PRINTED:	01/03/2018
FORM API	PROVED

OMB NO. 0938-039

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN	NT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIEI NITY ALTERNATIV	IDENTIFICATION NUMBER     A. BUILDING     00       15G627     B. WING			(X3) DATE SURVEY COMPLETED 11/22/2017		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
W 0000 Bldg. 00	licensure survey Dates of Survey and 22, 2017. Facility Number Provider Number Aim Number: 10 These deficience in accordance w	: November 14, 15, 16, 20 :: 001189 er: 15G627 00245700 es also reflect state findings ith 460 IAC 9. of this report completed by	W 0000				
W 0140 Bldg. 00	system that assur accounting of clie entrusted to the fa Based on record of 3 sampled cli failed to assure a	establish and maintain a es a full and complete nts' personal funds acility on behalf of clients. review and interview for 2 ents (#1 and #3), the facility a full and complete ients #1 and #3's	W 0140	<b>CORRECTION:</b> <i>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted the facility on behalf of clients.</i> Specifically, for clients #1 and #	' to		

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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.

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COMP	e survey leted 2/2017
	PROVIDER OR SUPPLIE		8044	ET ADDRESS, CITY, STATE, ZIP COD DARTMOUTH RD ANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETION DATE
IAG	Findings includ Client #1's finan 11/16/17 at 11:: indicated an inc funds from Aug Client #1's finan documentation August 2017 to Client #3's finan 11/16/17 at 11:: indicated an inc funds from Aug Client #3's finan documentation August 2017 to RM (Resident M interviewed on #1 was asked if ledgers/balance #1 stated, "No I the receipts." QIDPM (Qualif Professional Ma on 11/16/17 at 1 asked if the faci cash balance for #1 stated, "It is			and three additional clients, #6, personal financial ledge be updated by the Residenti Manager and reviewed by th Area Supervisor and certifier accurate per facility protoco new Residential Manager is place and will receive detailed training and will maintain and date ledger to track purchass all clients. All staff will assur clients provide receipts for purchases as appropriate and Residential Manager will ma copies of receipts for purchase recorded on the ledgers. <b>PREVENTION:</b> The Residential Manager will maintain responsibility for maintaining client financial r and the Area Supervisor will these records no less than v All staff will be retrained reg the need to assist clients with budgeting and collecting rec with appropriate accompany documentation. The Area Supervisor will turn in client financial records to the Busi Manager no less than month review and filing. Additional members of the Operations comprised of the Operations Managers, Program Manage Nurse Manager, Registered Executive Director, Quality	#4 - rs will al he d as l. A in ed h up to ses for re that d the intain ases l records audit veckly. larding th seipts, ring ness hly for y, Team s rs,	DATE

Event ID: QLOO11 Facility ID: 001189

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G627	î ź	ILDING	DNSTRUCTION 00	. Co	(X3) DATE SURVEY COMPLETED 11/22/2017	
	PROVIDER OR SUPPLIE			8044 D	ADDRESS, CITY, STATE, ZIP CO ARTMOUTH RD IAPOLIS, IN 46260	D		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
	9-3-2(a)				Assurance Manager, QIDP Manager and Quality Assu Coordinators, will include a client finances as part of a ongoing facility audit proce Operations Team audits w weekly until all staff and supervisors demonstrate competence. At the conclu this period of enhanced administrative monitoring support, the Executive Dir Regional Director will dete the level of ongoing suppor needed at the facility, whi occur no less than twice m Administrative support will assuring a complete and a accounting of client finance present.	rance audits of n ess. ill occur ision of and ector and rmine ort ch will nonthly. i include ccurate		
W 0154	483.420(d)(3)				<b>RESPONSIBLE PARTIES</b> Area Supervisor, Residenti Manager, Direct Support S Operations Team, Regiona Director	al taff,		
Bldg. 00	STAFF TREATM The facility must alleged violations Based on interv of 15 allegation mistreatment re complete an inv	ENT OF CLIENTS have evidence that all are thoroughly investigated. iew and record review for 1 s of abuse, neglect and viewed, the facility failed to restigation regarding a fight \$\overline{1}\$ and a former friend from	W O	154	<b>CORRECTION:</b> <i>The facility must have evid</i> <i>that all alleged violations a</i> <i>thoroughly investigated.</i> Specifically: the Operation	are	12/22/201	

