concluded until 6/17/14. There was no written documentation to indicate the results of the investigation were reported to the administrator within 5 business days. An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 4/28/15 at 4:15 P.M.. The QIDP indicated the results of the investigation should have been reported to the administrator within 5 business days. The QIDP further indicated the results of the investigations were not reported to the administrator within 5 business days. 9-3-2(a)		investigations that are open for their homes. Residential Managers 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 Clinical Supervisor will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to report the results of investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Operations Team	
W 186	483.430(d)(1-2) DIRECT CARE STAFF			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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	The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and interview, the facility failed for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7 and #8), to deploy direct care staff to supervise/manage clients in accordance with their plans. Findings include: A morning observation was conducted at the group home on 4/28/15 from 6:05 A.M. until 8:45 A.M.. Upon entering into the home, Direct Support Professional (DSP) #1 was the only staff on duty. DSP #1 walked into a client's room and shut the door. Client #1 exited his room and walked down the hallway to the living room, without utilizing a walker. At 6:15 A.M., DSP #1 prompted and assisted client #1 back to his room and assisted him showering and dressing with the door closed. At 6:20 A.M., clients #2, #3, #4, #5, #6 and #7 began exiting their rooms and sat on the couches with no activity and the television on infomercials with no	W 186	**CORRECTION:** *The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.* Specifically, the facility has hired an additional day shift staff and the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning medication administration, morning hygiene and breakfast. **PREVENTION:** The Residential Manager will submit schedule revisions to the Clinical Supervisor for approval prior to implementation. Members of the Operations Team, comprised of Clinical	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	volume, as DSP #1 worked with clients in the back of the house. At 7:01 A.M., DSP #1 walked into the kitchen and poured cereal into 8 bowls and poured grape kool aid into 8 cups as clients #1, #2, #3, #4, #5, #6 and #7 sat in the living room with no activity, with the television on infomercials with no volume and client #8 stayed in his bedroom. At 7:30 A.M., DSP #1 began mopping the floor. He then went into the back office and began writing in binders as clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the living room with no activity, with the television on infomercials with no volume. DSP #2 arrived for duty at the group home at 8:30 A.M.. At 8:45 A.M., DSP #2 began transporting the clients to Day Services. A review of client #1's record was conducted on 4/29/15 at 11:55 A.M.. Review of client #1's Individual Support Plan (ISP) dated 5/9/14 indicated the following objectives which could have been implemented during the observation period: "Will budget his money...Will interact and communicate with others in a positive manner...Will assist in meal preparation...Will state one reason why it is important to participate in an activity." A review of client #2's record was conducted on 4/29/15 at 12:55 P.M.. Review of client #2's Individual Support		Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: 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. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	Plan (ISP) dated 8/30/14 indicated "Will assist in cooking a side dish...Will state the side effects of his medications...Will budget for an activity." A review of client #3's record was conducted on 4/29/15 at 1:53 P.M.. Review of client #3's ISP dated 7/15/14 indicated "Will learn to communicate his frustrations...Will state side effects of his medications...Will state 3 reasons to secure his money so that he doesn't misplace it...Will participate in a physical activity exercise." A review of client #4's record was conducted on 4/29/15 at 2:45 P.M.. Review of client #4's ISP dated 7/21/14 indicated "Will state his daily dosage of his medication...Will participate in exercise of his choice." A review of the group home staff schedules dated 3/1/15 to 4/30/15 was reviewed on 4/28/15 at 3:00 P.M.. Review of the staffing schedules indicated 1 scheduled staff for the overnight asleep shift (12:00 A.M. to 8:00 A.M.) An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/28/15 at 4:15 P.M.. The QIDP indicated there should		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. As stated above, the Executive Director will participate directly in administrative monitoring of the *facility.* Administrative support at the home will include assuring adequate direct support staff are on duty to meet the needs of all clients.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G486		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
