STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for a recertification and state licensure survey. Dates of Survey: November 14, 15, 16, 20 and 22, 2017. Facility Number: 001189 Provider Number: 15G627 Aim Number: 100245700 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/7/17.	W 0000		
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 3 sampled clients (#1 and #3), the facility failed to assure a full and complete accounting of clients #1 and #3's expenditures/purchases.	W 0140	**CORRECTION:** *The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.* Specifically, for clients #1 and #3	12/22/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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: Client #1's financial record was reviewed on 11/16/17 at 11:52 AM. The financial review indicated an incomplete record of client #1's funds from August 2017 to the current date. Client #1's financial record did not include documentation of monthly cash ledgers from August 2017 to the current date. Client #3's financial record was reviewed on 11/16/17 at 11:52 AM. The financial review indicated an incomplete record of client #3's funds from August 2017 to the current date. Client #3's financial record did not include documentation of monthly cash ledgers from August 2017 to the current date. RM (Resident Manager #1) was interviewed on 11/16/17 at 12:37 PM. RM #1 was asked if he had current monthly cash ledgers/balances for clients #1 and #3. RM #1 stated, "No I don't. It's all I had (sic) was the receipts." QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 11/16/17 at 12:47 PM. QIDPM #1 was asked if the facility had a current monthly cash balance for clients #1 and #3. QIDPM #1 stated, "It is our expectation that the Resident Manager keep a monthly ledger."		and three additional clients, #4 - #6, personal financial ledgers will be updated by the Residential Manager and reviewed by the Area Supervisor and certified as accurate per facility protocol. A new Residential Manager is in place and will receive detailed training and will maintain an up to date ledger to track purchases for all clients. All staff will assure that clients provide receipts for purchases as appropriate and the Residential Manager will maintain copies of receipts for purchases recorded on the ledgers. **PREVENTION:** The Residential Manager will maintain responsibility for maintaining client financial records and the Area Supervisor will audit these records no less than weekly. All staff will be retrained regarding the need to assist clients with budgeting and collecting receipts, with appropriate accompanying documentation. The Area Supervisor will turn in client financial records to the Business Manager no less than monthly for review and filing. Additionally, members of the Operations Team comprised of the Operations Managers, Program Managers, Nurse Manager, Registered Nurse, Executive Director, Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	9-3-2(a)		Assurance Manager, QIDP Manager and Quality Assurance Coordinators, will include audits of client finances as part of an ongoing facility audit process. Operations Team audits will occur weekly until all staff and supervisors 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, which will occur no less than twice monthly. Administrative support will include assuring a complete and accurate accounting of client finances is present. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 1 of 15 allegations of abuse, neglect and mistreatment reviewed, the facility failed to complete an investigation regarding a fight between client #1 and a former friend from	W 0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: the Operations Team,	12/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 community. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/14/17 at 1:00 PM. A BDDS report dated 10/8/17 indicated on 10/7/17, "...Earlier in the evening staff heard [client #1] engaging in an argument on his telephone, in which threats were exchanged. At 12:00 AM, [client #1] was standing in the front yard with a housemate (client #5) while staff observed through a window. An unfamiliar car pulled up and an unknown make (sic) exited the vehicle and began hitting [client #1] in the face. Staff intervened immediately and the assailant drove away. [Client #1] ran down the road and evaded staff's line of sight. He (client #1) returned to the house within ten minutes. Staff filed a police report and a ResCare nurse came to the house and performed a physical assessment. The nurse noted [client #1's] left eye was swollen, with black and purple bruising and his left temple area was swollen. [Client #1] complained of a headache. His pupils were equal and reactive to light and his vital signs were stable and with (sic) normal limits. Per nurse		including the Operations Managers, Program Managers, Nurse Manager, 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, peer to peer aggression, discovered theft and medication errors. The QIDP and