	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	· /		COM	(X3) DATE SURVEY COMPLETED 11/22/2017	
		804	4 DARTMOUTH RD	COD		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
the community. Findings include The facility's BI Developmental and investigation 11/14/17 at 1:00 A BDDS report 10/7/17, "Earl [client #1] engage telephone, in wh At 12:00 AM, [client #1] infamiliar car propression make (sic) exiter hitting [client #1] immediately and [Client #1] ran client staff's line of sige the house withing police report and the house and police assessment. The eye was swollent bruising and his swollen. [Client headache. His police assessment. The	e: DDS (Bureau of Disabilities Services) reports ns were reviewed on PM. dated 10/8/17 indicated on ier in the evening staff heard ging in an argument on his nich threats were exchanged. client #1] was standing in ith a housemate (client #5) rved through a window. An ulled up and an unknown d the vehicle and began 1] in the face. Staff intervened d the assailant drove away. down the road and evaded ght. He (client #1) returned to a ten minutes. Staff filed a d a ResCare nurse came to erformed a physical nurse noted [client #1's] left h, with black and purple left temple area was #1] complained of a upils were equal and		including the Operation Managers, Program Ma Nurse Manager, Execut Director, Quality Assura Manager, Quality Assura Coordinators and QIDP will directly oversee all investigations. The Res Manager will receive ac training toward assistin gathering evidence, inc conducting thorough w interviews, with all pote witnesses including but to discovered injuries, i resulting from falls, pee aggression, discovered medication errors. The Quality Assurance Team Assurance Manager, QI Manager and Quality As Coordinators) will assur conclusions are develop match the collected evi governing body will assu complete responsibility investigating any discov injuries that require out medical treatment and allegations of sexual ab any evidence of staff ne uncovered or alleged th Operations Team will ta of all aspects of the inv process. Additionally, th Manager (QA Manager for ICF facilities) will pr	nagers, ive ance ance Manager, idential dditional g with duding itness ential not limited injuries er to peer theft and QIDP and n (Quality IDP ssurance re that dence. The sume for vered tside any puse. When egligence is ne ake control restigation he QIDP responsible ovide direct	DATE	
	TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIEN NITY ALTERNATIV SUMMARY (EACH DEFICIEN REGULATORY OF the community. Findings include The facility's BI Developmental and investigation 11/14/17 at 1:00 A BDDS report 10/7/17, "Earl [client #1] engage telephone, in wh At 12:00 AM, [of the front yard w while staff obsers unfamiliar car p make (sic) exite hitting [client #1] immediately and [Client #1] ran of staff's line of sign the house within police report and the house and po- assessment. The eye was swollent bruising and his swollen. [Client headache. His p reactive to light	OF CORRECTION IDENTIFICATION NUMBER 15G627 ROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	TOF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA       X2) MULTIPI         DENTIFICATION NUMBER       A. BUILDIN         BENTIFICATION NUMBER       STR         BOY       SUMMARY STATEMENT OF DEFICIENCIE       ID         ROVIDER OR SUPPLIER       STR       804         NITY ALTERNATIVES-ADEPT       INC       ROVIDER OR SUPPLIER       INC         SUMMARY STATEMENT OF DEFICIENCIE       ID       PREFI       TO         REGULATORY OR LSC IDENTIFYING INFORMATION       TAGE       TAGE       TAGE         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 temp	TO DEFICIENCIES       X1) PROVIDERSUPPLIERCLIA       X2) MULTIPLE CONSTRUCTION         DeCORRECTION       156627       A BULLDING       QQ         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP         SUMMARY STATEMENT OF DEFICIENCIE       ID       BOARDENTRATION         REGULATORY OR LSC IDENTIFYING INFORMATION       ID       PROVIDER HANGEC         REGULATORY OR LSC IDENTIFYING INFORMATION       ID       PROVIDER HANGEC         The facility'S BDDS (Bureau of       Including the Operation         Developmental Disabilities Services) reports       and investigations were reviewed on       Investigations. The Res         A BDDS report dated 10/8/17 indicated on       Including threader Receiption and 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       Manager and Quality Assurance Hanager, Quality Assurance Hanager, Develop         Mitting [client #1] in the face. Staff filed a       police report and a ResCare nurse came to       Manager and Quality Assurance Hanager, Quality Assurance Hanager, Will assurance Hanager, Pecutor Manager, Pecut	TO DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA       X2) MULTIPLE CONSTRUCTION       X3) DA         OCORRECTION       DENTIFICATION NUMBER       D       COM         15GE27       STREET ADDRESS, CITY, STATE, ZIP COD       B044 DARTMOUTH RD         NITY ALTERNATIVES-ADEPT       INDIANAPOLIS, IN 46260       11//         SUMMARY STATEMENT OF DEFICIENCIE       ID       PROVIDER ON SUPPLIER       ID         NUTY ALTERNATIVES-ADEPT       ID       INDIANAPOLIS, IN 46260       ID         SUMMARY STATEMENT OF DEFICIENCIE       ID       ID       PROVIDER OF COMMENTION DEPRETING OF COMMENTION OF COM	