	be more staff working when clients are awake. 9-3-3(a)		The Clinical Supervisor will perform periodic spot checks of attendance records to assure ongoing compliance. Prior to each schedule period, the Operations Team will follow-up verbally and via email to assure that appropriate coverage has been arranged. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to implement the clients' Individual Support Plan (ISPs) objectives when formal and/or informal opportunities for training existed.	W 249	**CORRECTION:** *As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in*	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	Findings include: A morning observation was conducted at the group home on 4/28/15 from 6:05 A.M. until 8:45 A.M.. Upon entering into the home, Direct Support Professional (DSP) #1 was the only staff on duty. DSP #1 walked into a client's room and shut the door. Client #1 exited his room and walked down the hallway to the living room, without utilizing a walker. At 6:15 A.M., DSP #1 prompted and assisted client #1 back to his room and assisted him showering and dressing with the room closed. At 6:20 A.M., clients #2, #3, #4, #5, #6 and #7 began exiting their rooms and sat on the couches with no activity and the television on infomercials with no volume, as DSP #1 worked with clients in the back of the house. At 7:01 A.M., DSP #1 walked into the kitchen and poured cereal into 8 bowls and poured grape kool aid into 8 cups as clients #1, #2, #3, #4, #5, #6 and #7 sat in the living room with no activity, with the television on infomercials with no volume and client #8 stayed in his bedroom. At 7:30 A.M., DSP #1 began mopping the floor. He then went into the back office and began writing in binders as clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the living room with no activity, with the television		*sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.*Specifically, all direct support staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide consistent, aggressive and continuous active treatment for all clients including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Additionally, the facility has hired an additional day shift staff and the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 6:00 AM and 8:00 AM to provide active treatment during morning medication administration, morning hygiene and breakfast. **PREVENTION:** The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G486		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
	on infomercials with no volume. DSP #2 arrived for duty at the group home at 8:30 A.M.. At 8:45 A.M., DSP #2 began transporting the clients to Day Services. A review of client #1's record was conducted on 4/29/15 at 11:55 A.M.. Review of client #1's Individual Support Plan (ISP) dated 5/9/14 indicated the following objectives which could have been implemented during the observation periods: "Will budget his money...Will interact and communicate with others in a positive manner...Will assist in meal preparation...Will state one reason why it is important to participate in an activity." Further review indicated client #1 was to use his walker at all times to prevent him from falling. A review of client #2's record was conducted on 4/29/15 at 12:55 P.M.. Review of client #2's Individual Support Plan (ISP) dated 8/30/14 indicated "Will assist in cooking a side dish...Will budget for an activity." A review of client #3's record was conducted on 4/29/15 at 1:53 P.M.. Review of client #3's ISP dated 7/15/14 indicated "Will learn to communicate his frustrations...Will state 3 reasons to secure his money so that he doesn't misplace it...Will participate in a physical		medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	activity exercise." A review of client #4's record was conducted on 4/29/15 at 2:45 P.M.. Review of client #4's ISP dated 7/21/14 indicated "Will participate in exercise of his choice." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/28/15 at 4:15 P.M.. The QIDP indicated the facility staff should implement clients #1, #2, #3 and #4's training objectives at all times of opportunity. 9-3-4(a)		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. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G486		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the *facility.* Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #1), to promote dignity by not ensuring client #1's clothing was ironed. Findings include: A morning observation was conducted at the group home on 4/28/15 from 6:05 A.M. until 8:45 A.M.. During the entire	W 268	**CORRECTION:** *These policies and procedures must promote the growth, development and independence of the client.* Specifically, direct support staff will be retrained regarding the need to assure all clients are dressed neatly in clothing appropriate for the weather and occasion. Through observation, the team has determined that this deficient practice may have affected all	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	the observation period, client #1 was observed with his clothing unironed and wrinkled. At 8:45 A.M., client #1 left to go to his Day Service program. Client #1 was not prompted to change his clothing. An evening observation was conducted at the group home on 4/28/15 from 4:50 P.M. until 6:10 P.M.. During the entire the observation period, client #1 was observed with his clothing unironed and wrinkled. Client #1 was not prompted to change his clothing. A review of client #1's record was conducted on 4/29/15 at 11:55 A.M.. Review of client #1's Individual Support Plan (ISP) dated 5/9/14 indicated client #1 could not iron his clothing independently. An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 4/29/15 at 4:15 P.M.. The QIDP indicated staff should ensure client #1's clothing is ironed and wrinkle free. 9-3-5(a)		clients. **PERVENTION:** The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt 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 assessing direct support staff interaction with clients and to provide hands on coaching and training including but not limited to staff train clients to dress neatly in clothing appropriate for the weather and occasion. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: 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. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