Quality Assurance Team (Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	recommendation, as a precaution, staff transported [client #1] to the [local hospital] Emergency department for evaluation. The attending ER (Emergency Room) physician diagnosed [client #1] with facial contusions and possible concussion and released him to ResCare staff....Staff will monitor [client #1] for signs and symptoms of concussion for 72 hours per protocol and report any concerns to ResCare nursing." A review of the BDDS report dated 10/8/17 indicated client #1 was standing outside the group home on 10/7/17 with client #5. The review indicated staff was observing clients #1 and #5 through a window. The review indicated an unknown person pulled up to the group home in a vehicle and began fighting/hitting client #1 in his face. The review indicated client #1 was assessed by the nurse and sent to the ER for evaluation. The review did not indicate documentation of an Investigation regarding the incident of client #1 being involved in a physical altercation on 10/7/17. Client #1's record was reviewed on 11/16/17 at 10:19 AM. Client #1's BSP (Behavior Support Plan) revised 10/7/17 indicated client #1 had the following Target Behaviors: "Self-injurious		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. **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 Manger (Administrative level management) 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Behavior...Physical Aggression...Verbal Aggression...Property Destruction...Threats to Harm Others: any time [client #1] makes a statement that he will harm staff and/or peers (kill them in their sleep, burn the house down, break their knee) or refer to events in the past when he has harmed others...Added 10/7/17: Leaves Assigned Area/Elopement...." A review of client #1's BSP revised 10/7/17 indicated client #1 had a targeted behavior for threatening to harm others. The review did not indicate client #1 had alone/unsupervised time in his BSP. Client #1's Progress note dated 10/6/17 4 PM-12 AM indicated, "...He (client #1) sat at the patio with another resident (client #5) while relaxing (sic). [Client #1] had a fight with who (sic) he (client #1) called his friend from [name of city] and he (client #1) had a bump on his face." Client #1 was interviewed on 11/14/17 at 4:25 PM. Client #1 was asked about the fight he had at the group home on 10/7/17. Client #1 stated, "It was a friend. I tried to talk things out. He did throw a punch at my right eye. I had to go to the ER." Client #1 was asked if he was dizzy or nauseous after being hit in his right eye. Client #1 stated,		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 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. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	"No." Client #1 was asked if he felt safe living at the group home. Client #1 stated, "Yes, I trust the staff." Staff #1 was interviewed on 11/14/17 at 4:42 PM. Staff #1 was asked if he witnessed the incident regarding a fight between client #1 and a former friend on 10/7/17. "Yes, [Staff #2] went outside to check on them (client #1 and #5). [Staff #2] went outside and saw [client #1] fighting. I saw [client #1] on the ground. I (staff #1) said stop I'll call the police. And they left, they ran away." Staff #1 was asked if he was watching clients #1 and #5 when they were outside of the group home on 10/7/17. Staff #1 stated, "Yes." QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 11/16/17 at 12:47 PM. QIDPM #1 was asked if he had documentation of an investigation regarding the incident of a fight between client #1 and a former friend on 10/7/17. QIDPM #1 stated, "No I do not." QIDPM #1 was asked if the facility should have completed an investigation of the incident on 10/7/17. QIDPM #1 stated, "Yes, because there was an incident where a person (client #1) was injured and there could have been less than appropriate supervision."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor the clients' program plans by failing to monitor the clients' progress on their training objectives for 12 of 12 months during the past year. Findings include: 1. Client #1's record was reviewed on 11/16/17 at 10:14 AM. Client #1's ISP (Individualized Support Plan) dated 3/28/17 indicated client #1 had formal training objectives for: hygiene, housekeeping, money, medication oral, cooking and Domestic skills. Client #1's ISP did not contain documentation the QIDP reviewed, revised, updated and monitored his individualized training objectives for 12 of 12 months from October 2016 to October 2017.	W 0159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.