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/22/2017 15G627 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8044 DARTMOUTH RD COMMUNITY ALTERNATIVES-ADEPT INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE recommendation, as a precaution, staff 90 days, including but not limited to assuring the investigation transported [client #1] to the [local hospital] reconciles discrepancies between Emergency department for evaluation. The witness testimony and attending ER (Emergency Room) physician documentary evidence. The diagnosed [client #1] with facial contusions Quality Assurance Manager and the QIDP Manager will review the and possible concussion and released him to scope of all open investigations to ResCare staff....Staff will monitor [client #1] assure all allegations receive for signs and symptoms of concussion for 72 appropriate examination and analysis. hours per protocol and report any concerns to ResCare nursing." A review of the BDDS report dated **PREVENTION:** 10/8/17 indicated client #1 was standing The QIDP Manager will maintain a outside the group home on 10/7/17 with tracking spreadsheet for incidents client #5. The review indicated staff was requiring investigation, follow-up observing clients #1 and #5 through a and corrective/protective window. The review indicated an unknown measures will be maintained and distributed daily to facility person pulled up to the group home in a supervisors and the Operations vehicle and began fighting/hitting client #1 in Team, comprised of the his face. The review indicated client #1 was **Operations Managers**, Program assessed by the nurse and sent to the ER for Managers, Nurse Manager, Registered Nurse, Executive evaluation. The review did not indicate Director, Quality Assurance documentation of an Investigation regarding Manager, Quality Assurance the incident of client #1 being involved in a Coordinators and QIDP Manager. The QIDP Manger (Administrative physical altercation on 10/7/17. level management) will meet with his/her QIDPs weekly to review the Client #1's record was reviewed on progress made on all 11/16/17 at 10:19 AM. investigations that are open for their homes. QIDPs will be required to attend and sign an Client #1's BSP (Behavior Support Plan) in-service at these meetings revised 10/7/17 indicated client #1 had the stating that they are aware of following Target Behaviors: "Self-injurious which investigations with which