			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. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assessing direct support staff interaction with clients and to provide hands on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G486		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			coaching and training including but not limited to assuring staff train clients to dress neatly in clothing appropriate for the weather and occasion. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) to provide an annual physical. Findings include: A review of client #1's record was conducted on 4/29/15 at 11:55 A.M.. Client #1's record indicated a most current annual physical dated 4/22/14. Client #1's record did not contain evidence he had an annual physical. An interview with the Licensed Practical Nurse (LPN) was conducted on 4/29/15 at 3:30 P.M.. The LPN indicated she	W 322	**CORRECTION:** The facility must provide or obtain preventive and general medical care. Specifically, the facility has obtained an annual physical examination for Client #1. A review of medical records indicated this deficient practice affected three additional clients -#5, #6 and #7. The facility will also obtain annual physical examinations for these three individuals. **PREVENTION:** The facility nurse will maintain a tracking grid for all clients to	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	would have to look to find documentation to indicate if client #1 had an annual physical. No written documentation was submitted for review to indicate there was no evidence of an annual physical. 9-3-6(a)		assure that routine medical assessments, including but not limited to physical evaluations, occur within required time frames. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than Monthly to assure that examinations including but not limited to visual evaluations take place as required. **RESPONSIBLE PARTIES:** Health Services Team, QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4), to have hearing and vision evaluation/assessments as recommended by the audiologist and optometrist.	W 323	**CORRECTION:** *The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.* Specifically, clients #1, #2, #3 and #4 will receive a visual examination. Clients #2 and #3	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	Findings include: A review of client #1's record was conducted on 4/29/15 at 11:55 A.M.. Client #1's record indicated a most current vision assessment/evaluation dated 3/27/14 which indicated "Myopia (near sighted), Astigmatism (imperfection in the eye's curvature) and Presbyopia (farsightedness due to ciliary muscle...Return 1 year for eye exam." Further review of the record did not indicate client #1 returned in 1 year for an eye exam as recommended by the optometrist. A review of client #2's record was conducted on 4/29/15 at 12:55 P.M.. Client #2's record indicated a most current hearing assessment/evaluation dated 8/15/15 (wrong year noted) which indicated "F/U (follow up) w/ENT (with Ear Nose and Throat)...Hearing aid if warranted." Client #2's most current vision assessment/evaluation dated 3/28/14 indicated "Get new glasses as current pair broken monitor cataracts yearly." Further review of the record did not indicate client #2 followed up with an ENT and failed to indicate client #2 returned for a vision assessment/evaluation. A review of client #3's record was		will also receive hearing evaluations. A review of medical records indicated this deficient practice affected four additional clients. The facility will assure that all clients have current visual and audiological assessments. **PREVENTION:** The Health Services Team will work with the Medical Director to develop a plan to assure the visual examination component of the Annual Physical is documented in a clear, understandable and accurate manner. In situations where the primary care physician is unable or unwilling to perform an annual visual examination, the facility will enlisted the services of an optometrist. Members of the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that examinations including but not limited to visual evaluations take place as required. **RESPONSIBLE PARTIES:** Health Services Team, QIDP, Residential Manager, Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G486		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
	conducted on 4/29/15 at 1:53 P.M.. Client #3's record indicated a most current hearing assessment/evaluation dated 8/15/05 (wrong year noted) which indicated "F/U (follow up) w/ENT (with Ear Nose and Throat)...Hearing aid if warranted." Further review of the record did not indicate client #3 followed up with an ENT as recommended. Client #3's most current vision assessment/evaluation dated 3/31/14 indicated "Glasses for distance correction...Return 1 year." A review of client #4's record was conducted on 4/29/15 at 2:45 P.M.. Client #4's record indicated a most current vision assessment dated 1/21/14 with the recommendation to return in 1 year. Further review of the record did not indicate client #4 returned in 1 year as recommended. An interview with the Licensed Practical Nurse (LPN) was conducted on 4/29/15 at 3:30 P.M.. The LPN indicated she would look for documentation to indicate the clients followed up as recommended. No documentation was submitted for review to indicate clients #1, #2, #3 and #4 had their vision and hearing evaluated/assessed as recommended. 