* Specifically the governing body will assure that the QIDP will complete ISP summaries for the past quarter that includes analysis of progression and regression on prioritized learning objectives. Moving forward, the QIDP will turn in copies of monthly ISP summaries to the QIDP Manager no later than the seventh calendar day of each month for review and guidance. Additionally the QIDP will turn in quarterly ISP summaries to the QIDP Manager for review prior to scheduled quarterly meetings. Failure to complete monthly and quarterly analysis of progression/regression of progress on ISP objectives will result in progressive performance action. A review of facility documentation indicated this deficient practice affected all	12/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	2. Client #2's record was reviewed on 11/15/17 at 10:40 AM. Client #2's ISP dated 10/9/17 indicated client #2 had formal training objectives for: adaptive behavior, money, medication, eating slowly, hanging up shirts and staying on task. Client #2's ISP did not contain documentation the QIDP reviewed, revised, updated and monitored his individualized training objectives for 12 of 12 months from October 2016 to October 2017. 3. Client #3's record was reviewed on 11/16/17 at 9:42 AM. Client #3's ISP dated 2/16/17 indicated client #3 had formal training objectives for: money, daily hygiene, shower, cooking, medication and safety. Client #1's ISP did not contain documentation the QIDP reviewed, revised, updated and monitored his individualized training objectives for 12 of 12 months from October 2016 to October 2017. QIDP #1 was interviewed on 11/15/17 at 12:37 PM. QIDP #1 was asked if he had documentation of QIDP monthly summaries for October 2016 to October 2017. QIDP #1 stated, "No I do not." QIDP #1 indicated the facility did not have documentation the QIDP reviewed, revised, updated and monitored clients #1, #2 and		clients. **PREVENTION:** The QIDP has been retrained regarding the need analyze progression and regression on prioritized learning objectives and make appropriate modifications and revisions. Members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate chart reviews of goal data and QIDP summaries into their formal audit process, which will occur no less than twice monthly to assure that prioritized learning objectives are analyzed and revised as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	#3's individualized training objectives for 12 of 12 months from October 2016 to October 2017. 9-3-3(a)			
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 3 sampled clients (#1 and #3), the facility failed to ensure clients #1 and #3 had an active treatment program with a plan of reduction to reduce or eliminate client #1 and #3's need for the use of psychotropic medications for the management of their behavior. Findings include: 1. Client #1's record was reviewed on 11/16/17 at 10:14 AM. Client #1's Physician's Orders dated 11/1/17 to 11/30/17 indicated client #1 took the following psychotropic medications: "Aptensio (Attention Deficit Hyperactivity	W 0312	**CORRECTION:** *Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.* Specifically the QIDP will incorporate the use of Aptensio into client #1's Behavior Support Plan and will develop a desensitization plan to reduce and eventually eliminate client #3's need for sedation prior to dental procedures. A review of facility support documents indicated that this deficient practice did not affect any additional clients.	12/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Disorder) 50 mg (milligrams) and Concerta (ADHD) 54 mg." Client #1's record did not indicate documentation of an active treatment program, or BSP (Behavior Support Plan) with a plan of reduction to reduce or eliminate the need for client #1 to receive Aptensio 50 mg and Concerta 54 mg for management of his behavior. 2. Client #3's record was reviewed on 11/16/17 at 9:42 AM. Client #3's Physician's Orders dated 11/1/17 to 11/30/17 indicated client #3 took the following psychotropic medications: "Diazepam Tab 10 mg Give one tablet by mouth 1 dose one hour prior to Dental Appt (appointment)...". Client #3's record did not indicate documentation of an active treatment program, or BSP with a plan of reduction to reduce or eliminate the need for client #3 to receive Diazepam for management of his behavior. QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 11/16/17 at 12:47 PM. QIDPM #1 was asked if the facility had documentation of a medication reduction plan for client #1's		**PERVENTION:** The QIDP has been retrained regarding the need to assure that active treatment programs are in place to support the reduction and eventual elimination of all currently prescribed psychotropic medications and that the use of all behavior controlling medications is incorporated into clients' behavior support plans. Additionally, members of the Operations Team (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manager) will incorporate audits of support documents into visits to the facility weekly until the QIDP demonstrates competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director (area manager) will determine the level of ongoing support needed at the facility. These ongoing administrative documentation reviews will include a review of facility Behavior	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Aptensio 50 mg and Concerta 54 mg and client #3's Diazepam 10 mg. QIDP #1 stated, "No. We should absolutely yes." 9-3-5(a)		Support Plans no less than twice monthly and to assure the plans include active treatment programs designed to reduce and eventually eliminate the use of behavior controlling medications. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