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

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QL0011

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	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	È É	JILDING	DNSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 11/22/2017	
	PROVIDER OR SUPPLIE			8044 D	ADDRESS, CITY, STATE, ZIP COD ARTMOUTH RD IAPOLIS, IN 46260			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON D BE DPRIATE	(X5) COMPLETION DATE	
	BehaviorPhys AggressionPr to Harm Others a statement that peers (kill them down, break the the past when h othersAdded Area/Elopemen A review of clid indicated client for threatening did not indicate alone/unsuperva Client #1's Prog PM-12 AM ind at the patio with while relaxing ( with who (sic) I	bical AggressionVerbal operty DestructionThreats : any time [client #1] makes : he will harm staff and/or in their sleep, burn the house bir knee) or refer to events in e has harmed 10/7/17: Leaves Assigned t" ent #1's BSP revised 10/7/17 #1 had a targeted behavior to harm others. The review client #1 had ised time in his BSP. gress note dated 10/6/17 4 icated, "He (client #1) sat n another resident (client #5) (sic). [Client #1] had a fight he (client #1) called his friend city] and he (client #1) had a			they are required to assist, a as the specific components of investigation for which they responsible, within the five business day timeframe. The Quality Assurance Team will review each investigation to ensure that they are thoroug -meeting regulatory and operational standards, and w designate an investigation, a completed, if it does not mee these criteria. The Program Manager will also conduct sp checks of investigations, foct on serious incidents that cou potentially have occurred as result of staff negligence. Th Program Managers will provi weekly updates to the Execu Director and Quality Assuran Manager on the status of investigations. Failure to con thorough investigations with allowable five business day timeframe will result in progressive corrective action applicable team members.	of the are gh vill not is et oot using ild a ie de tive ice nplete in the		
	4:25 PM. Clien fight he had at t Client #1 stated talk things out. right eye. I had	nterviewed on 11/14/17 at t #1 was asked about the he group home on 10/7/17. , "It was a friend. I tried to He did throw a punch at my to go to the ER." Client #1 was dizzy or nauseous after			<b>RESPONSIBLE PARTIES:</b> Area Supervisor, Residential Manager, Direct Support Sta Operations Team, Regional Director			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	TIFICATION NUMBER A. BUILDING		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2017		
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				DD				
	MUNITY ALTERNATIVES-ADEPT				APOLIS, IN 46260			
X4) ID PREFIX TAG	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	"No." Client #1	was asked if he felt safe						
	living at the gro "Yes, I trust the	oup home. Client #1 stated, staff."						
		erviewed on 11/14/17 at #1 was asked if he						
	witnessed the ir	ncident regarding a fight #1 and a former friend on						
		[Staff #2] went outside to (client #1 and #5). [Staff #2]						
		d saw [client #1] fighting. I on the ground. I (staff #1)						
	-	l the police. And they left, Staff #1 was asked if he						
	•	lients #1 and #5 when they the group home on 10/7/17. "Yes."						
		fied Intellectual Disabilities						
	on 11/16/17 at 1	anager #1) was interviewed 12:47 PM. QIDPM #1 was						
	investigation re	documentation of an garding the incident of a fight						
	10/7/17. QIDPN	#1 and a former friend on Af #1 stated, "No I do not."						
	have completed	asked if the facility should an investigation of the						
	"Yes, because t	7/17. QIDPM #1 stated, here was an incident where a						
	-	<ol> <li>was injured and there</li> <li>less than appropriate</li> </ol>						

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	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G627	A. BUILDING B. WING	00	COMPLETED 11/22/2017
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
COMMU		/ES-ADEPT		OARTMOUTH RD NAPOLIS, IN 46260	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPR	RIATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	9-3-2(a)				
W 0159	483.430(a)				
Bldg. 00	PROFESSIONAL	ITAL RETARDATION			
		/e treatment program must			
	be integrated, coo	ordinated and monitored by			
		l retardation professional.			
		l review and interview for 3	W 0159	CORRECTION:	12/22/2017
	_	ents (#1, #2 and #3), the		Each client's active treatment	
	QIDP (Qualified	d Intellectual Disabilities		program must be integrated,	
	Professional) fa	iled to integrate, coordinate		coordinated and monitored by	a
	and monitor the	clients' program plans by		qualified mental retardation	
	failing to monite	or the clients' progress on		professional. Specifically the	+ +h -
	their training ob	jectives for 12 of 12 months		governing body will assure tha QIDP will complete ISP summa	
	during the past	year.		for the past quarter that includ	
	Findings include	e:		analysis of progression and regression on prioritized learni objectives. Moving forward, th	e
	1. Client #1's re	cord was reviewed on		QIDP will turn in copies of mor ISP summaries to the QIDP	ntniy
	11/16/17 at 10:1	4 AM. Client #1's ISP		Manager no later than the seve	enth
	(Individualized	Support Plan) dated 3/28/17		calendar day of each month fo	
		#1 had formal training		review and guidance. Additionates the OIDP will turn in guarterly	-
		lygiene, housekeeping,		the QIDP will turn in quarterly summaries to the QIDP Manag	
	-	ion oral, cooking and		for review prior to scheduled	
		Client #1's ISP did not		quarterly meetings. Failure to	
		ntation the QIDP reviewed,		complete monthly and quarter	-
		and monitored his		analysis of progression/regress	
				of progress on ISP objectives v	
		raining objectives for 12 of		result in progressive performant action. A review of facility	
		October 2016 to October		documentation indicated this	
	2017.			deficient practice affected all	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/22/2017		
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT				8044 D	ADDRESS, CITY, STATE, ZIP COD ARTMOUTH RD JAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	e RIATE	(X5) COMPLETION DATE
	11/15/17 at 10:4 dated 10/9/17 in training objective money, medicate up shirts and state did not containe reviewed, revised his individualize	cord was reviewed on 40 AM. Client #2's ISP ndicated client #2 had formal wes for: adaptive behavior, tion, eating slowly, hanging aying on task. Client #2's ISP documentation the QIDP ed, updated and monitored ed training objectives for 12 om October 2016 to			clients. PREVENTION: The QIDP has been retrained regarding the need analyze progression and regression on prioritized learning objectives a make appropriate modifications and revisions.		
	3. Client #3's re 11/16/17 at 9:42 2/16/17 indicate training objective shower, cooking Client #1's ISP documentation updated and mod	the QIDP reviewed, revised, onitored his individualized wes for 12 of 12 months from			Members of the Operations Ter (comprised of the Operations Managers, Program Managers, Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Manage will incorporate chart reviews of goal data and QIDP summaries into their formal audit process, which will occur no less than to monthly to assure that prioritiz learning objectives are analyze and revised as required.	er) of s wice red	
	12:37 PM. QID documentation for October 201 #1 stated, "No I indicated the fac	terviewed on 11/15/17 at P #1 was asked if he had of QIDP monthly summaries 6 to October 2017. QIDP do not." QIDP #1 cility did not have the QIDP reviewed, revised,			RESPONSIBLE PARTIES: Area Supervisor, Residential Manager, Direct Support Sta Operations Team, Regional Director	l	