9-3-6(a)		Leader, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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 331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 sampled clients (client #1), the facility's nursing services failed to ensure client #1's prescribed medication was administered as ordered. Findings include: An observation was conducted at the group home on 4/28/15 from 4:50 P.M. until 6:10 P.M.. At 5:15 P.M., Direct Support Professional (DSP) #4 began administering client #1's prescribed medications. Review of the medication label, during the observation, indicated "Divalproex 500 mg (milligram) tablet (seizures)...2 tablets (1000 mg) by mouth daily...7:00 A.M. and 9:00 P.M.." A review of the Medication Administration Record (MAR) dated 4/15 was conducted at 5:20 P.M. and indicated a handwritten entry which indicated "Divalproex 500 mg tablet, 2 tablets 6:00 A.M. and 5:00 P.M." A review of client #1's record was	W 331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically, the agency has employed a new nurse to oversee healthcare at the facility. The facility nurse has reconciled the Medication Administration Record and medication card label with client #1's physician's order for Divalproex. A review of facility medications and records indicated this deficient practice did not affect any additional clients. **PREVENTION:** The facility nurse will complete weekly audits of medication orders, containers and administration records to assure they are reconciled and administered as ordered. When new medications are received after business hours, new transcriptions on the medication	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
	conducted on 4/29/15 at 11:55 A.M.. Review of client #1's 4/1/15 to 4/30/15 Physician's Orders (P.O.) indicated "Divalproex 500 mg tablet...2 tablets (1000 mg) by mouth daily...7:00 A.M. and 9:00 P.M.." An interview with the group home (LPN) was conducted on 4/29/15 at 4:30 P.M.. The LPN indicated the facility's nursing staff is responsible for reconciling medication labels, the MAR and P.O. to ensure they reflect the same information for proper medication administration. The LPN indicated she had not reconciled the label, MAR and P.O. for client #1's medication. 9-3-6(a)		administration record will be faxed electronically to the ResCare nurse-on-call to be reviewed for accuracy prior to administration of newly ordered medications. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will review medication orders, containers and administration records to assure they are reconciled and administered as ordered no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team	
W 336 Bldg. 00	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	frequent basis depending on client need. Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility's nursing services failed to conduct quarterly nursing assessments of the clients' health status and medical needs. Findings include: A review of client #1's record was conducted on 4/29/15 at 3:30 P.M.. Client #1's record indicated a nursing quarterly was completed on 2/27/15. Client #1's most current annual physical was dated 4/22/14. Client #1's medical record indicated client #1's diagnoses included, but were not limited to, seizures, Intermittent explosive disorder, hypertension, schizophrenia, muscle weakness and ataxia (poor coordination). Client #1's 4/15 physician orders indicated client #1 received routine medications. There was no further documentation available for review to indicate nursing assessments were conducted quarterly. A review of client #2's record was conducted on 4/29/15 at 2:55 P.M.. Client #2's record indicated nursing quarterlies were completed on 4/8/15. Client #2's most current annual physical	W 336	**CORRECTION:** *Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.* Specifically, the agency has employed a new nurse to oversee healthcare at the facility. The facility's current nurse has been trained on expectations for quarterly nursing physicals and nursing physicals which have been completed for the current quarter for Clients #1, #2, #3 and #4. A record review indicated the deficient practice also affected Clients #5, #6, #7 and #8, and nursing physicals have been completed for the current quarter for these individuals. **PREVENTION:** Copies of quarterly nursing physical examinations will be placed in the each individual's medical chart upon completion. The Nurse Manager will maintain a tracking system to assure quarterly nursing physical examinations are completed as required. Specifically when	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	was dated 4/24/14. Client #2's medical record indicated client #2's diagnoses included, but were not limited to, schizophrenia, emphysema and tinea pedis (athlete's foot). Client #2's 4/15 physician orders indicated client #2 received routine medications. There was no further documentation available for review to indicate nursing assessments were conducted quarterly. A review of client #3's record was conducted on 4/29/15 at 4:02 P.M.. Client #3's record indicated nursing quarterlies were completed on 3/14/14, 4/30/14 and 12/12/14. Client #3's most current annual physical was dated 6/9/14. Client #3's medical record indicated client #3's diagnoses included, but were not limited to, Bipolar, IBS (Irritable Bowel Syndrome) and Incontinence. Client #3's 4/15 physician orders indicated client #3 received routine medications. There was no further documentation available for review to indicate nursing assessments were conducted quarterly. A review of client #4's record was conducted on 4/29/15 at 4:30 P.M.. Client #4's record indicated a nursing quarterly was completed on 4/8/15. Client #4's most current annual physical was dated 4/22/14. Client #4's medical		physicals have not been completed by the beginning of the last month of each quarter the Nurse Manager will allot additional nursing resources to the facility to assist with timely completion of required assessments. Additionally, Operations Team members will review nursing documentation while conducting routine audits in the home, no less than monthly, to assure records of quarterly nursing evaluations are completed and filed appropriately. Copies of audits of medical charts will be provided to the facility nurse and nurse manager to facilitate appropriate follow-up. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Lead, Direct Support Staff, Health Services Team, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G486		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