W 0331 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 3 sampled clients (#2), the facility's nursing services failed to meet the health/nursing needs of client #2 regarding the need to ensure client #2's medication orders were correct and to ensure staff documented client #2's colostomy (surgical procedure) care on his MAR (Medication Administration Record). Findings include: 1. Client #2's record was reviewed on 11/15/17 at 10:40 AM. -Client #2's Physicians Orders dated	W 0331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.*Specifically: the facility nurse has corrected client #2's medication order for lorazepam and added colostomy care to client #2's Medication and Treatment Administration Record. A review of medical documentation indicated this deficient practice did not affect additional clients. **PERVENTION:** The Nurse Manager will provide	12/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	11/1/17 to 11/30/17 indicated, "...Lorazepam (anxiety) 0.5 mg (milligram) Give one-half (=0.25 mg) three times daily for anxiety and behaviors...". A review of client #2's Physicians Orders dated 11/1/17 to 11/30/17 indicated client #2's current physicians orders were for client #2 to receive Lorazepam 0.25 mg three times daily. -Client #2's MAR dated 11/1/17 to 11/30/17 indicated, "...Lorazepam (anxiety) 0.5 mg (milligram) Give one-half (=0.25 mg) three times daily for anxiety and behaviors... Order Changed...". A review of client #2's MAR dated 11/1/17 to 11/30/17 indicated client #2 was not receiving Lorazepam 0.25 mg three times daily. The review indicated the order had been changed and staff were no longer documenting/administering client #2's Lorazepam 0.25 mg three times daily. -Client #2's Physician's Orders PRN (As Needed) Medication Information record dated 11/1/17 to 11/30/17 indicated, "...9/9/17 Lorazepam 0.5 (mg) tablet Give 0.5 mg by mouth every 4 hours as needed for anxiety."		direct oversight of the facility nurse to assure physician's orders are transcribed as written and that all necessary treatments are included in the MAR. 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 reviews of the facility medical records 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, which will occur no less than twice monthly. Administrative support at the home will include assuring medical following including but not limited to assuring physician's orders are transcribed as written and that all necessary treatments are included in the MAR. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Heath Services Team, Direct Support Staff, Operations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A review of client #2's Physician's Orders PRN Medication Information record dated 11/1/17 to 11/30/17 indicated client #2's order for Lorazepam was documented as a PRN medication with an order start date of 9/9/17. Nurse #1 was interviewed on 11/16/17 at 1:07 PM. Nurse #1 was asked if she had an order to discontinue/change client #2's Lorazepam 0.25 mg to a PRN order. Nurse #1 stated, "When he (client #2) came back from the facility (Nursing Facility) it (Lorazepam) had been changed to PRN." Nurse #1 was asked if she had contacted client #2's PCP (Primary Care Physician) to determine if client #2's PCP wanted to resume the Lorazepam 0.25 mg to three times per day. Nurse #1 stated, "No I did not." 2. Client #2's record was reviewed on 11/15/17 at 10:40 AM. Client #2's CHRHP (Comprehensive High Risk Health Plan) not dated indicated, "Ostomy (Surgically created opening between the intestines and the abdominal wall) Care Plan...3. Changing Ostomy Unit: Ostomy Bag will need to be changed if it is not adhering to [client #2's] skin, or becomes soiled and as listed on MAR.		Team, Regional Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Steps to change ostomy: also see documentation in MAR...". -A review of client #2's CHRHP, not dated, indicated client #2's ostomy care instructions were listed on his MAR. Client #2's MAR dated 11/1/17 to 11/30/17 did not indicate documentation of Ostomy care/instructions. Nurse #1 was interviewed on 11/16/17 at 1:07 PM. Nurse #1 indicated client #2's Ostomy care instructions were not documented on client #2's MAR. Nurse #1 stated, "There isn't an order on the MAR. They (staff) just change it when they see fit. I could see where it would be helpful to document when they change it." 9-3-6(a)			