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER 15G627	A. BUILDING <u>00</u> B. WING		COMPLETED 11/22/2017	
	PROVIDER OR SUPPLIE		8044 D	ADDRESS, CITY, STATE, ZIP COD DARTMOUTH RD NAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION zed training objectives for 12	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE (X5) COMPLETION DATE	
	of 12 months fr October 2017. 9-3-3(a)	om October 2016 to				
V 0312 Bldg. 00	behavior must be part of the client's is directed specif of and eventual of for which the dru Based on record of 3 sampled cl failed to ensure active treatmen reduction to red and #3's need for medications for behavior. Findings includ 1. Client #1's re 11/16/17 at 10: Physician's Ord 11/30/17 indica	I review and interview for 2 ients (#1 and #3), the facility clients #1 and #3 had an t program with a plan of luce or eliminate client #1 or the use of psychotropic the management of their	W 0312	<b>CORRECTION:</b> <i>Drugs used for control of</i> <i>inappropriate behavior must be</i> <i>used only as an integral part of t</i> <i>client's individual program plan</i> <i>that is directed specifically towar</i> <i>the reduction of and eventual</i> <i>elimination of the behaviors for</i> <i>which the drugs are employed.</i> Specifically the QIDP will incorporate the use of Aptensio into client #1's Behavior Support Plan and will develop a desensitization plan to reduce an eventually eliminate client #3's need for sedation prior to dental procedures. A review of facility support documents indicated tha this deficient practice did not afferences.	rds : id	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	(X2) MULTI A. BUILD B. WING		onstruction 00	(X3) DATE SURVEY COMPLETED 11/22/2017	
NAME OF PROVIDER OR SUPPLIER			80	044 D	ADDRESS, CITY, STATE, ZIP COD DARTMOUTH RD NAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	Disorder) 50 m (ADHD) 54 mg	g (milligrams) and Concerta					
	Client #1's reco documentation program, or BS with a plan of r eliminate the no Aptensio 50 mg management of 2. Client #3's re 11/16/17 at 9:4 Physician's Ord 11/30/17 indica following psych	rd did not indicate of an active treatment P (Behavior Support Plan) eduction to reduce or eed for client #1 to receive g and Concerta 54 mg for This behavior. Excord was reviewed on 2 AM. Client #3's lers dated 11/1/17 to ted client #3 took the notropic medications: 0 10 mg Give one tablet by ne hour prior to Dental Appt			PERVENTION: The QIDP has been retrained regarding the need to assure th active treatment programs are place to support the reduction eventual elimination of all curre prescribed psychotropic medications and that the use of behavior controlling medication incorporated into clients' behave 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	in and ently f all is is vior	
	documentation program, or BS reduce or elimi receive Diazepa behavior. QIDPM (Quali Professional M on 11/16/17 at asked if the fac	rd did not indicate of an active treatment P with a plan of reduction to nate the need for client #3 to am for management of his fied Intellectual Disabilities anager #1) was interviewed 12:47 PM. QIDPM #1 was ility had documentation of a action plan for client #1's			Quality Assurance Coordinators and QIDP Manager) will incorporate audits of support documents into visits to the fac weekly until the QIDP demonstrates competence. At a conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regiona Director (area manager) will determine the level of ongoing support needed at the facility. These ongoing administrative documentation reviews will incl a review of facility Behavior	tility the	