	record indicated client #4's diagnoses included, but were not limited to, Psychosis, Depression, Convulsions, hypertension and hyperlipidemia. Client #4's 4/15 physician orders indicated client #4 received routine medications. There was no further documentation available for review to indicate nursing assessments were conducted quarterly. An interview with the group home Licensed Practical Nurse (LPN) was conducted on 4/29/15 at 3:30 P.M.. The LPN indicated nursing quarterlies are to be completed every three months. The nurse further indicated there was no written evidence to indicate nursing quarterlies were completed every three months. 9-3-6(a)			
W 436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and	W 436	**CORRECTION:**	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	interview, for 3 of 4 sampled clients who wore prescribed eyeglasses and hearing aids (clients #1, #2 and #3), the facility failed to provide, repair and teach the use of their prescribed eyeglasses and hearing aids. Findings include: A morning observation was conducted at the group home on 4/28/15 from 6:05 A.M. until 8:45 A.M.. During the entire observation period, client #1 wore eyeglasses. Client #1's left and right lenses were cracked and the frame sat lopsided. Client #1 did not wear hearing aids. Clients #2 and #3 did not and were not prompted to wear eyeglasses. An evening observation was conducted at the group home on 4/28/15 from 4:50 P.M. until 6:10 P.M.. During the entire observation period, client #1 wore eyeglasses. Client #1's left and right lenses were cracked and the frame sat lopsided. Client #1 did not wear hearing aids. Clients #2 and #3 did not and were not prompted to wear eyeglasses. An interview with client #1 and Direct Support Professional (DSP) #2 was conducted on 4/28/15 at 8:30 A.M.. Client #1 and DSP #2 indicated client #1's other eyeglasses were broken and the		*The facility must furnish, maintain in good repair, and teach clients to use and to make informed* *choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.* Specifically, new eyeglasses for Clients #1, #2 and #3 will be purchased by the facility. Additionally, the facility has located Client #1's hearing aids and determined that they are in good working order. A review of current adaptive equipment needs demonstrated that this deficient practice affected one additional client and therefore the facility will obtain new eyeglasses for client #5. **PERVENTION:** Facility Professional staff have been retrained regarding the need to furnish all necessary adaptive equipment to all clients. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will review assessment data and compare it to adaptive equipment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
	ones he was currently wearing were broken as well. When asked how long the glasses had been broken, client #1 stated "A while." A review of client #1's record was conducted on 4/29/15 at 11:35 A.M.. The ISP dated 5/9/14 indicated "Will come to the med room and place his hearing aids in both of his ears." Client #1's vision evaluation dated 3/27/14 indicated he was prescribed eyeglasses. Client #1's hearing evaluation/assessment dated 11/20/14 indicated he was prescribed hearing aids. A review of client #2's record was conducted on 4/29/15 at 12:55 P.M.. Client #2's current vision evaluation dated 3/28/14 "Get new glasses as current pair broken, monitor cataracts yearly." A review of client #3's record was conducted on 4/29/15 at 1:53 P.M.. The ISP dated 7/16/14 indicated "Far sighted wears corrective lens." An interview with the group home Licensed Practical Nurse (LPN) was conducted on 4/29/15 at 3:30 P.M.. The LPN indicated she was not aware client #1's eyeglasses were broken. The LPN indicated she has never seen client #1		available at the facility, making recommendations and expediting the acquisition of new and additional adaptive equipment as appropriate. These reviews will occur as needed but no less than quarterly. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G486		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
	wear hearing aids. The LPN indicated she was not aware clients #2 and #3 were prescribed eyeglasses. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed at the facility's administrative office on 4/29/15 at 4:30 P.M.. The QIDP indicated staff should be teaching clients to wear their eyeglasses and hearing aids at all times. The QIDP further indicated she did not notice client #1's eyeglasses were broken. 9-3-7(a)			
W 455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, for 2 of 4 sampled clients (clients #2 and #3) observed during meal time. Findings include: A morning observation was conducted at	W 455	**CORRECTION:** *There must be an active program for the prevention, control, and investigation of infection and communicable diseases.*Specifically for Client #2 and Client #3, staff will be retrained regarding the need to assure that clients wash their hands prior to setting the dining	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	the group home on 4/28/15 from 6:05 A.M. until 8:45 A.M.. At 6:50 A.M., DSP #1 walked into the kitchen with gloves on holding soiled bath towels and face towels, put them into the washing machine and then walked over to the kitchen sink, with the gloves still on, took dirty cups out of the sink and placed them into the dishwasher. Clients #2 and #3 walked into the kitchen, retrieved the cups out of the dishwasher, poured coffee and began drinking the cups of coffee. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/28/15 at 4:15 P.M.. The QIDP indicated staff should not have handled the cups without removing the gloves and washing his hands. 9-3-7(a)		table and at other appropriate intervals. **PREVENTION:** The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt 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 assessing direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff practice universal precautions and train clients toward infection control facilitated by frequent hand washing. Members of the Operations Team, comprised of Clinical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: 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. Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			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. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assessing direct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G486		05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff practice universal precautions and train clients toward infection control facilitated by frequent hand washing. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	
W 460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the staff provided food in accordance with the menu. Findings include: A morning observation was conducted at the group home on 4/28/15 from 6:05 A.M. until 8:45 A.M.. At 7:10 A.M., clients #1, #2, #3, #4, #5, #6, #7 and #8 ate their breakfast which consisted of	W 460	**CORRECTION:** *Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.*Specifically, all staff will be retrained regarding the need to follow the facility's menu or to provide documentation to the dietician that appropriate, nourishing substitution occurs. Additionally, the Residential Manager and Team Lead will assure that menued food items are available in the home to prepare as scheduled.	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	cold sweetened cereal with 2% (percent) milk and a cup of prepared grape kool aid. At 7:15 A.M., review of the menu indicated "Week 1...Tuesday, Regular, Lite NAS (No added sodium)...2 1/2 fluid ounces grape kool aid, cold cereal 3/4 cup, English muffin 1/2 each, skim milk, diet jelly, margarine. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not have skim milk, English muffins, diet jelly or margarine. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/29/15 at 4:15 P.M.. The QIDP indicated staff should follow the menus at all times. 9-3-8(a)		**PREVENTION:** The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that all prescribed medications are available. The Team Lead (non-exempt 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 the staff assists clients with preparing meals according to the established menu. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: 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. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			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. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring the staff assists clients with preparing meals according to the established menu. **RESPONSIBLE PARTIES:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team, Dietician	
W 488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview, the facility failed to assure 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) served themselves independently. Findings include: A morning observation was conducted at the group home on 4/28/15 from 6:05 A.M. until 8:45 A.M.. At 7:01 A.M., Direct Support Professional (DSP) #1 walked around the dining table and poured cold cereal into 8 bowls and poured prepared grape kool aid into 8 cups while clients #1, #2, #3, #4, #5, #6, #7 and #8 sat in the living room with no activity. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not and were not prompted to assist in meal preparation and serve themselves. At 7:10 A.M., clients #1, #2, #3, #4, #5, #6, #7 and #8 were prompted to the dining table and ate their meal independently.	W 488	**CORRECTION:** *The facility must assure that each client eats in a manner consistent with his or her developmental level.* Specifically, staff will be retrained regarding the need to assure all clients participate in all aspects of meal preparation to the extent of their capabilities. Additionally, the facility will modify the staffing matrix to assure that there are no less than two staff on duty at meal times. **PREVENTION:** The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed and that	05/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		STREET ADDRESS, CITY, STATE, ZIP CODE 7919 SAN RICARDO DR INDIANAPOLIS, IN 46256	

(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
	An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/29/15 at 4:15 P.M.. The QIDP indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 were capable of assisting in meal preparation and serving themselves and further indicated they should assist in meal preparation and serve themselves at all times. 9-3-8(a)		all prescribed medications are available. The Team Lead (non-exempt Residential Manager) will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation and other domestic activities. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active Treatment sessions and documentation reviews no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			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. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(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
			review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to meal preparation and family style dining. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	