W 0368 Bldg. 00	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. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1 received his medications	W 0368	**CORRECTION:** *The system for drug administration must assure that all*	12/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	as ordered by the physician. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/14/17 at 1:00 PM. A BDDS report dated 10/29/17 indicated on 10/28/17, "...During an audit on 10/28/17, the Area Supervisor (#1) discovered that due to a delay in receiving Medicaid prior approval for refills (medication refills), [client #1] had not received his physician prescribed Aptensio (Attention Deficit Hyperactivity Disorder) 50 mg (milligrams) and Concerta (ADHD) 54 mg since 10/26/17...". -A review of the BDDS report dated 10/29/17 indicated client #1 did not receive his prescribed medications Aptensio 50 mg and Concerta 54 mg from 10/26/17 through 10/29/17. Client #1's record was reviewed on 11/16/17 at 10:19 AM. -Client #1's Physician's Orders dated 11/1/17 to 11/30/17 indicated client #1 had a physician's order for, "...Aptensio XR		*drugs are administered in compliance with the physician's orders.* Specifically, all facility staff and supervisors will be retrained to work with the facility nurse re-order medication with sufficient time to obtain Medicaid prior approval before the current medication supply runs out. . **PREVENTION:** 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 medications are available and administered as ordered. The Area Supervisor will be present at the facility observing the staff's provision of skills training and documentation no less than weekly.Members of the Operations Team comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and the QIDP will conduct observations during active treatment sessions and documentation reviews no less than weekly until staff demonstrate competence. At the conclusion of this period of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(Extended Release) Cap (capsule) 50 MG...Methylphenid (Concerta) 54 MG ER (Extended Release)...". A review of client #1's physicians orders dated 11/1/17 to 11/30/17 indicated client #1 had current physicians orders for Aptensio 50 mg and Concerta 54 mg. Nurse #1 was interviewed on 11/16/17 at 1:07 PM. Nurse #1 was asked if client #1 had received his prescriptions for Aptensio 50 mg and Concerta 54 mg as ordered by the physician from 10/26/17 through 10/29/17. Nurse #1 stated, "No, we were waiting for a prior approval, Medicaid wouldn't cover it." Nurse #1 indicated client #1 should have received his prescription medications Aptensio 50 mg and Concerta 54 mg as ordered by the physician. 9-3-6(a)		intensive administrative monitoring and support, the Executive Director will determine the level of ongoing support needed at the facility, which will occur no less than twice monthly. 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. In addition to active treatment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			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 administer medications without error. Administrative oversight will include assuring medications are available and administered as ordered. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, facility nurse, Direct Support Staff, Operations Team	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the facility failed to conduct fire drills quarterly for each shift of personnel. Findings include: The facility's fire evacuation drills were reviewed on 11/16/17 at 10:20 AM. The review did not indicate documentation of a fire evacuation drill being conducted on the 7:00 AM to 3:00 PM shift for the first quarter of 2017 (January, February, March) for clients #1, #2, #3, #4, #5 and #6. The review did not indicate documentation of a fire evacuation drill being conducted on the 3:00 PM to 11:00 PM shift and the 11:00 PM to 7:00 AM shift for the second quarter of 2017 (April, May, June) for clients #1, #2, #3, #4, #5 and #6. The review did not indicate documentation of a fire evacuation drill being conducted on the 7:00 AM to 3:00 PM shift and the 11:00 PM to 7:00 AM shift for the fourth quarter of 2016/2017 (October, November, December) for clients #1, #2, #3, #4, #5 and #6. QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 11/16/17 at 12:47 PM. QIDPM #1	W 0440	**CORRECTION:** The facility must hold evacuation drills at least quarterly for each shift of personnel. Specifically, the facility has conducted additional evacuation drills on each shift during the current quarter. **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. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	12/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G627	A. BUILDING 00 B. WING	11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	8044 DARTMOUTH RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	indicated the facility should complete fire evacuation drills for every shift of personnel during every quarter of the year. QIDPM #1 indicated he did not have documentation of fire evacuation drills for the 7:00 AM to 3:00 PM for the first quarter of 2017, the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shift for the second quarter of 2017 and the 7:00 AM to 3:00 PM shift and 11:00 PM to 7:00 AM for the fourth quarter of 2016/2017. 9-3-7(a)			