Event ID: QLOO11 Facility ID: 001189

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 15G627	A. BUILDING <u>00</u> B. WING		COMPLETED 11/22/2017	
	ROVIDER OR SUPPLIE		8044 E	ADDRESS, CITY, STATE, ZIP COD DARTMOUTH RD NAPOLIS, IN 46260		
(X4) ID PREFIX TAG	JNITY ALTERNATIVES-ADEPT SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) Support Plans no less than twide monthly and to assure the plan include active treatment progra designed to reduce and eventue eliminate the use of behavior controlling medications. <b>RESPONSIBLE PARTIES:</b> QI Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	DATE DATE	
Bidg. 00 T s I I I I I I I I	services in accor Based on record of 3 sampled cli- nursing services health/nursing r the need to ensu orders were cor documented cli- procedure) care Administration Findings includ	provide clients with nursing dance with their needs. I review and interview for 1 ents (#2), the facility's failed to meet the needs of client #2 regarding are client #2's medication rect and to ensure staff ent #2's colostomy (surgical on his MAR (Medication Record). e: cord was reviewed on	W 0331	CORRECTION: The facility must provide client with nursing services in accordance with their needs.Specifically: the facility nurse has corrected client #2's medication order for lorazepan and added colostomy care to c #2's Medication and Treatment Administration Record. A review medical documentation indicate this deficient practice did not a additional clients. PERVENTION:	n lient t w of ed	
	-Client #2's Phy	sicians Orders dated		The Nurse Manager will provide	e	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627		ILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2017	
	PROVIDER OR SUPPLIE		_	8044 D	ADDRESS, CITY, STATE, ZIP COD ARTMOUTH RD IAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
		anxiety) 0.5 mg (milligram) =0.25 mg) three times daily			direct oversight of the facility nurse to assure physician's or are transcribed as written and all necessary treatments are included in the MAR.		
	dated 11/1/17 to #2's current phy client #2 to rece three times daily -Client #2's MA 11/30/17 indica 0.5 mg (milligra three times daily Order Changed A review of clie to 11/30/17 indi receiving Loraz daily. The revie been changed an documenting/ac Lorazepam 0.25 -Client #2's Phy Needed) Medica dated 11/1/17 to "9/9/17 Loraz	R dated 11/1/17 to ted, "Lorazepam (anxiety) am) Give one-half (=0.25 mg) y for anxiety and behaviors			Members of the Operations Tec (comprised of the Executive Director, Operations Managers Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger a Registered Nurse) will review facility support documents and reviews of the facility medical records no less than weekly u all staff demonstrate compete At the conclusion of this perio intensive administrative monit and support, the Operations T will determine the level of ong support needed at the facility, which will occur no less than to monthly. Administrative suppor the home will include assuring medical following including bu limited to assuring physician's orders are transcribed as writt and that all necessary treatme are included in the MAR.	s, ind d ntil nce. d of coring feam going feam going twice ort at fut not ten ents pIDP, m,	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	(x2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/22/2017	
	PROVIDER OR SUPPLIE		8044 E	ADDRESS, CITY, STATE, ZIP COD DARTMOUTH RD NAPOLIS, IN 46260	)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	(X5) COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION ent #2's Physician's Orders	TAG	Team, Regional Director		DATE
	PRN Medicatio 11/1/17 to 11/30 order for Loraze PRN medication 9/9/17. Nurse #1 was in 1:07 PM. Nurse order to discont Lorazepam 0.25 #1 stated, "Whe from the facility (Lorazepam) ha Nurse #1 was as client #2's PCP	n Information record dated D/17 indicated client #2's epam was documented as a n with an order start date of nterviewed on 11/16/17 at #1 was asked if she had an inue/change client #2's 5 mg to a PRN order. Nurse on he (client #2) came back 7 (Nursing Facility) it d been changed to PRN." sked if she had contacted (Primary Care Physician) to ent #2's PCP wanted to				
	times per day. N not."	azepam 0.25 mg to three Jurse #1 stated, "No I did cord was reviewed on 40 AM.				
	Risk Health Pla "Ostomy (Surgi between the into wall) Care Plan Ostomy Bag wi not adhering to	RHP (Comprehensive High n) not dated indicated, cally created opening estines and the abdominal 3. Changing Ostomy Unit: Il need to be changed if it is [client #2's] skin, or and as listed on MAR.				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

	MEDICARE & MEDIC				OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15G627	B. WING		11/22/2017
	ROVIDER OR SUPPLIEF		8044 D.	ADDRESS, CITY, STATE, ZIP COD ARTMOUTH RD IAPOLIS, IN 46260	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETIO
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Steps to change	ostomy: also see			
	documentation in	n MAR".			
	-A review of clie	ent #2's CHRHP, not dated,			
		#2's ostomy care instructions			
	were listed on hi	•			
	Client #2's MAR	t dated 11/1/17 to			
		indicate documentation of			
	Ostomy care/ins				
	Nurse #1 was in	terviewed on 11/16/17 at			
		#1 indicated client #2's			
		tructions were not			
		client #2's MAR. Nurse #1			
		n't an order on the MAR.			
	-	change it when they see fit. I			
		it would be helpful to			
		•			
	document when	they change it."			
	9-3-6(a)				
	9-3-0(a)				
/ 0368	483.460(k)(1)				
	DRUG ADMINIST	RATION			
Bldg. 00	The system for dr	ug administration must			
		gs are administered in			
		ne physician's orders.	W 0368	CORRECTION:	12/22/20
		review and interview for 1	W 0308		12/22/201
	-	ents (#1), the facility failed		The system for drug	
	to ensure client #	#1 received his medications		administration must assure that	all

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	(X2) MULTIPL A. BUILDING B. WING	<u></u>		(X3) DATE SURVEY COMPLETED 11/22/2017	
	PROVIDER OR SUPPLIE		804	eet address, city, state, zip c 4 DARTMOUTH RD IANAPOLIS, IN 46260	OD		
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIEVING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION	
TAG	as ordered by the Findings includ The facility's B1 Developmental and investigation 11/14/17 at 1:00 A BDDS report on 10/28/17, " 10/28/17, the A discovered that Medicaid prior (medication refin received his phy (Attention Define 50 mg (milligrat 54 mg since 10/ -A review of the 10/29/17 indica his prescribed m and Concerta 54 10/29/17. Client #1's reco 11/16/17 at 10:1	e: DDS (Bureau of Disabilities Services) reports ons were reviewed on D PM. dated 10/29/17 indicated .During an audit on rea Supervisor (#1) due to a delay in receiving approval for refills ills), [client #1] had not visician prescribed Aptensio cit Hyperactivity Disorder) ms) and Concerta (ADHD) /26/17". e BDDS report dated ted client #1 did not receive nedications Aptensio 50 mg 4 mg from 10/26/17 through	TAG	drugs are administered if         compliance with the phy         orders. Specifically, all fa         and supervisors will be re         to work with the facility of         re-order medication with         time to obtain Medicaid of         approval before the curre         medication supply runs of         .         PREVENTION:         The Residential Manager         present, supervising active         treatment during no less         active treatment sessions         week, on varied shifts to         with and monitor skills tr         including but not limited         assuring medications are         and administered as order         Area Supervisor will be p         the facility observing the         provision of skills training         documentation no less th         weekly.Members of the O         Team comprised of the E         Director, Operations Mar         Program Managers, Qual         Assurance Manager, QID         Manager, Quality Assura         Coordinators, Nurse Man         the QIDP will conduct ob         during active treatment sa         and documentation revise         less than weekly until	in sician's icility staff etrained hurse sufficient prior ent but. will be ve than five s per assist raining to available ered. The resent at staff's g and han Operations executive hagers, lity ip nce ager and servations sessions wys no aff	DATE	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLL ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G627				(X3) DATE SURVEY COMPLETED 11/22/2017
	PROVIDER OR SUPPLIE		8044 D	ADDRESS, CITY, STATE, ZIP CO VARTMOUTH RD JAPOLIS, IN 46260	D
COMMU (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE) REGULATORY O (Extended Rele MGMethylph (Extended Rele A review of clid dated 11/1/17 to #1 had current p Aptensio 50 mg Nurse #1 was in 1:07 PM. Nurse had received his 50 mg and Cond the physician fr 10/29/17. Nurse waiting for a pr	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ase) Cap (capsule) 50 enid (Concerta) 54 MG ER	INDIAN ID PREFIX TAG	PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) intensive administrative m and support, the Executive will determine the level of support needed at the fac which will occur no less th monthly. Active Treatmen sessions to be monitored a defined as: Mornings: Beginning at 6: and through morning tran and including the following Medication administration, preparation and breakfast morning hygiene and dom skills training through tran work and day service. Mon active treatment monitorin include staff from both the	DULD BE PROPRIATE     COMPLET       DATE     DATE       nonitoring     E       e Director     Forgoing       illity,     nan twice       t     are       30 AM     sport       g:     , meal       ;     nestic       nsport to     rning       ng will     Image: Image and the sport to
	medications Ap	received his prescription tensio 50 mg and Concerta ed by the physician.		overnight shifts. Evenings: Beginning at approximately 4:30 PM the the evening meal and inclu- following: domestic and he skills training, leisure skills training, medication administration, meal preparand dinner. Evening monit will also include unannour checks later in the evening bed time.	uding the ygiene aration toring need spot g toward

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	(X2) MULTIPLE ( A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/22/2017	
NAME OF	PROVIDER OR SUPPLIE	R		TADDRESS, CITY, STATE, ZIP COD	
COMMU	NITY ALTERNATI	/ES-ADEPT		DARTMOUTH RD NAPOLIS, IN 46260	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLET
TAG		R LSC IDENTIFYING INFORMATION	TAG	observations, Operations Tea         Members and/or the Resident         Manager will perform spot ch         at varied times on the overning         shift no less than twice month         -more frequently if training is         or problems are discovered.         The Executive Director and         Director of Operations/Region         Manager (area manager) will         review documentation of         administrative level monitorin         the facility –making         recommendations as appropriate direct         administrative monitoring of the facility. Administrative suppor         As stated above, the Executive         Director will participate direct         administrative monitoring of the home will include assuring         staff administer medications         without error. Administrative         oversight will include assuring         medications are available and         administered as ordered.	tial ecks ght hly ssues hal g of iate. re ly in the t at g
W 0440 Bldg. 00		RILLS hold evacuation drills at r each shift of personnel.		Manager, facility nurse, Direc Support Staff, Operations Tea	

AND PLAN OF CORRECTION IDENTI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/22/2017	
	PROVIDER OR SUPPLIE			8044 D	ADDRESS, CITY, STATE, ZIP COD DARTMOUTH RD JAPOLIS, IN 46260		
	T						(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(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:		W	)440	<b>CORRECTION:</b> 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.	:he	12/22/2017
	reviewed on 11/ review did not i fire evacuation of 7:00 AM to 3:00 quarter of 2017 for clients #1, # review did not i fire evacuation of 3:00 PM to 11:0 PM to 7:00 AM of 2017 (April, #2, #3, #4, #5 an indicate docume drill being cond 3:00 PM shift an AM shift for the 2016/2017 (Oct December) for of and #6.	re evacuation drills were (16/17 at 10:20 AM. The ndicate documentation of a drill being conducted on the 0 PM shift for the first (January, February, March) 2, #3, #4, #5 and #6. The ndicate documentation of a drill being conducted on the 00 PM shift and the 11:00 shift for the second quarter May, June) for clients #1, nd #6. The review did not entation of a fire evacuation ucted on the 7:00 AM to nd the 11:00 PM to 7:00 e fourth quarter of ober, November, clients #1, #2, #3, #4, #5 Need Intellectual Disabilities mager #1) was interviewed 12:47 PM. QIDPM #1			PREVENTION: Professional staff will be retrain 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 a follow up with professional staff needed to assure drills occur as scheduled. Program Manager w track evacuation drill compliance and follow up with facility professional staff and the agend Safety Committee accordingly. RESPONSIBLE PARTIES: QII Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	or ind as ill e	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				0	MB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G627	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/22/2017			
	JAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8044 DARTMOUTH RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE A COTION SHOUL CROSS-REFERENCED TO THE APPE TAG DEFICIENCY)		D BE	(X5) COMPLETION DATE	
	evacuation drills during every qua indicated he did fire evacuation of 3:00 PM for the 3:00 PM to 11:0 7:00 AM shift fo 2017 and the 7:0	cility should complete fire s for every shift of personnel arter of the year. QIDPM #1 not have documentation of drills for the 7:00 AM to first quarter of 2017, the 00 PM and 11:00 PM to or the second quarter of 00 AM to 3:00 PM shift and 00 AM for the fourth quarter						

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